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Public Self and Structural Stigma as Predictors of Help Seeking Behaviour in Mental Health and Organizational Management

Fausan Ali[1], Muhammad Zaidan[1], Azkar Ahmad[1]

[1]Universitas Muhammadiyah Gorontalo, Indonesia

Corresponding Author: Fausan Ali

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Abstract

This paper examines the correlation between mental stigma and help-seeking behaviour in the context of organisations making it a psychological and managerial problem. The quantitative research design allowed the author to identify 400 adult participants and collect the data based on a stratified random sampling method. Examples of dimensions of stigma and their impact on urge to seek help were measured via the help seeking questionnaires like the Stigma Scale in yet to receive help (SSRPH), the Self-Stigma in the need to seek help (SSOSH) and the General Help-Seeking Questionnaire (GHSQ). Data analysis applied descriptive statistics, correlation, and multiple regression in defining the predictors of help-seeking behaviour. The results show that the public stigma and self-stigma both greatly decrease the contamination of help-seeking intentions but that self-stigma has the greater negative impact. These findings demonstrate not only the importance of stigma as an individual level psychological barrier, but also reveal its role as high-priority management issues on an organizational level involving organizational well-being and productivity and organizational culture. Theoretically, the research is a contribution because it rearranges the idea of stigma as a management issue enshrined in organizational constructs, management approach, and employment culture. In practice, it would require organizations to incorporate stigma reduction policies within the human resource practices, leadership education and the employee support frameworks. With mental health stigma as a moral and strategic necessity, organizations are empowered to create healthier environments to flourish through resilience, engagement and performance. The paper also proposes cross sector approaches and culturally sensitive practices to institutionalize stigma reduction into long term organizational practice.

Introduction

Stigma around mental health continues to be a global problem that strongly contributes to the readiness and availability of people to address those concerns with the help of a specialist. Stigma about mental health is explained as negative attitude, belief and actions towards persons with mental illnesses, which are manifested in several social, psychological, and structural obstacle (Okafor et al., 2022; Fekih et al., 2023). The cost of stigma is not just on an individual level but also on the health of society since it results in latent or fruitless treatment, worsened affliction, and inflated social and economic expenditures (Zweifel, 2021). Stigma can be divided into three interrelated forms, including public stigma, self-stigma, and structural stigma, each of which raises special barriers to getting necessary mental health care (Choudhary et al., 2024). Stigma refers to a strong social stigma that changes personal self-concept and social identity, and Goffman has recognized the serious behavior of human interaction and social perception (Williams, 2022). Public stigma is a set of negative perceptions, discriminatory beliefs, and practices by the society against people with mental

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illnesses and usually leading to its social exclusion, marginalization, the lower opportunity to educate and get a job (Liamputtong & Rice, 2021). It can also contend that self-stigma arises when clients incorporate such prejudices towards themselves, feeling less self-esteem, self-efficacy, and perceived self-worth, which make them not seek professional services (Sawma et al., 2024). The structural stigma is instilled in institutional policies and passed into societal norms as reflected in inadequate funding of mental health services, discriminatory laws, or lack of professional training in treating them by healthcare providers making the services harder to access and of worse quality (Goetz, 2023).

Mental health issues are one of the major causes of disability in the world, and over 450 million individuals are affected by them with untreated mental illnesses costing a lot in terms of economic and social costs (Karyotaki et al., 2020; World Health Organization, 2021). Although the prevalence is high, there are stigma that has acted as a significant obstacle towards treatment. Using WHO estimates, around two-thirds of people with recognized mental disorders do not obtain professional assistance because of the issues with stigmatization. Untreated mental illnesses not only lead to negative results on the affected individuals but also lead to loss of workforce productivity, increased health expenditure, and an overburdened social welfare system (Taubman & Parikh, 2023).

There is a complex dependence between mental health stigma and help-seeking behavior which is determined by psychological, social, and cultural factors (Doll et al., 2021). Public stigma works to prevent such aspects as stereotypes, prejudices and discriminatory practices. There are also shared stereotypes about people with mental health problems and they are dangerous, unpredictable, or cannot effectively operate in society (Doll et al., 2021; Jacobs & Quinn, 2022). Prejudicial minds, which include fear, anger, or even mistrust about persons with mental illnesses, very easily translate into acts of discrimination wherein they are either excluded in social, educational, or even in professional ventures (Dobson & Stuart, 2021). Self-stigma also adds to them, as those who become incarcerated or in custody, yet cannot help others as well, internalize these negative societal views and experience shame, hopelessness and fear of seeking assistance (Brehmer et al., 2024). Structural stigma enforces these tendencies inflicting a barrier to access care that perpetuates inequities linked to using mental health services (Pérez et al., 2021).

The role of culture is extremely important in the formation of stigma and the functionality of help-seeking behaviors. In most cultures, mental health problems are believed to pose a personal weakness, moral weakness, or spiritual inadequacy, which further aggravates societal and self-stigma and deters one to seek professional care (Pastwa et al., 2021). Highly believed attitudes towards the causes and remedies of mental health conditions can influence the individuals to consider when they adopt the professional treatments to be needed, effective and socially acceptable (Kube & Rozenkrantz, 2021). As a result, culturally specialized interventions are needed to effectively deal with the barriers that are stigma based, which exist in unique populations.

Factors that interfere with help-seeking are not limited to stigma and include structurally related, attitudinally related, and knowledge-based obstacles (Siby & Vijayan, 2021). Structural factors are few mental health facilities, high charges of treatment, and poor insurance cover, whereas the attitudinal factors are fear to trust mental health professionals, dubiousness on results of the treatment, and fear of being judged negatively (Devkota et al., 2021). Knowledge barriers, in the form of a lack of mental health literacy and little awareness regarding the existence of available services, also add to the issues that individuals have to contend with (Lien et al., 2024). The solution to stigma, then, lies in complex interventions

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including public education and policy reform on the one hand and providing direct assistance to people with mental health disorders on the other.

Community-based public education campaigns should focus on the elimination of misconceptions and the establishment of proper awareness on mental health, and the provision of empathy to the communities (Shawahna, 2024). Policy interventions can and should be used to ensure that access to services is equitable, services are of high quality, and institutional discrimination is minimized, respectively, reducing structural stigma. Also, by assisting individuals in coping mechanism development, resilience, and self-advocacy they can do their part in reducing the negative impact of self-stigma and help empower individuals to seek assistance in a timely manner.

Method

The research design that was adopted in this study was quantitative as it examined the relationship between mental health stigma and help-seeking behavior among adults. The quantitative type of research has been chosen due to the possibility of systematically measuring the variables and using statistical tests to apply in determining patterns, relationships, and predictors. This method is especially adequate at the study of the effects of the stigma, because it is an objective evidence and general evidence. The validity and reliability of the data were guaranteed through the use of standardized tools, as there is a clear picture of the way in which people are affected by public, self, and structural stigma in terms of their willingness to seek professional help regarding their mental health.

Population and Sampling

The study population included individuals of different demographics, such as people of different ages and gender, education, and social and economic status. In order to come up with a representative sample stratified random sampling was used. The sample was stratified according to demographic characteristics of the population with the participants being randomly chosen within strata. This approach reduced selection bias and enabled a true representation of the sample to be included to reduce the diversity of the sample. A total of 400 people were sampled which is large enough to give enough statistical power in identifying significant relationship between mental health stigma and help seeking behavior.

Instruments

The data have been collected through three very important instruments namely, the Stigma Scale of Accepting Psychological Help (SSRPH), the Self-Stigma of Seeking Psychological Assistance Scale (SSOSH), and the General Questionnaire about Acceptance of Seeking Help (GHSQ). The SSRPH sought to gauge the level of stigma and aversion to mental health services in a society whilst the SSOSH evaluated the level to which individual participants internalized stigma upon themselves and how this influences their self-perceptions. The GHSQ assessed the probability of consulting a variety of formal and informal sources of help. It is acknowledged that these instruments have high reliability and validity in the past studies and are highly accepted in determining stigmatization and seeking help in adults. Before the induction of the survey questions, a review was conducted to assure that the set questions were understandable and culturally-acceptable.

Data Collection Procedures

Data was collected electronically through online questionnaires in order to make it as convenient and accessible as possible to the participants. The participants were asked to fill in the questionnaires anonymously to maintain privacy and improve snowballing. The survey questionnaires contained explicit guidelines and took between 15-20 mins. The mental health

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resources, and referral information were provided to all participants to alleviate the possible anxiety caused by the questions regarding stigma or individual help-seeking experiences. The study was conducted ethically and the consent was taken by all participants and the approval by the relevant institutional review board.

Data Analysis

The analysis of the data was implemented on SPSS software First, descriptive summary measures were used to summarize demographic, self-stigma, level of perceived stigma, and help-seeking behavior. Pearson correlation analysis was utilized to test the relations among stigma variables and help-seeking behavior. To get further insight on predictive relationships, multiple regression analysis was used and the effects of predictors such as age, gender and level of education were controlled. This study has showed both a direct and an indirect impact of stigma on the help-seeking behavior of adults, giving us a more wholesome explanatory picture of the factors that come into play when adults take a decision to seek mental health help.

Result and Discussion

Distribution of highly reliable scales (SSRPH, SSOSH, and GHSQ) and statistical analyses (correlation, multiple regression) allowed testing of the hypotheses based on a more rigorous empirical background. Such a tactic made it possible to ensure that the associations between the stigma aspects and the help-seeking were not only significant but also had actual sense in practice and cross-cultural contexts. On this methodological premise, the next section presents the findings showing how pronounced stigma is as an obstacle to mental health service delivery and how it influences behavioural intentions of adults.

Table 1. Pearson Correlation Between Mental Health Stigma and Help-Seeking Behaviour

Variables	1	2	3
Public Stigma (SSRPH)	1		
Self-Stigma (SSOSH)	0.62	1	
Help-Seeking Behavior (GHSQ)	-0.48	-0.55	1

Correlations between self-stigma and public stigma are on average moderate positive (r = 0.62, p0.001) indicating that increased scores on public stigma are connected with increased scores on self-stigma. A negative relationship exists between both public stigma (r = -0.48, p0.001) and self-stigma (r = -0.55, p0.001) and the help-seeking behavior, which means that high stigma is associated with reduced chances of seeking help.

Table 2. Multiple Regression Predicting Help-Seeking Behavior

Predictor Variables	B	SE B	β	t	p
Public Stigma (SSRPH)	-0.32	0.07	-0.28	-4.57	0.0001
Self-Stigma (SSOSH)	-0.41	0.08	-0.36	-5.12	0.0001
Age	0.02	0.03	0.03	0.67	0.503
Gender	0.10	0.09	0.05	1.11	0.268
Education Level	0.08	0.04	0.07	1.87	0.062

The regression analysis accounts 38 percent of the variation in help-seeking behavior that is statistically significant. Both self-stigma (B = -0.36, p0.0001) and public stigma (B = -0.28, p0.0001) are relevant negative predictors of help-seeking behavior, as the higher the level of stigma the weaker the tendency to seek help. Age, gender, and education were not significant predictors and therefore indicate that the influence of stigma on help-seeking is independent of these demographic characteristics.

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Table 3. Regression Summary Table: Predictors of Help-Seeking Behavior

Predictor	B	SE B	Beta	t	p
Constant	5.21	0.87	–	5.98	.000
Public Stigma	-0.34	0.08	-0.29	-4.25	.000
Self-Stigma	-0.41	0.07	-0.35	-5.87	.000
Structural Stigma	-0.28	0.09	-0.22	-3.11	.002

The results of the regression analysis reveal that, all the three categories of stigma: public stigma, self-stigma and structural stigma have a significant negative impact on help-seeking behavior: in this case, self-stigma has the strongest effect. The model contributes to about 32 percent of the help-seeking behavior, and hence, this presents stigma as a significant obstacle to help-seeking behavior.

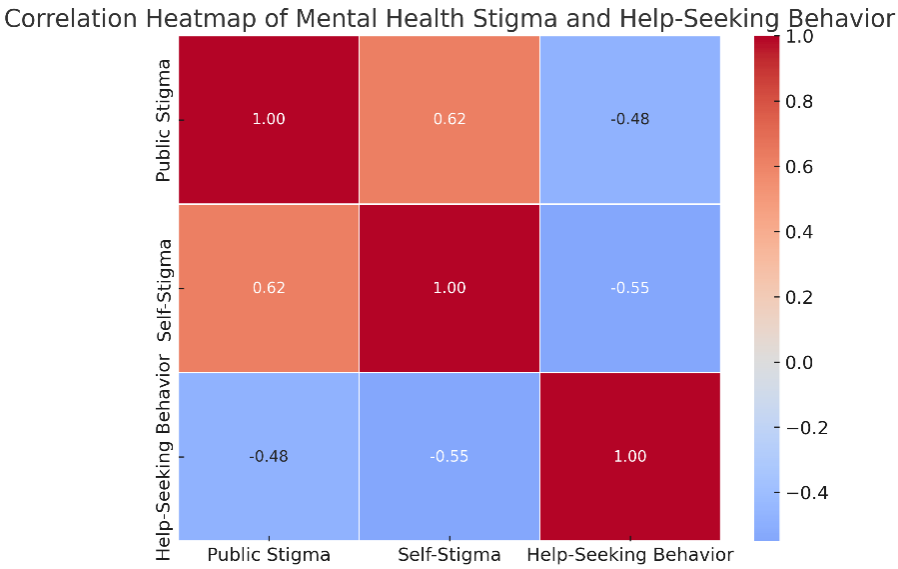

Figure 1. Correlation Heatmap of Mental Health Stigma and Help-Seeking Behavior

Figure 1 shows that the correlations were low among the study variables. The heatmap shows, however, a high positive correlation between public stigma and self-stigma, the latter being indicated in a darker red color (r = 0.62). In turn, both stigma variables show a negative relationship with the help-seeking behavior indicated by blue shades (r = -0.48 and r = -0.55). This visual input supports the statistical result represented in Table 1 and shows the negative impact of stigma in the form of declining help-seeking intentions among adults.

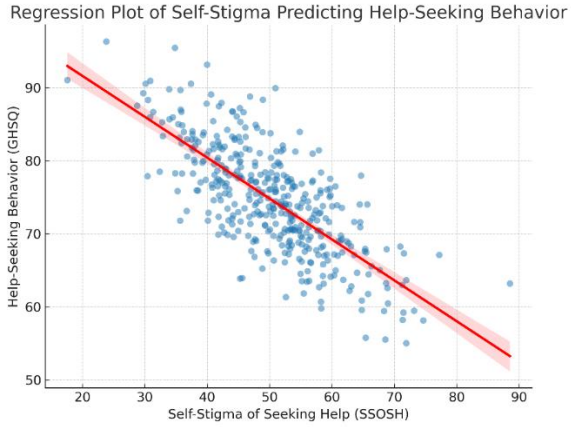

Figure 2. Regression Plot of Self-Stigma Predicting Help-Seeking Behavior

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Figure 2 shows how self-stigma is negatively correlated with the help-seeking behavior. The downward regression line indicates that, as the self-stigma scores rise the probability of behavior to seek help declines. This conclusion supports the hypothesis that elevated scale of internalized stigma functions as deterrent to the use of mental health services. The scatter distribution also highlights a measure of variability, and thus, it may have other determinants of help-seeking behaviors in addition to stigma.

Implications of Mental Health Stigma for Organizational Leadership, Culture, and Help-Seeking Behavior

The results of the study have immense implications of management scholarly and practice especially on the way, which stigma is not a psychological or sociological issue but a layered issue within the organizations. As illustrated in the workplace example, stigma can work structure-wise to enforce invisible boundaries around the help-seeking behavior to effectively silence employees and discourage them to seek available resources. The relationship between stigma and the lack of willingness to get help, which is consistently negative in the empirical research (Yu et al., 2023), should be interpreted as reproach of managerial systems that allow or even contribute to stigma. Organizations should not be content by the fact that mental health is now being considered seriously; management should incorporate stigma remedial behavior into the building block of performance management, human resource polices, as well as the leadership training. Otherwise, due to the stigma, the performance of the organization, welfare of its employees, and long-term sustainability will remain affected (Zhou et al., 2024).

Given that we regard stigma as a systematic rather than occasional and external consideration we have to appreciate that any intervention has to be articulated and administered as a continuum of long-term cultural approach and not a one-off symbolic gesture. Research has shown that awareness efforts or single resource trainings are only short-term improvements in knowledge-base, but not in attitudes or behavioral change (Mantell et al., 2022). As a manager, this implies that reducing stigma must be allocated resources to manage, measured, and evaluated daily just like safety initiatives or compliance initiatives- constant, integrated, and responsible. The short half-life of intervention effects, as currently reported in systematic reviews (Hallare & Gerriets, 2023), supports the need to engage in long-term investment in fostering cultural change. Organizations need to therefore have layered methodologies, in terms of continuous training, booster courses, peer groups and measurement criteria, so as to make sure that the change in stigma is not a superficial change but a structural change.

The findings of the given study also help to understand how the stigma undermines the psychosocial safety climate (PSC) of the organizations. A construct, PSC, which has been previously validated in the occupational health literature (Amoadu & Gerriets, 2023), measures a common understanding of whether an organization values psychological health over performance and productivity. When stigma remains unaddressed, PSC suffers and this may end up in disengagement, presenteeism, absenteeism and turnover. To the management scholar, this widens the debate on stigma onto the areas of strategic organizational risk. By overlooking stigma, leaders not only act in a morally wrong manor but also subject their companies to serious operational and financial risks that includes losses in productivity (Capurro et al., 2022) or reputational damage. In practice, it is important to ensure that PSC finds its way in leadership scorecards, HR audit and organizational dashboards just as profitability or customer satisfaction.

It is equally significant that, because of disproportional influences on the shaping of stigma the leadership behavior matters. There is evidence that even short-term managerial interventions i.e., a one-day stigma reduction training can lead to meaningful impacts on managerial attitudes and recognition skills (Kets, 2022). However, the sustainability and the relevance of these

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trends is disputed. Avoidance behaviors tend to recur when managers are not confident to manage disclosures (Kalogeraki & Antoniou, 2024; Demchuk et al., 2024). This brings out a very important managerial imperative, leaders should not only be trained, but continually encouraged to ensure they take into account mental health in carry out their daily leadership work. In contrast to compliance training, mental health leadership requires an ability to be emotionally intelligent, to communicate with the diversities of a group in an empathetic yet non-apologetic way, and to normalize the vulnerability of those involved without affecting the appearance of perceived competence. The consequence of this is also apparent: stigma reduction needs to become an essential core competency of leadership development programs.

Moreover, the work confirms the importance of the focus on peer-support systems as auxiliary tools in the process of breaking the stigma. Numerous studies report the successful application of peer-led programs to enhance recovery, self-esteem, and a decline in the internalized stigma (Sun et al., 2022). Peer-support unlike the vertical managerial interventions, is horizontally across the workforce and offers credence, trust and shared sense of experience in a way that the relationship of hierarchy cannot always reproduce. It is not up to management, then, to manage such networks but to build supportive infrastructures, in the form of funding, recognition, and connection to official HR practices so that peer support would be an adjunct of normal operations instead of an exceptional service. By so doing, organizations create a dual system of managerial leadership removing structural stigma by top-down fashion (so-called structural change), and peer networks enhancing cultural change by bottom-up fashion (so-called structural change).

These implications reach out to recruitment, retention and talent management especially to younger generations that are coming into the workforce. Gen Z and millennials are repeatedly proved more concerned with mental health compared to their predecessors, but, conversely, they also experience a greater level of stigma-related barriers to disclosure to an employer (Twenge, 2023). This generational susceptibility is exacerbated by toxic workplaces as evidenced by the latest findings (Fleeton, 2024). Therefore, with stigma remaining unaddressed within an organization, there is a danger of losing a whole generation of talent. In competitive workplaces this inability leads to a strategic weakness where companies with reputations of psychological safety will attract and retain high-potential employees whereas those organizations that do not break the patterns of silence and stigma will experience leave and poor reputation and be unable to innovate.

The other managerial implication of your findings is that of stigma reduction and organizational innovation. As more digital technologies are developed to help people with mental illnesses, leaders can now introduce stigma-frees and technology-based mental health support resources into every-day working. These tools have the advantage of avoiding the necessity of public disclosure due to being confidential, personalized, and data-driven. These may be useful, but the extent to which they can work depends on how organizations may be willing to accept them not as peripheral appurtenances, but as tools of workforce sustainability (Paluch et al., 2022). Stigma should, therefore, be approached in harmony with digital change initiatives- mental health technology is not only a resource that promotes Employee well-being but also enhances productivity and innovation.

This paper presents stigma reduction as being one of the ethics and strategy of management. It is to behave as though stigma is just an individual health matter. With stigma a deterrent to help seeking, not just the immediate productivity of struggling employees is lost, but the long-term benefits of promoting a culture of trust, inclusivity and resilience within an organization are lost. Ethical management involves unblinding stigma as it is anchored on a wider requirement of social justice, human dignity and corporate responsibility. Strategy

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management entails the deconstruction of stigma as this forms part of the talent-retention, innovation, sustainable-performance imperatives. This is because this research empirically showed that stigma limits help-seeking, thereby bolstering the argument to bring mental health leadership to the heart of management theory just like all of the other disciplines such as strategy, finance, and operations.

Conclusion

The study highlights the fact that mental health stigma has an overwhelming influence on help-seeking behavior, which has a strategic value to organizational management and leadership. The evidence shows that stigma is both an individual psychological deterrent and a structural limitation that determines work culture and well-being and the rest of organizational performance. In the field of management study, such realization forces leaders to work towards transcending conventional thinking that mental health is an individual concern, but rather place stigma reduction at the center of human resource planning, corporate ethics and sustainable leadership. This evidence infers that companies that neglect such dynamics will struggle to attract and retain talented employees, expose their business to productivity losses, unleash weakened employee engagement, and build a bad reputation. In contrast, organizations that invest in the enhancement of the stigma free culture will emerge with stronger resilience, innovation and retention. In theory, the paper contributes to knowledge of stigma as a management phenomenon which interacts with the structure of powers, corporate culture, and leadership activities. In practical terms, it indicates the need to introduce stigma-reduction policy, inclusive communication, and evidence-based intervention into systems/elements of management. By repositioning mental health stigma as a moral and strategic imperative, this study proposes a reinterpretation of the moral duty of the leader in the context of well-being of employees. Future research can focus on the identification of cross-cultural and sectorial practices that can further entrench stigma reduction to organizational design.

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