EPH–International Journal of Humanities and Social Science
Published by: **Southern Cross Academic Press**
ISSN (Online): **2208-2174**
Volume 11 Issue 04 October 2026
DOI:https://doi.org/10.69980/j58ks696

DECODING THE STIGMA-CONSULTATION AXIS: GENDER, AGE, AND EDUCATION AS PREDICTORS OF ISMI-29 AND PROFESSIONAL HELP-SEEKING (ATSPPH-SF) IN INDIA

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ABSTRACT

Mental health challenges have been exacerbated over time in the post covid era and with the increase in smartphone dependency, social media identity crises, gaming addiction, and emerging digital phenomena like AI-induced distress, which collectively heighten psychological vulnerability and suicide risk. In India, epidemiological research demonstrates a wide variation in psychiatric morbidity. Despite this these high-risk individuals frequently exhibit a reluctance to consult mental health professionals. This paper investigates the relationship between mental health stigma and help-seeking behaviors among Indian adults, while examining the mediating influences of gender, age, educational attainment, and prior exposure to mental health concerns.

This paper empirically evaluates the reluctance to seek mental health services in India. A quantitative survey design was conducted with a sample of 250 adults (18–50 years) across the Delhi-NCR region. Following ethical clearance and informed consent, participants completed standardised evaluations using the ISMI-29 and ATSPPH-SF alongside a detailed demographic profile capturing age, gender and educational attainment. The data were analysed using descriptive and inferential statistics. The results confirmed a significant main effect, demonstrating that internalised stigma accounts for substantial variance in professional consultation inclinations. Educational attainment emerged as a fundamental dismantling mechanism against public stigma, whereas age and economic resources moderated the internalization of cultural shame and self-stigma.

Article History:

Article Type: **Research**

Received Date: **18/16/2026**
Revised Date: **22/09/2026**
Accepted Date: **05/10/2026**
Published Date **28/10/2026**

Keywords: Stigma, help-seeking behaviour, mental health, mental illness.

1. Introduction

In modern society, mental health concerns are escalating in both prevalence and complexity, driven in part by technology-induced challenges such as smartphone addiction, digital identity crises, problematic gaming, and AI-related psychological distress that elevate self-harm risk. Mental health is defined by the World Health Organisation (WHO) as a "state of subjective well-being in which an individual realises their own abilities, copes with the normal stressors of life, works productively and fruitfully, and can make a contribution to their community" (George, N. et al. 2022).

Epidemiological data from India reflect this growing burden, with psychiatric disorder prevalence rates spanning from 9.5 to 370 per 1,000 people (Gururaj & Isaac, 2004; Reddy & Chandrasekar, 1998). A critical bottleneck in mitigating this crisis is that vulnerable individuals consistently hesitate to seek professional care, creating a profound treatment gap of 70% to 92% across the nation that threatens long-term well-being and economic potential. According to the National Mental Health Survey (NMHS) of India, the overall weighted prevalence of psychiatric morbidity stands at 13.7% for lifetime occurrences and 10.6% for active, current conditions (Gururaj et al., 2016). These epidemiological metrics indicate that approximately one in seven individuals in India will experience a mental health condition over the course of their lifetime (Murthy, 2017; National Institute of Mental Health and Neuro Sciences (NIMHANS, 2016). Addressing this intervention deficit requires a deeper understanding of attitudinal and structural barriers. Accordingly, this study examines how stigma influences help-seeking inclinations among Indian adults, evaluating the specific roles of gender disparities, age gradients, educational levels, and personal history of mental health exposure.

The treatment gap reflects the vast disparity between the proportion of individuals experiencing mental morbidity and those who actually access evidence-based psychiatric care. Help-seeking behavior functions as the primary adaptive coping process that bridges this divide by translating recognized psychological distress into active engagement with healthcare providers or supportive social networks. (Math, S. B., & Srinivasaraju, R. 2010). When demand-side barriers such as public prejudice, self-stigma, and help negation disrupt this coping process, the intention-behavior gap widens, leaving the majority of affected individuals untreated. Addressing India's severe treatment gap therefore requires transforming public attitudes to support help-seeking as a normative, adaptive coping strategy rather than a sign of personal or familial weakness (Sanghvi, P. B., & Mehrotra, S. (2022).

1.2 Stigma in mental illness

Mental health stigma is a complex, multidimensional sociocultural phenomenon conceptualized by Goffman (1963) as a deeply discrediting attribute that reduces an individual to a spoiled social identity. It operates across a tripartite framework encompassing knowledge deficits (ignorance), negative emotional attitudes (prejudice), and discriminatory actions (behavioral avoidance) (Thornicroft et al., 2007). Stigma manifests primarily as public stigma societal endorsement of negative stereotypes and devaluation and internalized self-stigma, wherein individuals absorb public prejudices, resulting in diminished self-efficacy, pervasive shame, and social withdrawal (Corrigan & Watson, 2002; Ritsher et al., 2003). In collectivistic settings, this extends to familial or courtesy stigma, where mental illness is viewed as a collective lineage stain that threatens marriage prospects and social standing (Livingston & Boyd, 2010). Psychometric evaluation of these constructs relies heavily on gold-standard instruments, such as the Community Attitudes to Mental Illness (CAMI) scale (Taylor & Dear, 1981) to assess public tolerance and social restrictiveness, and the Internalized Stigma of Mental Illness (ISMI) scale

(Ritsher et al., 2003; Boyd et al., 2014; Hammer & Toland, 2016) to quantify self-stigma. Crucially, both public prejudice and internalized devaluation act as formidable demand-side barriers to healthcare utilization (Corrigan, 2004; Clement et al., 2015), exacerbating "help negation"—the active avoidance of clinical care—and driving the substantial treatment gap observed across healthcare systems.

1.3 Help-Seeking Behaviour

Mental health help-seeking represents an adaptive coping mechanism through which an individual transforms a personal experience of psychological distress into interpersonal engagement to receive support. (Rickwood et al., 2005). This process requires recognising the need for care, expressing distress to others, identifying appropriate resources, and actively drawing upon formal or informal support systems. While help sources span both formal clinical services (psychiatrists, psychologists, primary physicians) and informal networks (relatives, peers, and faith healers), individual pathways are heavily moderated by mental health literacy, prior experiences, perceived stigma, and cultural aetiology beliefs. Epidemiological and community studies reveal a pronounced underutilization of formal psychiatric services, particularly in rural populations where initial help-seeking is heavily skewed toward traditional and faith-based healers due to widespread stigma, financial constraints, and localised health beliefs.

1.4 Treatment Gap in India

The treatment gap for mental disorders in India remains substantial despite decades of policy attention. The National Mental Health Survey (NMHS) dataset have shown that the treatment gap is even higher among specific groups, such as older adults, for whom the overall treatment gap has been estimated at 84%, rising to over 90% for severe mental disorders (Gururaj et al., 2016).Community attitudes and stigma are widely regarded as key contributors to this persistent gap, since they shape whether a person experiencing distress ever moves from private suffering to seeking formal, professional help-seeking behaviour is central to closing the treatment gap in India.

1.5 Present Challenges towards the Treatment Gap

There are many challenges in mental health care services and inclination towards seeking help. Major challenges are Attitude towards mental illness, personal barriers, Insufficient Supply and Infrastructure Barriers in seeking help for mental health concerns. Mental health services are inadequately integrated into primary healthcare frameworks. Primary care personnel often lack the specialised training or standardised screening tools required to detect psychiatric conditions early, leading to missed diagnoses and delayed referrals. Pervasive Stigma and Derogatory Labelling is one of important concerns in mental health and seeking help. Anticipated discrimination and internalized self-stigma force individuals into social withdrawal. Patients frequently face derogatory labelling (such as “Paagal”. “Aalsi”) from family, friends, or colleagues, leading to shame and treatment avoidance.

Superstitious Causal Attributions and Faith Healing is a concern. Misattributing mental illness to supernatural forces, black magic, evil spirits, karma, or a lack of self-discipline remains widespread (such as “Devi Anana”, “kala jadu”, “uperi”. Consequently, families frequently consult traditional faith healers like “jhaar fua”, “baba”, “tantarik”, etc as their first contact, undergoing multiple informal transitions before seeking evidence-based psychiatric care (Kulkarni, K. S., et al., 2023).

The “Marriage Filter” and Collective Family Honour play an important role in decision-making about seeking help with respect to mental health discomfort. In collectivistic structures, mental

illness is perceived as a collective family stain rather than an individual health issue. Families often conceal symptoms and reject marriage proposals associated with affected lineages due to fears of genetic inheritance, prioritising secrecy over clinical care (Raghavan et al., 2023).
Distress Normalisation and Help Negation: Distressed individuals, particularly young adults, frequently normalise psychological distress as a temporary life phase or personal weakness. This fuels an excessive preference for exclusive self-reliance (help negation), actively suppressing consultation inclinations (Vogel, D. L., et al., 2009; Santini, Z. I., et al., 2020).
Gender-Specific Vulnerabilities also play an important role in heightened vulnerability and low autonomy levels. In India, women experience a two- to three-times greater risk of developing common mental disorders (such as depression and anxiety) due to systemic gender disadvantage, domestic violence, low decision-making autonomy, and limited family support. Gender-related biases further compound internalized devaluation, alienation, and social withdrawal, creating substantial barriers to seeking care (Reddy, P. V. (2017).

Review Literature

The empirical literature evaluating the Internalized Stigma of Mental Illness (ISMI) scale and its impact on help-seeking behavior reflects a robust synthesis of psychometric development, psychological correlates, and clinical barriers across diverse populations. Ritsher et al. (2003) originally validated the 29-item ISMI scale (alpha = .90) across five subscales, though initial exploratory factor analysis was constrained by a small sample size (N = 127); subsequent scale-reduction efforts by Boyd et al. (2014) established the 10-item brief form (ISMI-10), which retained strong convergent validity (r = .94) with the full scale despite psychometric instability in two-item subscales. Addressing factor structure and respondent burden, Hammer and Toland (2016) utilised bifactor modelling to demonstrate that a single dominant general factor accounts for 92% of reliable total score variance, justifying a univocal scoring approach and engineered the 9-item unidimensional ISMI-9 (alpha = .86), though generalizability remains limited by sample homogeneity.
Livingston and Boyd (2010) established through a systematic meta-analysis of 127 studies that self-stigma strongly correlates with heightened depression severity (r = .53) alongside substantial reductions in self-esteem (r = -.64) and recovery orientation, while Vogel, Wade, and Haake (2006) and Tucker et al. (2013) demonstrated that self-stigma attached specifically to receiving psychological care operates as a distinct and proximal predictor of treatment avoidance. When individuals internalize public stereotypes, seeking therapy is perceived as a personal failure or sign of weakness, leading directly to negative help-seeking inclinations.
In collectivistic cultures, mental health stigma extends beyond the individual to the family unit, where mental illness is often viewed as a stain on lineage that threatens marriage prospects and family honour. Families often use traditional faith healers as an initial resort, undergoing multiple informal transitions before seeking biomedical psychiatric care (Sanghvi & Mehrotra, 2022; Raghavan et al., 2023). Path analysis among non-treatment-seeking distressed young adults revealed that while help negation directly inhibits consultation (p = .039), encouragement from significant others acts as a powerful moderating mechanism (p = .008) that buffers against self-stigma and facilitates formal help-seeking behavior (Sanghvi et al., 2025).
According to Clement et al., 2015 comprehensive meta-analysis of 144 quantitative and qualitative studies confirmed a consistent, negative association between stigma and help-seeking across diverse cohorts. Stigma, specifically self-stigma and fear of disclosure or judgment, ranked among the top reported barriers to care, disproportionately deterring vulnerable groups such as men, ethnic minorities, and young adults. Empirical synthesis demonstrates that stigma impedes healthcare participation across three distinct levels public stigma a fear of societal judgment and discrimination, self-stigma define a diminished self-esteem and self-efficacy, and

institutional stigma is a systemic underfunding and restrictive care policies (Corrigan, Druss, & Perlick, 2014) and Schnyder et al. (2017) confirm that personal stigmatizing attitudes and self-stigma significantly suppress active clinical consultation with Sum et al. (2024) highlighting that stigma acts as a critical bottleneck specifically for individuals experiencing clinically significant depressive symptoms. Finally, in collectivistic contexts like India, Sanghvi et al. (2022, 2025) identified self-stigma as self-labelling and help negation as directly impeding consultation; encouragement from significant others serves as a powerful moderating buffer ($p = .008$) that facilitates formal care seeking, to adopt help negation an active avoidance or refusal of clinical services driven by intense self-reliance and fear of being labelled mentally ill (Link et al., 1989).

Methodology

3.1 Aim

This paper investigates the relationship between stigma towards help-seeking behaviour among Indian adults, while examining the influence of socio-demographic factors.

3.2 Objectives:

- To evaluate the stigma toward mental illness impact on inclinations toward seeking professional mental health care.
- To examine the difference in stigma towards mental illness across socio-demographic categories like age, gender, and education attainment.
- To examine the difference in attitude towards professional help-seeking across socio-demographic categories like age, gender, and education attainment.

3.3 Hypothesis:

- Ha1 There are significant impacts of stigma toward mental illness on individuals toward inclination to seek professional mental health care.
- H02 There are no significant differences in stigma towards mental illness and help-seeking inclinations across age groups (young vs middle age).
- Ha3 There are significant differences in stigma towards mental illness and attitude towards help-seeking inclinations across gender.
- H04 There are no statistically significant differences in stigma towards mental illness and attitude towards help-seeking inclinations across education attainment.

4. Research Design

This study employed a survey research design, which involves collecting information from a sample of individuals through structured questions. A sample of 18- to 50-year-olds was randomly drawn from the Delhi-NCR region. A sample of $N = 250$ (male and female) adults between the ages of 18 and 50 years of age. Those individuals who agreed to participate willingly were included in the study, except for those who are currently undergoing psychiatric treatment. In this study the tools and measurement used Attitude towards Seeking Professional Help Scale-Short Version (ATSPPH-SF; Fischer & Farina, 1995) and Internalized Stigma of Mental Illness (ISMI-29; Ritsher J. B., 2003).

5. Procedures

The data were collected from adults after obtaining informed consent from each individual. Participation in this research is entirely voluntary. All responses were treated with strict confidentiality, and no personally information will be revealed. It's quantitative research where variables are measured and analyzed using statistical procedures. All the questionnaires were scored individually with the help of the scoring key, and data were computed using SPSS

software (version 23). Data were analysed using descriptive statistics and inferential statistics.

6. Result and Discussion

The data for this study were collected from a sample size of 250 (male and female) adults between the ages of 18 to 50 years of age. The findings are organized to provide a clear overview of the descriptive and inferential statistics. The study identifies the significant patterns observed within the sample and how it can be analysed to predict the tendency of other Indian adults.

The following Table 1, results of analysis of variance between the self stigma towards mental illness and attitude towards seeking professional help that clearly state the F ratio as 1.586, which is significance at 0.00 level which means that the attitude towards mental illness impacts on inclination towards professional help (p=0.008). A one-way analysis of variance (one way ANOVA) explains whether community attitudes toward mental illness, measured using the ISMI, impact on attitudes toward seeking professional help, measured using the ATSPPH-SF-10. The significance value (p = .008) is well below the standard alpha threshold (alpha = .05), the null hypothesis is rejected, that means selfstigma directly impacts and predicts individual inclinations toward professional psychological care. The researchers highlighted the educational status as the primary driver of mental health literacy, reduced community stigma, and positive help-seeking behaviors.

Table 1 One way analysis of variance (ANOVA) ISMI-29 and Attitude towards Seeking Professional Help -10 (ATSPPH-SF)

	SS	df	MS	F	Sig.
Between Groups	2580.612	71	36.347	1.586	.008
Within Groups	4079.613	178	22.919		
Total	6660.224	249			

Note. SS = Sum of Squares; df = degrees of freedom; MS = Mean Square; p= .00

Individuals absorb societal prejudice and negative stereotypes, they experience diminished self-esteem, self-worth, and heightened shame. This internalized devaluation directly generates negative attitudes toward professional help, giving rise to help negation to avoid the professional services despite psychological distress. Similar research, expressed the negative help-seeking attitudes and personal stigmatizing attitudes significantly reduce active professional consultation (Schnyder et al. 2017) Clement et al. (2015) and Corrigan, Druss, & Perlick (2014) confirmed across extensive systematic reviews that self-stigma and fear of disclosure rank among the most formidable demand-side barriers to active healthcare utilization.

The following Table 2 shows the descriptive statistics of age, gender and education towards stigma and help seeking attitude towards mental illness. Table 2.1 clearly state that young adult has less stigma than middle and lesser help seeking behaviour as compare to middle age. Table 2.2 clearly state that female participants show less stigma than male and more help seeking behaviour as compare to male participants. Table 2.3 clearly state that Ph. D and higher education participants show less stigma than senior secondary and more help seeking behaviour as compare to senior secondary.

Table 2.1

Gender		N	Mean	Std. Deviation	Std. Error Mean
ISMI-29	Male	138	2.35	0.657	0.056
	Female	112	2.44	0.674	0.064
ATSPPH-SF	Male	138	16.62	4.791	0.408
	Female	112	20.04	5.012	0.474

Shows the descriptive statistics of Young and Middle towards Institutional stigma mental illness (ISMI-29) and Attitude towards Seeking Professional Help -10 (ATSPPH-SF)

Table 2.2

Shows the descriptive statistics of Male and Female towards Institutional stigma mental illness (ISMI-29) and Attitude towards Seeking Professional Help -10 (ATSPPH-SF)

Gender		N	Mean	Std. Deviation	Std. Error Mean
ISMI-29	Male	138	2.35	0.657	0.056
	Female	112	2.44	0.674	0.064
ATSPPH-SF	Male	138	16.62	4.791	0.408
	Female	112	20.04	5.012	0.474

T

able 2.3

Shows the descriptive statistics of Education towards Institutional Stigma of Mental Illness (ISMI-29) and Attitude towards Seeking Professional Help -10 (ATSPPH-SF)

Education		N	Mean	Std. Deviation	Std. Error Mean
ISMI-29	Senior Secondary	55	2.75	.337	.045
	Ph. D & Other	8	2.47	.717	.253
ATSPPH-SF	Senior Secondary	55	14.62	4.143	.559
	Ph. D & Other	8	20.63	3.926	1.388

Table 3. Socio-demographic variables like Age, gender and education function as pivotal factors that influence mental health literacy, stigma levels, and help-seeking behaviors. Age exhibits a significant positive correlation with help-seeking ($r = .330$, $p < .001$) and a strong positive relationship with education ($r = .644$, $p < .001$), while its direct correlation with stigma non-significant ($r = .066$, $p = .299$), where age-related effects on stigma vary depending on cultural context, literacy levels, and traditional social norms. The null hypothesis is rejected, as age act as a predictor towards help seeking behaviour whereas age plays no impact on stigma thus accepting the null hypothesis. Gender displays no direct correlation with stigma ($r = -.017$, $p = .787$) or help-seeking ($r = .004$, $p = .948$) in this dataset, aligning with studies indicating that gender alone does not directly dictate professional consultation when controlling for proximal psychological mechanisms or broader structural factors, even though females frequently

demonstrate higher literacy or lower prejudice in specific community cohorts. The null hypothesis is accepted, as gender has no impact on stigma or help-seeking behaviors. Finally, education is the strongest predictor of help-seeking ($r = .389$, $p < .001$) and shows a significant negative correlation with stigma ($r = -.173$, $p = .006$), confirming empirical findings that higher educational attainment increases mental health knowledge while reducing public and personal stigma. Thus, the null hypothesis is rejected.

Table 3.
Shows the Pearson correlation between Stigma, help-seeking, age, Education, and Gender.

		Stigma	**Help-Seeking**	**Age**	**Education**	**Gender**
Stigma	Pearson Correlation	1	-.192**	.066	-.173**	-.017
	Sig. (2-tailed)		.002	.299	.006	.787
Help-Seeking	Pearson Correlation	-.192**	1	.330**	.389**	.004
	Sig. (2-tailed)	.002		.000	.000	.948
Age	Pearson Correlation	.066	.330**	1	.644**	-.192**
	Sig. (2-tailed)	.299	.000		.000	.002
Education	Pearson Correlation	-.173**	.389**	.644**	1	-.169**
	Sig. (2-tailed)	.006	.000	.000		.007
Gender	Pearson Correlation	-.017	.004	-.192**	-.169**	1
	Sig. (2-tailed)	.787	.948	.002	.007	
	N	250	250	250	250	250
**. Correlation is significant at the 0.01 level (2-tailed).						

The findings indicate that socio-demographic factors including age, gender, education do not function as direct, isolated determinants of help-seeking behavior. Instead, their influence is mediated through the individual's perception framed by the community attitude and the degree to

which an individual internalizes cultural shame. Among the socio-demographic variables evaluated, educational attainment emerged as the primary factor for dismantling attitudinal barriers. Higher educational levels correlate strongly with enhanced mental health literacy, reduced authoritarian and restrictive views, and greater willingness to engage with formal clinical care. Education plays a strong predictor for reduce stigma and reduce in reluctance towards seeking professional help. Conversely, variables such as age and gender vulnerability interact with deep-seated cultural beliefs such as perceived family dishonour, gender norms, and reliance on informal or spiritual healers shaping how internalized devaluation is experienced and expressed. Similar study by Tanabe et al. (2016) stated that age-related variation in stigmatizing attitudes depends heavily on contextual factors such as cultural literacy, traditional social norms, and personal contact with individuals with mental illness.

Help-seeking behavior is governed by proximal psychological factors such as help-seeking inclination, help negation, and encouragement from significant others rather than distal demographic variables like gender (Sanghvi et al. 2025). By framing help-seeking as an adaptive coping process that unfolds from symptom appraisal to active professional consultation, this study shows how internalised self-stigma disrupts this sequence, giving rise to distress normalisation, help negation, self-reliance and fear of social labelling. In community studies across India, higher educational status among individuals and household decision-makers significantly accelerates professional consultation, whereas lack of education leads individuals to consult traditional faith healers or informal sources (Bitta, M. A., et al. 2022; Sánchez-Iglesias, I. et al., 2026; Shirley, A. 2022). In collectivistic social structures, where personal health decisions are deeply tied to family reputation and social standing, internalised stigma amplifies secrecy and delays biomedical consultation, worsening long-term disability and suicide risk.

Conclusion

Indian adults' primary psychological concerns are suppressed to avoid formal psychological consultation. The Socio-demographic influences are mediated through age, gender and educational literacy. Effectively reducing stigma and closing India's mental health treatment gap demands a comprehensive, policy-driven strategy, culturally grounded sensitization campaigns, incorporating primary mental health care services, expanded specialist capacity, and robust public health funding, health care systems to reduce reluctance towards professional consultation and fostering a sustainable infrastructure for mental well-being, to reduce suicide rates and mental health concerns.

Future Research

Future empirical research will focus on refining mental health help-seeking models by examining the financial, resilience, and religious dimensions of the Indian family. Analysing the burden of out-of-pocket financial strain, assessing family resilience as a protective buffer against internalised stigma, and evaluating the role of religious beliefs and traditional faith healers in pathways to care will yield vital evidence for designing culturally tailored, family-centred anti-stigma interventions.

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