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Mental Health Stigma Among Medical Professionals in Pakistan: Its Role in Shaping Help-Seeking Behaviors

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Abstract

This study explored just how self-stigma as well as perceived stigma relate to the question of whether medical professionals in Pakistan seek help, while it focused on gender plus work setting differences. Researchers employed a cross-sectional correlational design, collecting data through convenience sampling from 150 doctors working in government hospitals, private hospitals, and clinics. By administration of the Self-Stigma of Seeking Help Scale (SSOSH) and the Perceived Stigma and Barriers to Care Scale (PSB-PC), internalized and external stigma were assessed. Findings showed an important positive correlation of perceived stigma with self-stigma for external judgments contribute to internalized shame when people seek psychological support. For male doctors, reported levels of self-stigma were higher than those for females, which differed by gender, too. Doctors at government hospitals demonstrated greatly greater self-stigma compared to those at private clinics. Institutional culture has an influence, as is indicated by the results. The study results show it is vital to fix bias in the medical field. Interventions attentive to gender provide organizational support to normalize medical professionals seeking psychological help.

Keywords: Self-Stigma, Perceived Stigma, Mental Health, Help-Seeking, Doctors, Pakistan.

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Introduction

Medical practitioners (doctors, nurses, and integrated health personnel) work in intense settings where they encounter incessant psychological and emotional strain as a part of day-to-day operations. The continuous onslaught of dealing with crises, working in shifts, and shouldering the emotional load of caring for patients creates mental health problems for them, such as burnout, anxiety, depression, stress disorders, and more. Strikingly, with all their training and available health services, many practitioners resist getting help during times of psychological distress. Stigma is one such barrier, and without question, it is one of the more persistent and more damaging forms of help-seeking barriers in medicine (Corrigan et al., 2014; Schulze, 2007).

Stigma has two sides, internal and external. Self-stigma includes internalized shame and feelings of unworthiness and inadequacy for needing to seek help, and perceived stigma refers to fear of being judged by colleagues, superiors, or patients. These forms of stigma often reinforce each other; hence, we see many healthcare providers suffering in silence. The consequences of mental health challenges that are untreated are dire. Research shows links reduced empathy for sufferers, impaired decision making, clinical errors, and decline in overall quality of care being provided stems from these challenges (Clement et al., 2015; Dyrbye et al., 2017).

Mental health conditions represent a significant part of the overall disease burden. As reported by the World Health Organization, over 450 million people suffer from mental illness, which accounts for approximately 14% of the world's health burden (Liu et al., 2004). Healthcare professionals have a particularly alarming rate of psychological distress; some estimates show that close to 25% of healthcare professionals have some form of diagnosable disorder. More disturbingly, female physicians have a greater tendency to commit suicide than women in the general population (Firth-Cozens, 2003; Shanafelt et al., 2011). Despite the alarming statistics, mental health services continue to be avoided due to fears of professional stigma and backlash (Imo, 2017). Stigma itself is a social phenomenon that includes labeling, stereotyping, separation, and discrimination (Link & Phelan, 2001). About the practice of medicine, these elements are exacerbated by organizational settings that admire grit, perfection, and emotional silence. Such an ethos perpetuates the resistance to vulnerability, making it nearly impossible for those experiencing psychological distress to admit it. Consequently, mental health stigma is not only an individual problem but an institutional problem that shapes behavior, attitude, and care access (Garelick, 2012; Knaak et al., 2017).

In countries like Pakistan, the perception of mental illness is further influenced by cultural and spiritual beliefs. Particularly in rural areas, mental illness is viewed as the result of supernatural forces or a form of divine retribution. Among trained healthcare practitioners, such beliefs endure and sometimes supersede the biomedical framework of mental health (Shah et al., 2019). Psychiatrists and psychologists within the population are often viewed as signs of weakness, contributing to the underutilization of psychological services (McCabe & Priebe, 2004). Marked differences in stigma based on gender also stand out. While self-stigma may not markedly change for either sex, female professionals in more conservative societies tend to care more about social judgment and professional reputation. Women are likely to be more reluctant to access support for fear of being labeled as emotionally unstable or unqualified for leadership positions (Haddad et al., 2016; Wijeratne et al., 2021).

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There is also an aspect of professional hierarchy. Junior doctors, who are at the early stages of career development tend to focus on confidentiality, acceptance by peers, and institutional norms. These factors may obscure open dialogue around mental health problems. Senior professionals might be more liberated from these factors and hence more likely to seek help. As with everyone else, these individuals may opt for medication instead of receiving therapy due to differences in generational attitudes towards mental health (Shabbir et al., 2019). Policies at institutions may reinforce stigma by creating new forms of it. For example, health professionals often shy away from seeking help due to the mandatory reporting laws, which require them to report to an impaired practitioner, therefore, making them less likely to receive help (Bismark et al., 2014). Pakistan lacks clear guidelines on confidentiality and is dominated by non-medical healers, which fosters deep-seated suspicion towards mental health systems (Foster et al., 2008).

There are no exceptions to these trends, including mental health practitioners. There is evidence to suggest that psychiatric training does not guarantee the presence of compassion or acceptance. Most psychiatrists isolate themselves emotionally from their patients. This suggests mental health literacy is important, but by itself, does not guarantee the removal of stigma (Oliveira et al., 2020; Yashikhina et al., 2023).

Rationale

This study looks at the stigma around mental health issues, both self-directed and perceived, among medical professionals in Pakistan. This study shows how these views affect people's willingness to ask for help, with a focus on how gender and professional experience play a role. This study intends to fill a major vacuum in the literature by exploring at the specific cultural, institutional, and spiritual factors that define mental health conversations in the country. The study helps to create culturally sensitive interventions that promote mental health and reduce the silent suffering of healthcare personnel by showing how stigma works in the medical field.

Methodology

Objectives

The present study aimed to explore stigma-related beliefs and help-seeking behaviors among medical professionals in Pakistan. The specific objectives were:

a) To assess the prevalence of self-stigma and perceived stigma associated with mental health.
b) To examine how perceived stigma influences self-stigma and subsequently impacts willingness to seek psychological support.
c) To explore work setting differences and gender roles in stigma-related attitudes.

Hypotheses

H1: Higher levels of perceived stigma will be significantly associated with greater self-stigma regarding help-seeking for psychological problems among medical professionals.

H2: Male doctors will report significantly higher levels of self-stigma compared to female doctors.

H3: Perceived stigma and gender will significantly predict barriers to psychological help-seeking, with female doctors reporting more perceived stigma-related barriers.

H4: There will be a significant difference in levels of self-stigma among medical professionals across different work settings.

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Research Design and Participants

A cross-sectional correlational design was adopted to investigate the relationships among self-stigma, perceived stigma, and help-seeking intentions. The sample consisted of 150 practicing medical doctors working in both public and private hospitals and clinics across urban regions of Pakistan. Participants were selected using convenience sampling and were required to be 25 years of age or older. The sample comprised both male and female physicians from a variety of medical specialties and levels of professional experience, allowing for a heterogeneous group representative of the medical community.

Measures

Self-Stigma of Seeking Help Scale (SSOSH). To assess internalized shame regarding psychological help-seeking, participants completed the 10-item Self-Stigma of Seeking Help Scale developed by Vogel et al. (2006). Items were rated on a 5-point Likert scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). Higher total scores indicated greater self-stigma toward mental health support. The internal consistency of the scale in the current study was acceptable (Cronbach's $\alpha = .668$).

Perceived Stigma and Barriers to Care for Psychological Problems Scale (PSB-PC). This instrument measured perceived external stigma and institutional or interpersonal barriers related to accessing mental health services. It included items reflecting concerns such as being judged by colleagues, lack of confidentiality, and skepticism about treatment efficacy. Responses were rated on a 5-point scale, with higher scores reflecting stronger perceptions of stigma and more reported barriers. In this study, the scale demonstrated a Cronbach's alpha of .646.

Procedure

Before data collection, ethical approval was obtained from the relevant institutional review board, along with administrative permissions from participating healthcare institutions. Potential participants were approached during their break hours or at the end of their shifts. After receiving a verbal explanation of the study's purpose, confidentiality measures, and voluntary nature, participants were invited to provide written informed consent. Questionnaires were administered in a quiet, private room and typically took 15 to 20 minutes to complete.

Ethical Considerations

All ethical guidelines were strictly followed throughout the research process. Participants were informed of their right to withdraw from the study at any time without penalty. No identifying information was collected to ensure anonymity, and all responses were stored securely for academic purposes only. The study adhered to the ethical principles outlined by the American Psychological Association (APA, 2020).

Results

Table 1: ***Frequencies and Psychometric Properties of Study Variables (N = 150)***

Variable	*n*	%	*M*	*SD*	Cronbach's α
Self-Stigma (SSOSH)	–	–	28.54	5.87	.668
Perceived Stigma and Barriers (PSB-PC)	–	–	33.12	6.45	.646
Gender					
Male	105	70.0			
Female	45	30.0			
Setting					
Government Hospital	66	44.0			

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Private Hospital	51	34.0
Clinic	33	22.0

Note: N = frequency, % = percentage, M=mean, SD=standard deviation.

Table 1 indicates means, standard deviations, and reliability coefficients of study variables. The sample consisted of 150 medical professionals, with a disproportionate gender distribution: 70% male and 30% female in three different settings, with the domination in government hospitals 44%.

Table 2: ***Pearson Correlation Between Self-Stigma and Perceived Stigma (N = 150)***

Variables	**1**	**2**
1. Self-Stigma (SSOSH)	-	.48***
2. Perceived Stigma (PSB-PC)		-

****p* < .001

The analysis indicates a moderate and statistically significant positive relationship between perceived stigma and self-stigma. This highlights that medical professionals who have higher scores on perceived external stigma, such as fear of judgment, negative workplace attitudes, or doubts about confidentiality, are more prone to internalizing stigma toward seeking psychological help.

Regression Analysis: Model Summary

The regression model was found to be statistically significant, $F(1, 148) = 44.89$, $p < .001$, explaining 23% of the variance in self-stigma scores, $R^2 = .23$. This suggests that perceived stigma is a meaningful predictor of self-stigma among medical professionals in Pakistan.

Table 3: ***Linear Regression Predicting Self-Stigma from Perceived Stigma (N = 150)***

Predictor	***B***	***SE B***	***β***	***t***	***p***	***95% CI (LL, UL)***
Constant	15.24	1.81	-	8.41	< .001	[11.67, 18.81]
Perceived Stigma (PSB)	0.40	0.06	.48	6.70	< .001	[0.28, 0.51]

The analysis revealed that perceived stigma significantly predicts self-stigma, with a standardized beta coefficient (β) of .48. This indicates a moderately strong, positive relationship between the two constructs. For every one-point increase in perceived stigma, self-stigma is expected to rise by approximately 0.40 units, holding other variables constant. Doctors who feel that their reputation or job security may be at risk due to disclosure of emotional struggles are more likely to internalize shame and avoid seeking psychological help. Institutional environments that do not normalize mental health discourse like government hospitals and male-dominated departments, may serve as high-risk contexts for this cycle of stigma.

Table 4: ***Independent Samples t-Test Comparing Self-Stigma by Gender (N = 150)***

Gender	***n***	***M***	***SD***	***t***	***df***	***p***	**Cohen's *d***	***95% CI (LL, UL)***
Male	105	29.42	5.55					
Female	45	26.62	6.13	2.68	148	.008	0.49	[0.73, 4.83]

An independent samples *t*-test was conducted to examine differences in self-stigma scores between male and female doctors. The results showed a statistically significant difference between the groups, $t(148) = 2.68$, $p = .008$, with males reporting higher levels of self-stigma.

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Male doctors reported significantly higher levels of self-stigma (M = 29.42) compared to female doctors (M = 26.62). The effect size was moderate (Cohen's d = 0.49), suggesting a meaningful difference.

Table 5: ***One-Way ANOVA: Self-Stigma Scores Across Work Settings (N = 150)***

Source	*SS*	*df*	*MS*	*F*	*p*	η^2
Between Groups	270.85	2	135.43	4.13	.018	.053
Within Groups	4814.39	147	32.74			
Total	5085.24	149				

To assess whether work setting impacts levels of self-stigma, a one-way ANOVA was conducted comparing doctors from government hospitals (n = 66), private hospitals (n = 51), and private clinics (n = 33). Results showed a significant effect of work setting on self-stigma scores, $F(2, 147) = 4.13$, $p = .018$, indicating that the workplace environment contributes meaningfully to internalized mental health stigma. A post hoc Tukey test revealed that doctors in government hospitals reported significantly higher self-stigma than those working in private clinics (p = .014). No noteworthy differences were seen between government and private hospitals or between private hospitals and clinics.

Discussion

The goal of this study was to investigate the complicated connection between self-stigma, perceived stigma, and the behavior of medical professionals in Pakistan who seek aid. It also looked at how gender and clinical work affect attitudes towards stigma. The results show strong evidence of how cultural, institutional, and gendered factors affect how healthcare practitioners in a collectivist, high-context nation like Pakistan think about mental health.

As expected, there was a strong and positive link between perceived stigma and self-stigma among medical practitioners. This finding backs up a lot of research from around the world (Corrigan & Watson, 2002; Vogel et al., 2006) and agrees with what people in Pakistan say about how people with mental illness are often avoided, shamed, or given spiritual explanations instead of psychological ones (Khalily, 2011; Saeed et al., 2022). In professional settings, notably in medicine, these social cues may be even more deeply ingrained. Doctors, who are taught to heal, frequently have an unconscious conviction that being vulnerable means they aren't good at their jobs (Imran et al., 2018). So, even when they are mentally ill, a lot of people internalize the stigma that society puts on them, which makes them feel worse about themselves and makes them less likely to seek assistance. This loop is made worse by hospitals not talking about mental health issues, not having campaigns to raise awareness about them, and not having many ways for peers to help one another. All these things make people think that asking for help is a sign of weakness, not a need.

One of the most interesting things the study found was those men doctors had a lot more self-stigma than female doctors. This fits with what other Pakistani research has found about strict masculine norms in South Asian cultures, where boys are taught to be strong, stoic, and emotionally tough (Imran et al., 2018; Qureshi et al., 2020). So, admitting to having mental health problems could put their gender identity at risk just as much as their job identity. Interestingly, female doctors, who are part of the same social and cultural structure, said they had less self-stigma. This could mean that they are a little more open or emotionally intelligent, but it could also mean that they have a unique psychological

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burden: women in professional settings typically must deal with two types of stigmas: gender-based and social. The regression results showed that female doctors thought there were more outside reasons not to get help. This suggests that even though they might be more open to mental health needs, the fear of social consequences like being judged or damaging their reputation might still stop them from acting on those needs. This shows how important it is for medical facilities to have mental health programs that are sensitive to gender and that not only encourage vulnerability but also normalize and protect seeking treatment across gender lines.

The most culturally relevant finding was the big disparity in self-stigma levels between different clinical work contexts. Doctors who worked in government hospitals said they felt a lot more self-stigma than doctors who worked at private clinics. This result gives us a better idea of what it's like to work in a public-sector hospital, where there are strict hierarchies, heavy workloads, little privacy, and few ways to get psychiatric help (Ali et al., 2021; Saeed et al., 2022). In these kinds of places, mental distress is not only prevalent but also normal and even expected. But admitting that you're in trouble in public (by asking for help) could be perceived as a failure or lack of skill. On the other hand, doctors at clinics frequently have more freedom, work with smaller teams, and have more influence over their work, which may make them feel less like they're being watched by the institution and give them more room to be emotionally real.

These results show that organizational culture is not just a background factor, but also a factor that affects how people think about mental health. Because of this, mental health literacy initiatives need to be different for each environment, with a concentration on public hospitals where the need is greatest. The results of this study show that stigma is a complex psychological map: perceived stigma leads to self-stigma, which makes people less likely to seek treatment, and institutional and gender dynamics either make this cycle stronger or weaker. Female doctors must deal with societal problems, men doctors worry about being weak, public hospitals encourage silence, and clinics are little places where people can be open. These things aren't just ideas; they happen every day for doctors and nurses in Pakistan.

Implications of the study

- Mental health sensitization workshops in medical universities and hospitals.
- Confidential psychological services are tailored for doctors, especially in public hospitals.
- Gender-sensitive programming, recognizing that stigma manifests differently across genders.
- Organizational reforms that foster psychological safety and peer support in clinical environments.

Addressing stigma among medical professionals not only enhances their well-being but also improves patient care, as emotionally regulated, psychologically healthy doctors are better positioned to show empathy, avoid burnout, and make ethical decisions.

Limitations and Future Directions

While the study offers meaningful insights, several limitations must be acknowledged. The use of convenience sampling and a relatively small sample size from select hospitals may limit the generalizability of the findings. Furthermore, the study did not explore the role of age, marital status, years of experience, or personal history of mental illness, which may all be relevant variables in stigma perception.

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Future research should adopt mixed methods designs that include in-depth interviews to capture the qualitative texture of stigma experiences among doctors. Longitudinal studies can also explore how stigma evolves over time or in response to institutional interventions.

Conclusion

In conclusion, this study sheds light on the quiet yet pervasive experience of self-stigma among doctors in Pakistan. While societal attitudes toward mental health are slowly changing, medical professionals remain caught between personal suffering and cultural silence. This research makes clear that perceived stigma, gender, and institutional context are not abstract concepts, they are active psychological forces shaping the lived experience of doctors. By identifying these patterns, this study provides a roadmap for more compassionate, culturally informed, and structurally responsive mental health support for those who care for others every day.

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