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A Study of the Relationship Between Perceived Mental Health Stigma and Barriers to Accessing Professional Mental Health Care Among Corporate Employees

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ABSTRACT

Mental health concerns are increasingly recognised as a workplace issue, yet employees may avoid professional care because of stigma and practical or attitudinal barriers. This study examined the relationship between perceived mental health stigma and barriers to accessing professional mental health care among corporate employees. A quantitative, cross-sectional correlational design was used. Eighty-five employed adults from varied sectors and Indian cities completed an online questionnaire. Perceived stigma was measured using six items adapted from Britt et al. (2008), and barriers were measured with the 30-item Barriers to Access to Care Evaluation (BACE; Clement et al., 2012); five practical-barrier items adapted from Britt et al. were also administered. Spearman's correlation showed a positive association between perceived stigma and total BACE barriers ($\rho = .55$, 95% CI [.37, .69], $p < .001$). Stigma was also associated with treatment-stigma barriers ($\rho = .59$) and non-stigma barriers ($\rho = .48$). In hierarchical regression ($n = 79$), perceived stigma explained an additional 13.3% of variance in BACE scores after demographic variables and practical barriers were considered. The most highly rated barrier was wanting to solve the problem independently; concern about career harm was the highest-rated stigma-related barrier. Because the study was cross-sectional and based on a modest, non-probability sample, the findings do not establish causation. The results suggest that workplace mental health initiatives should address stigma, confidentiality and career-related fears while making routes to professional support clear.

Keywords: perceived stigma, barriers to care, professional help-seeking, workplace mental health, corporate employees, BACE

I. INTRODUCTION

Work occupies a substantial part of adult life, and workplace conditions can support or strain psychological well-being. Long working hours, performance pressure, job insecurity and competing work–family responsibilities may contribute to stress, anxiety, low mood and burnout. Professional care from psychologists, counsellors and psychiatrists can support recovery and functioning, but access to services does not necessarily translate into service use. Many people experiencing mental health difficulties do not seek help or delay doing so (Clement et al., 2012).

Stigma is a frequently discussed barrier to help-seeking. Public stigma concerns negative attitudes held by others, while self-stigma involves internalising such attitudes (Corrigan & Watson, 2002). Treatment stigma refers to anticipated stigma or discrimination associated with receiving mental health care (Clement et al., 2012). Employees may fear being judged, treated differently, viewed as weak, or perceived as less capable. They may also worry that disclosure or counselling could affect their reputation, employment or promotion prospects.

Barriers extend beyond stigma. Practical barriers include cost, transport, appointment availability, not knowing where to go and difficulty taking time away from work (Britt et al., 2008). Attitudinal barriers include preferring to solve problems independently, believing that difficulties will improve without treatment, or doubting that professional care will help. These barriers can coexist and may reinforce one another.

A. Theoretical Background

Modified labelling theory proposes that people learn social beliefs about mental illness and may anticipate devaluation or rejection if labelled, responding through secrecy or avoidance (Link et al., 1989). Corrigan's social-cognitive account describes how stereotypes, prejudice and discrimination can interfere with care-

seeking (Corrigan, 2004; Corrigan & Watson, 2002). The Theory of Planned Behaviour further suggests that attitudes, subjective norms and perceived behavioural control shape intentions (Ajzen, 1991). Together, these perspectives suggest that employees who anticipate negative reactions may report more barriers to professional care.

B. Review of Literature and Research Gap

Evidence across populations identifies stigma and practical barriers as distinct but related concerns. Britt et al. (2008), using student and military samples, found that perceived stigma and barriers to care were separable constructs and that their relationship differed by population. Clement et al. (2012) developed the BACE to assess a broad range of barriers and reported that both stigma-related and non-stigma-related concerns were endorsed. Moore (1989) found that confidentiality concerns, fear that others would find out, and worries about effects on one's job were common reasons employees might avoid an employee assistance programme.

In India, Poddar and Chhajer (2024) identified stigma, low awareness and fear of negative consequences as obstacles to workplace disclosure, while psychological safety and supportive organisational practices could encourage help-seeking. Sanghvi et al. (2026) developed a measure of barriers to professional help among distressed young adults in urban India, identifying stigma and minimisation, instrumental barriers, problem perception, service-use self-efficacy and negative service expectancies. However, much quantitative evidence comes from students, military personnel or people already using services. The quantitative relationship between perceived stigma and a broad range of care barriers among Indian corporate employees remains insufficiently examined.

C. Aim and Objectives

The study aimed to examine the relationship between perceived mental health stigma and barriers to accessing professional mental health care among corporate employees. The objectives were to assess perceived stigma and care barriers, identify the barriers most strongly endorsed, examine associations between stigma and total, stigma-related and non-stigma-related barriers, and explore differences across selected demographic and work-related groups.

D. Hypotheses

H1: Perceived stigma is positively related to total BACE barriers. H2: Perceived stigma is positively related to BACE treatment-stigma barriers. H3: Perceived stigma is positively related to BACE non-stigma barriers. H4: Perceived stigma accounts for additional variance in total BACE barriers beyond demographic variables and practical barriers.

II. METHODOLOGY

A. Research Design and Participants

A quantitative, cross-sectional, correlational design was used. Data were collected once through an online self-report questionnaire. The target population was adults aged 18 years or older who were currently employed. Eighty-five participants provided eligible responses. The sample included employees from information technology, fashion and retail, banking and finance, manufacturing, real estate and infrastructure, staffing and recruitment, education, health care and other sectors. Participants were based in Bengaluru and other Indian cities, with two reporting employment outside India. Sampling was non-probability based; therefore, the sample should not be treated as representative of all corporate employees.

TABLE I. SELECTED SAMPLE CHARACTERISTICS

Characteristic	n	%
Age 35–39 years	22	25.9
Age 40–44 years	18	21.2
Age 45 years or older	16	18.8
Male	51	60.0
Female	32	37.6
Master's degree	45	52.9
Married	59	69.4
IT sector	20	23.5
Fashion and retail	13	15.3
Onsite work arrangement	48	56.5
46–50 hours worked weekly	34	40.0
Never consulted a mental health professional	66	77.6
Knows someone who sought professional help	38	44.7

Note. Selected categories are shown; percentages are based on N = 85 and may not total 100 because other categories are omitted.

B. Measures

Perceived stigma was assessed using six items adapted from Britt et al. (2008), rated from 1 (strongly disagree) to 5 (strongly agree). Items covered embarrassment, reputation, being treated differently, blame, being seen

as weak and the opinions of important people. A mean score was calculated, with higher scores indicating stronger perceived stigma.

Barriers to care were assessed with the 30-item BACE v3 (Clement et al., 2012), rated from 0 (not at all) to 3 (a lot). The instrument includes 12 treatment-stigma items and 18 non-stigma items. Mean scores were calculated for the total scale and subscales; higher scores indicated greater barriers. "Not applicable" responses were treated as missing for the relevant item.

Five practical-barrier items adapted from Britt et al. (2008) assessed uncertainty about where to seek help, transport, appointment scheduling, time away from work or responsibilities, and cost. A demographic questionnaire recorded age, gender, marital status, education, job level, experience, sector, organisation size, work arrangement, working hours, city, previous consultation and knowing someone who had sought professional help.

C. Procedure and Ethics

The online questionnaire presented participant information and obtained consent through a compulsory consent question. Eligibility required participants to be at least 18 years old and currently employed. Responses were exported to a spreadsheet and checked before analysis. Participation was voluntary, and participants could decline to answer sensitive items. The study used self-report data and reported findings in aggregate.

D. Statistical Analysis

Analyses were conducted in Python using pandas and SciPy. Frequencies and percentages described the sample; means, standard deviations and medians summarised scale scores. Internal consistency was assessed using Cronbach's alpha. Shapiro–Wilk tests and distributional statistics were used to examine normality. Spearman's rank-order correlations were used for the primary association tests. Hierarchical multiple regression examined whether perceived stigma accounted for additional variance in BACE total scores after demographic variables and practical barriers. Mann–Whitney U and Kruskal–Wallis tests explored group differences. Tests were two-tailed with $p < .05$.

III. RESULTS

A. Descriptive Statistics and Reliability

The mean perceived-stigma score was 2.56 (SD = 0.92) on a 1–5 scale, and the mean practical-barrier score was 2.70 (SD = 0.87). The mean BACE total score was 0.82 (SD = 0.61) on a 0–3 scale. Internal consistency was good for perceived stigma ($\alpha = .88$), acceptable for practical barriers ($\alpha = .79$), and excellent for the BACE total ($\alpha = .95$), treatment-stigma subscale ($\alpha = .94$) and non-stigma subscale ($\alpha = .91$). BACE scores departed from normality, supporting the use of rank-based correlations.

TABLE II. DESCRIPTIVE STATISTICS AND INTERNAL CONSISTENCY

Measure	n	M	SD	Scale	α
Perceived stigma	85	2.56	0.92	1–5	.88
Practical barriers	85	2.70	0.87	1–5	.79
BACE total	85	0.82	0.61	0–3	.95 (79)
BACE treatment stigma	85	0.74	0.72	0–3	.94
BACE non-stigma	85	0.87	0.58	0–3	.91 (79)

Note. Scores are item means. Alpha sample sizes in parentheses reflect available complete cases where applicable.

B. Relationship Between Stigma and Barriers

Perceived stigma was positively associated with total BACE barriers, $\rho = .55$, 95% CI [.37, .69], $p < .001$, $N = 85$. The association was also significant for treatment-stigma barriers ($\rho = .59$, 95% CI [.42, .72], $p < .001$) and non-stigma barriers ($\rho = .48$, 95% CI [.29, .64], $p < .001$). Perceived stigma was positively related to practical barriers as well ($\rho = .46$, 95% CI [.26, .62], $p < .001$). Thus, all three correlational hypotheses were supported.

TABLE III. SPEARMAN CORRELATIONS WITH PERCEIVED STIGMA

Outcome	N	ρ	95% CI	p
BACE total	85	.55	[.37, .69]	< .001
BACE treatment-stigma subscale	85	.59	[.42, .72]	< .001
BACE non-stigma subscale	85	.48	[.29, .64]	< .001
Practical barriers	85	.46	[.26, .62]	< .001

Note. ρ = Spearman rank-order correlation; all tests were two-tailed.

C. Hierarchical Regression

The regression analysis used 79 complete cases. Demographic variables accounted for 12.3% of the variance in total BACE barriers. Adding practical barriers increased explained variance by 21 percentage points ($p < .001$). Adding perceived stigma explained a further 13.3% of variance, $\Delta R^2 = .13$, $p < .001$. In the final model, perceived stigma was a significant predictor ($B = 0.27$, $\beta = .42$, $p = .005$), as were practical barriers ($B = 0.20$, $\beta = .28$, $p = .022$). The final model explained approximately 47% of the variance. H4 was supported.

TABLE IV. FINAL HIERARCHICAL REGRESSION MODEL

Predictor	B	SE (HC3)	β	p
Gender (female = 1)	0.07	0.13	.06	.565
Age group	0.03	0.04	.08	.406
Previous consultation	−0.01	0.13	−.00	.954
Knows someone who sought help	0.29	0.14	.24	.042
Practical barriers	0.20	0.08	.28	.022
Perceived stigma	0.27	0.10	.42	.005

Note. N = 79. Final model $R^2 = .47$; perceived stigma added $\Delta R^2 = .13$, $p < .001$. B = unstandardised coefficient.

D. Most Strongly Endorsed Barriers

The highest-rated barrier was wanting to solve the problem independently ($M = 1.72$, $SD = 0.92$); 91.8% rated it as a barrier to some degree. This was followed by preferring help from family or friends ($M = 1.18$) and preferring alternative forms of care ($M = 1.14$). Concern that seeking care might harm career prospects or promotion was the highest-rated stigma-related item ($M = 0.96$); 60.0% endorsed it to some degree. Uncertainty about where to obtain professional care was also prominent.

TABLE V. TEN HIGHEST-RATED BACE BARRIERS

Rank	Barrier (shortened)	Type	M	SD	% any
1	Wanting to solve the problem on my own	NS	1.72	0.92	91.8
2	Preferring help from family or friends	NS	1.18	1.05	68.2
3	Preferring alternative forms of care	NS	1.14	1.00	70.6
4	Thinking the problem would improve by itself	NS	1.05	0.95	64.7
5	Unsure where to go for professional care	NS	1.01	0.88	67.1
6	Concerns about available treatments	NS	1.01	1.01	61.2
7	Concern about career or promotion harm	S	0.96	1.02	60.0
8	Thinking professional care would not help	NS	0.95	1.02	58.8
9	Thinking there was no problem	NS	0.95	0.95	60.0
10	Concern about being seen as weak	S	0.91	1.02	55.3

Note. Ratings range from 0 to 3. % any = percentage rating the item 1 or higher. S = treatment-stigma item; NS = non-stigma item.

E. Group Comparisons

Perceived stigma did not differ significantly across the two-group comparisons. Neither perceived stigma nor total barriers differed significantly by work arrangement or age group. One exploratory difference was observed for knowing someone who had sought professional help: those who knew someone reported higher BACE barriers ($p = .032$, $r = .23$), a small effect. Given the

exploratory nature of these comparisons and the number of tests, this finding should be interpreted cautiously.

IV. DISCUSSION

The study found a positive, statistically significant association between perceived mental health stigma and barriers to professional care among employed adults. Employees who more strongly anticipated negative reactions to seeking help also tended to report more barriers overall, including treatment-stigma and non-stigma barriers. Perceived stigma also explained additional variance in barriers after demographic characteristics and practical barriers were considered. These findings are consistent with modified labelling theory and social-cognitive accounts, which propose that anticipated devaluation and negative social reactions can discourage care-seeking (Link et al., 1989; Corrigan, 2004).

The correlation between stigma and total BACE scores should not be interpreted as wholly independent of the measurement content: the BACE total includes a treatment-stigma subscale whose content overlaps conceptually with perceived stigma. Nevertheless, the significant relationship with the non-stigma subscale suggests that stigma may coexist with broader concerns about treatment, self-reliance and access. The cross-sectional design cannot establish whether stigma leads to barriers, whether barriers heighten perceptions of stigma, or whether both reflect other factors.

The most prominent barrier was wanting to solve the problem independently. Preference for informal support and alternative forms of care, and the belief that the problem might improve on its own, were also frequently endorsed. This pattern suggests that barriers are not exclusively structural; beliefs about self-reliance and the perceived need for professional care may also matter. Career-related concerns were the most highly rated stigma-related barrier, consistent with workplace research highlighting confidentiality and employment-related fears (Moore, 1989; Poddar & Chhajer, 2024).

A. Practical Implications

Workplace initiatives should address stigma alongside practical access. Employers can explain confidentiality protections clearly, separate counselling records from performance management, and communicate how to access internal or external support. Career-related fears should be addressed explicitly rather than assuming that a service's availability is sufficient. Mental health literacy programmes can frame help-seeking as a responsible form of coping rather than a weakness, while acknowledging that employees may also value family, friends and culturally familiar forms of support. Managers and senior leaders can reinforce psychologically safe practices by responding supportively to distress and avoiding language that penalises disclosure.

Organisations should also make support pathways visible: where services are available, how appointments are arranged, what costs may apply, and how time away from work can be managed. Periodic, anonymous barrier assessments may help HR teams and mental health professionals identify local needs and evaluate whether interventions address the concerns employees actually report.

B. Limitations and Future Research

The sample was modest and non-random, limiting generalisability. Participants came from multiple sectors and locations, and a few were outside the core corporate target population. All measures were self-reported at one time point, raising the possibility of social-desirability and shared-method effects. The BACE was developed with people who had used secondary mental health services, whereas many participants in this study had never consulted a professional; item interpretation may therefore differ. Some perceived-stigma and practical-barrier items were adapted from Britt et al. (2008). The group comparisons were exploratory and were not adjusted for multiple testing.

Future studies should recruit larger, more representative samples across Indian cities, sectors and organisation sizes. Including a measure of current distress could help distinguish barriers among employees who need care from general attitudes about treatment. Longitudinal research could examine whether stigma predicts later service use, including employee assistance programme utilisation. Qualitative interviews may clarify the prominence of self-reliance and the unexpected association between knowing someone who sought help and reporting more barriers.

V. CONCLUSION

Among the 85 employed adults in this study, perceived mental health stigma was positively associated with total barriers to professional care, treatment-stigma barriers and non-stigma barriers. It also explained additional variance in barriers after demographic variables and practical barriers were considered. Wanting to solve problems independently was the most strongly endorsed barrier, while concern about career harm was the highest-rated stigma-related barrier. The findings support workplace approaches that combine stigma reduction, confidentiality assurance, visible access pathways and practical support. The results are

correlational and should be confirmed in larger and more representative samples.

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