

Predictors of access to Psychiatric Care: Examining the role of Stigma, Mental Health Knowledge and Pathways of care - A Hospital Based cross sectional Study

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Abstract

Background: Healthcare utilization among individuals with psychiatric disorders remains comparatively low, with most seeking psychiatrist help only at severe stages. Psychiatric care seeking pathways are shaped by individual, cultural, and systemic barriers, including stigma, misconceptions, and distrust, leading to significant treatment delays. Scouring the factors and addressing these disparities is critical for improving early access and reducing global mental healthcare gaps.

Aims: In this background, the present study is aimed at assessing mental health knowledge, internalized stigma, and care-seeking pathways in patients with first psychiatric consultation and factors affecting it.

Methods and Material: A hospital-based cross-sectional study was carried out at a tertiary care center. Patients who were first-time psychiatry care seeking were included in the study via consecutive sampling. Sociodemographic data was gathered using a self-designed questionnaire. ISMI (Internalized Stigma of Mental Illness), MHKQ (Mental Health Knowledge Questionnaire), and WHO encounter proforma were used. Data were analyzed using SPSS-27, with $p < 0.05$ as significant.

Results: A total of 150 patients participated in the study with an equal number of males and females with a mean age of 37 years and a median duration to reach psychiatrist being 12 months. Many patients initially consulted faith healers, and the family initiated consultations often. Most referrals to psychiatry were from other medical practitioners. Patients reported of having mild internalized stigma. The median mental health knowledge score was 12 (59.23% awareness rate). Higher stigma and lower mental health knowledge were significantly associated with treatment delays.

Conclusion: Stigma, MHK, and referral sources significantly impacted time to psychiatric care. Targeted stigma reduction, MHK improvement, and collaboration with alternative practitioners may enhance timely access.

Keywords: Mental health literacy, Stigma, Help seeking behaviour, Treatment delay, Referral

Introduction

Mental health disorders represent an escalating global public health challenge, with a disproportionate impact on individuals from socioeconomically disadvantaged backgrounds. Low- and middle-income countries (LMICs) bear a staggering 80% of the worldwide mental health burden^[1]. Despite the existence of effective interventions, a critical treatment gap persists, particularly in regions like

India, where low mental health literacy and entrenched stigma continue to hinder access to care^[2,3]. Societal stigma portrays individuals with mental illness as dangerous and unpredictable^[4], leading to internalized shame, social withdrawal and treatment avoidance^[5,6]. This is exacerbated by poor mental health knowledge about the aetiology of mental illness, and treatment options that contradict medical perspectives^[2].

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In India, poor mental health knowledge and stigma of mental illness lead to improper help-seeking patterns. People believe mental illness to be of magico-religious origin, which makes them to initially consult alternative health providers or faith healers, with only severe cases reaching psychiatric care^[7,8].

These delays arise from a complex interplay of factors, including sociocultural beliefs, educational background, family attitudes, healthcare accessibility, and referral patterns^[9]. These delays have profound consequences; when psychiatric care becomes a last resort, critical early intervention opportunities are lost, worsening outcomes and increasing disease burden^[10]. While mental health infrastructure continues to improve in India, systemic barriers rooted in stigma and poor health literacy persist.

There are not many studies done in India looking into all three aspects. Thus, the current study examines internalized stigma, mental health knowledge, and care-seeking pathways among patients visiting psychiatric care in a tertiary center. By analysing these interconnected factors, we aim to identify modifiable barriers to timely treatment. Our findings can inform targeted interventions to improve mental healthcare access.

Materials and Methods

Study setting and design

This is an observational, hospital-based cross-sectional study that employed consecutive sampling to recruit participants from both outpatient and inpatient psychiatry services in tertiary care hospital. The study period extended from June 2023 to June 2024. Prior to commencement, ethical approval was obtained from the Institutional Ethics Committee.

Study participants

Sample size estimation was done using OpenEpi software version 2.3.1^[11]. Patients seeking psychiatry care for the first time with at least partial insight ($\geq$ Grade 3), aged between 18-60 years were selected consecutively. Participants were evaluated by consultant psychiatrists in OPD or IPD settings and diagnosed as per ICD-10 criteria. Following informed consent, each participant completed three standardized assessments: the Internalized Stigma of Mental Illness (ISMI) scale, Mental Health Knowledge (MHK) questionnaire, and WHO care-seeking proforma. These structured interviews required 15-20 minutes per session. Individuals requiring emergency care, those exhibiting aggression, or patients with intellectual disabilities/organic mental disorders were excluded.

Scales Used

1] Socio demographic proforma:

It is a self-designed proforma which includes basic demographic details of the patients.

2] WHO Encounter proforma for assessing various care seeking pathways:

The WHO Encounter Proforma is a validated tool designed to systematically map care-seeking pathways for mental health conditions, capturing key details such as provider types, referral trajectories, treatment delays, and sociodemographic factors^[12]. This structured instrument facilitates the analysis of healthcare navigation patterns and identifies barriers in service utilization.

3] Internalized Stigma of Mental Illness Inventory (ISMI):

The Internalized Stigma of Mental Illness (ISMI) scale (Ritsher et al.) assesses five domains-alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance using 29 items (score range: 1-4; higher = greater stigma). Domain scores were computed by summing individual item scores and dividing by the total number of items answered. Severity levels were classified as minimal (1.00- 2.00), mild (2.01-2.50), moderate (2.51- 3.00), and severe (3.01- 4.00). The scale shows strong reliability ($\alpha = 0.85$)^[13].

4] Mental Health Knowledge Questionnaire:

The 20-item Mental Health Knowledge Questionnaire (China's Ministry of Health) assesses mental health literacy, with higher scores (range: 0- 20; $\alpha = 0.69$) indicating better knowledge, with 16 items testing basic concepts (1 point is given for each 'yes' response on items 1, 3, 5, 7, 8, 11, 12, 15, 16 and one point for each 'no' response on items 2, 4, 6, 9, 10, 13 and 14) and 4 items evaluating awareness of mental health promotion days (1 point for "Know"). Overall awareness rate of MHK was calculated as: sum of items correctly answered by all individuals/ (total number of participants x total number of items) x 100%^[14,15].

Treatment delay was operationalized as the time interval (months) between symptom onset and first contact with psychiatric services. Using the median duration of psychiatric care as the cutoff, participants were categorized into two groups: 1) early treatment-seekers (those accessing care before the median duration) and 2) delayed treatment-seekers (those presenting after the median duration) in our study.

Statistical Analysis: Data were analyzed using SPSS version 27 (IBM Corp.)^[16]. After assessing distribution normality with Kolmogorov-Smirnov tests, non-parametric tests (Mann-Whitney U and Kruskal-Wallis) were employed for categorical variables. Multivariate logistic regression identified predictors of treatment delay (defined as time to psychiatric care), with results expressed as adjusted odds ratios (AOR) and 95% confidence intervals. Statistical significance was set at $p < 0.05$. All analyses controlled for potential confounding variables.

Results

Table 1: Socio-demographic features of the sample

Variable	Categories	Number of patients (%)
Gender	Male	76 (50.7)
	Female	74 (49.3)
Marital status	Married	90 (60)
	Unmarried	43 (28.7)
	Widow/divorced/separated	17 (11.3)
Educational status	Illiterate	10 (6.7)
	Primary	18 (12)
	Secondary	91 (60.7)
	Degree	31 (20.7)
Residence	Urban	54 (36)
	Rural	96 (64)
Employment status	Employed	74 (49.3)
	Unemployed	76 (50.7)
Mean + SD		
Age of the sample (years)		36.9±12.3

The study sample consisted of 150 participants, with an almost equal distribution between males (50.7%) and females (49.3%). The majority were married (60%), had secondary level schooling (60.7%) were from rural area (64%). The employment status of the participants was balanced, with a nearly equal number of employed (49.3%) and unemployed (50.7%). The mean age of participants was 36.9 ± 12.3 years.

Kolmogorov-Smirnov test was conducted to assess the normal distribution of duration in reaching psychiatric care. The results showed that the data were not normally distributed, $D(150) = 0.232$, $p < 0.001$. Histogram and Q-Q plots further supported this finding, showing noticeable skewness. Therefore, the data was summarized using median (IQR).

Median (IQR)=12(30), Min=1 & Max=120

Hence, the median duration in reaching psychiatric care is 12 (30) months.

Diagnostic Profiles of the participants

The distribution of psychiatric diagnoses showed schizophrenia and related psychotic disorders as most common (29.3%), followed by mood disorders (23.3%), anxiety/OCD (22.7%), and substance use disorders (12.7%). Adjustment disorder/PTSD (6.7%) and dissociative/somatoform disorders (5.3%) were less frequent. Median time to seek care was longest for substance use (72 months), followed by dissociative/somatoform (30 months) and psychotic disorders (18 months), while mood, anxiety, and adjustment disorders had shorter durations (7, 8, and 4 months, respectively), indicating significant disparities in help-seeking timelines.

Table 2: Internalized Stigma of Mental Illness Inventory - Median total score and the level of internal stigma

Total score-Median (IQR)- 2.5 (0.45)	
ISMI level	No. of patients (%)
Minimal/no stigma	4 (2.7%)
Mild	70 (46.7%)
Moderate	70 (46.7%)
Severe	6 (4%)
Total	150 (100%)

The median ISMI score was 2.5 (0.45), which comes in at the mild level as per the scoring norms; however, the percentage of scores was equal in both the mild and moderate level as shown in Table 2.

Mental Health Knowledge of the Sample

Mental health knowledge (MHK) median total score of the participant was 12. Quartile 1 was 10, quartile 3 was 13, and the interquartile range (Q3- Q1) was 3. The awareness rate of mental health knowledge among patients was 59.23% (the formula of calculation outlined in the methodology).

Table 3: Care Seeking Pathways

Variable	Categories	Number of participants (%)
Help seeking behavior initiated by	Others (relatives/ friends/neighbours)	124 (82.7)
	Self	26 (17.3)
Referred to psychiatrist by	Medical Practitioner / Alternative medicine	71 (47.3)
	Community members (Neighbours/friends/ colleague)	48 (32)
	Relatives/Self	20 (13.3)
	Social Worker	11 (7.3)
	Median (IQR)	
Time taken for first encounter with any Provider (months)		4 (4)

As shown in Table 3, help-seeking was primarily initiated by individuals other-than patients such as relatives, friends, or neighbors, in the majority of cases, whereas only a small proportion of patients sought help themselves. Most referrals to psychiatrists were from medical practitioners & providers of alternative medicine, followed by community members such as neighbors, friends, or colleagues. The median duration between symptom onset and first contact with any healthcare provider was 4 months, with an interquartile range (IQR) of 4 months. This suggests that the median duration for any seeking care behavior was 4 months.

Table 4: Patient's Help-Seeking Preferences in Sequential Healthcare Encounters for Mental Health Illness

Encounters	Number of patients (%) seeking help in healthcare encounters			
	1 st	2 nd	3 rd	4 th
Faith Healer	76 (50.7)	6 (4.7)	0	0
Unqualified practitioner	16 (10.7)	17 (13.4)	1 (1.1)	0
Alternative medicine	14 (9.3)	20 (15.7)	4 (4.3)	0
Social Worker	1 (0.7)	8 (6.3)	2 (2.2)	0
Medical Practitioner (other than psychiatrist)	20 (13.3)	41 (32.3)	13 (14.1)	0
Psychiatric Care	23 (15.3)	35 (27.6)	72 (78.3)	20 (100)
Total	150 (100)	127 (100)	92 (100)	20 (100)

Table 4 illustrates the evolving pattern of help-seeking behavior among participants across successive healthcare encounters. Half of the participants sought help from faith healers initially, reflecting a strong reliance on traditional or spiritual support during early stages of distress. In contrast, only 15.3% initially approached psychiatric services, with a comparable proportion turning to other medical (healthcare) providers. However, this trend changed significantly in subsequent encounters. In the second encounter, there was a sharp decline in visits to faith healers, alongside a notable rise in psychiatric consultations and a slight increase in the use of other health services. In the third encounter, psychiatric services had become the key choice, with more than three-quarters of participants seeking care from psychiatrists. A few consulted Psychiatrists only in the fourth encounter; at this point all participants in the study had accessed psychiatric care, as only four encounters were analyzed. This progression underscores a delayed but distinct shift from alternative or informal services of care to formal psychiatric treatment.

Table 5: Comparison between Mental Health Knowledge (MHK) and Internalized Stigma of Mental Illness Inventory (ISMI) with sociodemographic variables and psychiatric disorder using Mann-Whitney U Test / Kruskal-Wallis Test

		ISMI Median (IQR)	p-value	MHK Median (IQR)	p-value
Gender	Male	2.51 (0.46)	0.484	12 (4)	0.330
	Female	2.41 (0.45)		12 (3)	
Marital Status	Unmarried	3 (1.5)	0.029*	13 (3)	0.001*
	Married	3 (1)		11 (2)	
	Divorced/Separated/Widow	3 (0.05)		10 (3)	
Religion	Hindu	2.50 (0.47)	0.175	12 (3)	0.958
	Muslim	2.32 (0.49)		12 (2.2)	
Residence	Urban	2.45 (0.49)	0.120	13 (2.7)	0.001*
	Rural	2.50 (0.48)		11 (2)	
Education	Illiterate	2.33 (0.43)	0.007 *	11.5 (3.5)	0.001*
	Primary	2.41 (0.41)		11 (1.8)	
	Secondary	2.51 (0.44)		12 (2)	
	Degree	2.30 (0.42)		14 (2)	
Occupation	Employed	2.39 (0.48)	0.214	12 (3)	0.891
	Unemployed	2.51 (0.48)		12 (3)	
Psychiatric disorders	Substance Use Disorders	2.65 (0.48)	0.001*	12 (3)	0.126
	Schizophrenia And Related Psychosis	2.65 (0.25)		12 (2)	
	Mood Disorders	2.41 (0.37)		12 (3.5)	
	Anxiety Disorders/OCD	2.20 (0.23)		12 (2.7)	
	Dissociative/Somatoform Disorders	2.34 (0.32)		11 (2)	
	Adjustment Disorder/PTSD	2.15 (0.21)		13.5 (1)	

Patients from urban areas demonstrated significantly higher MHK scores than those from rural areas. Marital status and education level were found to significantly influence both MHK and ISMI scores, while the type of psychiatric disorder showed a significant association with ISMI scores alone, shown in Table 5.

Dunn's post-hoc analysis further revealed significant differences in ISMI and MHK scores based on marital status and education. Unmarried individuals had significantly lower ISMI scores than those who were divorced, separated, or widowed ($p = 0.009$), and they also demonstrated higher MHK scores ($p = 0.001$) compared to the other marital status groups. Participants holding a college degree had significantly

higher MHK scores ($p = 0.001$) and lower ISMI scores than those with only secondary education ($p = 0.001$).

Patients diagnosed with schizophrenia and related psychoses, as well as those with substance use disorders, exhibited the highest levels of internalized stigma. When examining specific domains of stigma, these groups showed significantly elevated scores in alienation (47.6, $p < 0.001$), stereotype endorsement (57.4, $p < 0.001$), perceived discrimination (48.3, $p < 0.001$), and social withdrawal (48.3, $p < 0.001$), compared to patients with mood disorders, anxiety disorders, dissociative/somatoform disorders, and adjustment disorders/PTSD.

Table 6: Multivariate logistic regression analysis of factors predicting Duration in reaching psychiatric care

Variables	Responses	AOR (95%CI)	Significant value (p value)
Gender	Male	0.437(0.415-0.045)	0.437
	Female	0	-
Age	Age(years)	0.945(0.793-1.128)	0.533
ISMI	ISMI total score	0.028(0.002-0.432)	0.010*
Marital status	Married	0.441(0.025-7.733)	0.575
	Unmarried	1.416(0.067-29.795)	0.823
	Widow/divorced/separated	0.	-.
Residence	Urban	.737(0.099-5.466)	0.765
	Rural	0.	.
Education	Illiterate	0.833(0.029-24.017)	0.773
	Primary	0.141(0.006-3.185)	.
	Secondary	0.734(0.089-6.028)	0.133
	Degree	0.	.
Occupation	Employed	6.664(0.561-79.137)	0.133
	Unemployed	.	-
Psychiatric disorders	Substance use disorder	4.587E-28(000)	0.990
	Schizophrenia and related psychosis	8.205E-11(00-0)	0.995
	Mood disorder	2.707E-10(00-0)	0.995
	Anxiety disorder/OCD	5.064E-11(00-0)	0.994
	Dissociative/Somatoform disorder	1.905E-11(00-0)	0.994
	Adjustment disorder/ PTSD	0.	-
Help seeking behavior initiated	Others (relatives/friends/ neighbour)	0.323(0.119-0.879)	0.995
	Self	0	0
Referred to psychiatrist by	Medical practitioner/Alternative medicine	4.423((1.325-14.765)	0.027*
	Community members (neighbours/ friends/workmate)	1.820(0.850-3.899).	0.123
	Relatives/ Self	0.670(0.176-2.543)	0.556
	Social worker	.0	-
MHK	MHK Total score	1.231(1.0.481-1.446)	0.011*

*: Statistically significant-

The multivariate logistic regression analysis examined factors associated with the duration in reaching psychiatric care, identifying several predictors in Table 6. Higher internalized stigma was significantly associated with a longer delay in seeking care, indicating that greater stigma markedly reduced the likelihood of early help-seeking. Better mental health knowledge (MHK total score) was significantly associated with earlier care-seeking, suggesting that increased awareness facilitates timely access. Referral by medical practitioners or alternative medicine providers was linked to faster psychiatric care access.

Other variables, including gender, age, marital status, education, residence, occupation, and psychiatric disorders did not show statistically significant associations.

Discussion

Our study intended to assess the mental health knowledge, various care-seeking pathways, and the internalized stigma experienced by psychiatric patients attending the psychiatry department at a tertiary care center. There are hardly any studies in India examining these factors all together.

In our study, the gender distribution was nearly equal, with 50.7% male and 49.3% female participants. This balanced representation is encouraging, as it suggests no significant gender differences in help-seeking for psychiatric care. These findings align with a Canadian study that identified social support as a key factor encouraging women to seek mental health services [17]. However, in contrast to our findings, an earlier study from India reported a marked male predominance that can be attributed to prevailing gender biases that men are more likely to seek or be brought for psychiatric treatment [7]. The near-equal gender participation observed in our study may reflect a positive shift in societal attitudes, improved awareness, and stronger social support networks, and this boosts the ongoing efforts to promote gender equity in access to psychiatric care.

Our study also showed a balanced distribution in employment status, with approximately half of the participants being employed. This is a significant difference compared to the 78.6% unemployment rate among individuals with mental illness reported in the 2011 Census of India [18]. The improvement may reflect better access to mental health services, increased awareness, stronger social support systems, and improved psychiatric treatment over the past decade. However, despite this progress, a considerable proportion of psychiatric patients in society and our study remained unemployed. This highlights the need

for vocational rehabilitation programs to support individuals with mental illness in achieving economic independence and social integration.

In our study, schizophrenia and related psychotic disorders accounted for 29.3% of the sample, followed by mood disorders at 23.3% and anxiety disorders/OCD at 22.7%. Collectively, neurotic conditions such as anxiety disorders, somatoform disorders, and mild to moderate depression represented a significant portion of psychiatric consultations. These findings are consistent with those reported in a previous study conducted in a general hospital setting [19]. There may be a possibility that these results likely indicate patterns in help-seeking behavior rather than reflecting true prevalence rates. Individuals with psychotic and mood disorders are more likely to seek treatment due to the severity of symptoms and the associated functional impairment. It is possible that service availability and referral patterns play a role in shaping this diagnostic distribution. Patients with severe disorders are more likely to be referred to specialized psychiatric services, whereas individuals with neurotic or adjustment-related conditions may be managed at lower levels of care or remain untreated or be normalized, especially in socio-cultural contexts where psychological distress is somatically expressed or attributed to situational stressors rather than mental illness. Therefore, while our findings provide important insights into service utilization trends, they may not fully capture the burden of common mental disorders in the community.

Psychiatric disorders generally carry greater stigma than other medical conditions, though this varies across cultural and geographic contexts. Our findings indicate that participants experienced internalized stigma mild while wide variability in stigma severity was reported in prior studies [20]. Notably, individuals with substance use disorders and schizophrenia in our study exhibited the highest stigma levels across all ISMI subdomains (except stigma resistance) compared to other diagnoses. This likely reflects pervasive societal stereotypes - schizophrenia is frequently associated with dangerousness and unpredictability, while substance use disorders are often wrongly viewed as moral failings rather than medical conditions. This result aligns with existing evidence demonstrating greater internalized stigma among schizophrenia spectrum disorders relative to depressive disorders [21]. The impact of such stigma is far-reaching. Internalized stigma is associated with reduced self-esteem, increased social withdrawal, lower treatment adherence, and poorer psychosocial outcomes.

For individuals with substance use disorders, stigma may be particularly damaging, as it not only affects public perception but also influences how healthcare providers engage with this population, potentially resulting in suboptimal care and further marginalization.

The mental health knowledge awareness rate in our study was 59.23%, indicating a moderate level of awareness. This is a relatively lower rate. A study on Chinese college students reported awareness rate as 83%, which may be due to differences in educational attainment and rural-urban disparities ^[15]. The higher awareness among college students likely results from both their general education level and specific mental health education incorporated in academic curricula.

Help-seeking was mainly initiated by relatives/neighbors rather than patients themselves, consistent with Indian family-centric decision-making ^[22]. Nearly half of psychiatric referrals originated from medical/alternative practitioners, reflecting the somatic presentation of mental illness, which increases acceptance of referral when framed medically, and growing primary care competency in mental health recognition, particularly where specialist services are accessible ^[23,24]. This pathway underscores the critical role of general healthcare providers as gatekeepers to mental health services in this cultural context. This also underlines the importance of educating the general public and medical practitioners about signs of mental illness and appropriate referral services availability in their locality.

Faith healers served as the primary initial contact for most participants, likely due to cultural trust, accessibility, and affordability. However, when traditional methods failed, patients typically progressed to other healthcare providers before finally seeking psychiatric care, often as a third resort. This stepped care pattern mirrors findings from other Indian studies where nearly 80% of the population initially utilized alternative treatments (Ayurveda, Unani) or spiritual interventions before accessing mental health services, reflecting both cultural health beliefs and systemic service gaps ^[25]. The persistence of traditional and spiritual healing practices in the care pathway highlights the need for culturally sensitive public health strategies. Rather than dismissing traditional healers, efforts can be made to engage and educate them as potential allies in mental health promotion and early identification. Community-level awareness campaigns, gatekeeper training, and collaborative models involving both biomedical and indigenous systems of care may offer a more holistic and acceptable approach in such settings.

The median time from the onset of illness to first contact with any healthcare provider was 4 months. Previous study differs on this finding, which showed 1 month with any provider ^[26].

While initial healthcare contact occurred relatively early (median 4 months), the median duration to reach psychiatric care was 12 months. This treatment gap likely reflects both systemic and perceptual barriers: inadequate referral protocols, which are the lack of structured pathways linking general healthcare services to mental health specialists. In many cases, general practitioners may either miss early signs of psychiatric illness or manage symptoms within the limits of their training, without prompt referrals or provider reluctance in general cases.

Our study revealed significant variation in duration to reach psychiatric care across disorders. Substance use disorders showed the longest duration (median 72 months), consistent with a prior study which reports 90 months to reach psychiatrist ^[22]. This protracted help-seeking likely stems from the normalization of alcohol use as a "habit" rather than a medical condition, compounded by patient reluctance until complications arise. Dissociative disorders and somatoform disorders followed with substantial delays (30 months). Dissociative disorder often presents with sudden, culturally misinterpreted symptoms (e.g., possession-like states), leading to initial consultations with faith healers or alternative medicine practitioners ^[27]. Similarly, somatoform disorders are frequently underdiagnosed in primary care due to their overlap of somatic nature with medical symptoms, delaying psychiatric referral ^[28]. This was followed by schizophrenia (18 months), attributable to poor insight, magico-religious attributions ^[29]. In contrast, mood, anxiety, and adjustment disorders had a shorter duration to reach (4-8 months), possibly because their stress-related aetiology or physical symptoms (e.g., insomnia, fatigue) prompt earlier help-seeking. This aligns with findings from India, where psychiatrists were often the first contact for symptoms of anxiety/depression ^[30]. The discordance in delays highlights how illness attribution (medical vs. stress vs. supernatural) shapes care pathways.

Unmarried, urban residents and graduates demonstrated greater mental health knowledge, aligning with findings that higher education correlates with improved mental health literacy ^[31]. Similarly, degree holders reported lower internalized stigma, consistent with prior research linking education to reduced self-stigmatization ^[32]. This suggests that formal education enhances awareness of mental health conditions, diminishes misconceptions, and may foster more adaptive perceptions of societal

attitudes toward mental illness. Unmarried individuals reported lower levels of internalized stigma, a finding consistent with earlier research conducted among primary healthcare professionals in China [33]. Interestingly, we also observed that unmarried participants demonstrated higher levels of mental health knowledge, which contrasts with previous findings from China, where married individuals were reported to have better awareness [34]. This discrepancy may be attributed to changing social dynamics and greater mental health exposure among younger, unmarried, who are often more engaged with digital platforms, training opportunities, and open discussions about mental health. Additionally, unmarried individuals may face fewer role-based stressors or societal expectations, allowing for more objective attitudes and reduced vulnerability to stigma.

Our findings underscore the crucial interplay between mental health literacy, internalized stigma, and the pathways to psychiatric care. Individuals with higher awareness of mental health conditions and lower levels of self-stigma tended to seek psychiatric services earlier, particularly when their initial contact was with medical or alternative practitioners. This aligns with a study from Ethiopia, where individuals who initially sought religious treatment or perceived mental illness as shameful experienced longer duration in accessing psychiatric care [26]. Similarly, an Indian study identified older age, male gender, and lower educational attainment as significant predictors of delayed treatment-seeking [22].

Notably, few studies have examined the combined impact of mental health knowledge and internalized stigma on the duration of untreated illness. Enhanced mental health literacy helps individuals and families recognize psychological symptoms as legitimate medical concerns, rather than dismissing them as personal weakness, spiritual afflictions, or temporary stress. Conversely, internalized stigma can significantly hinder help-seeking, as individuals who perceive mental illness as shameful or indicative of personal failure may be less inclined to disclose symptoms or pursue treatment even when services are accessible.

These findings highlight the importance of public education campaigns aimed at improving mental health awareness and reducing stigma. Additionally, primary care providers, often the first point of contact in the healthcare system, play a pivotal role in either facilitating or delaying access to specialized psychiatric care. Integrating training programs for these providers on basic psychiatric screening, referral pathways and non-stigmatizing communication

could substantially improve early identification and treatment engagement.

There are few limitations in our study. The cross-sectional design of our study precludes causal interpretations of the relationships between stigma, mental health knowledge, and care-seeking behaviors. As the study was conducted at a single tertiary care center, the findings may not generalize to community or primary care settings. Reliance on self-reported measures introduces potential recall and social desirability biases, particularly for sensitive topics like stigma. Absence of longitudinal data limits insights into how stigma and mental health literacy evolve over time or with sustained treatment engagement.

Conclusion

This study highlights the importance of mental health knowledge and the awareness needed to achieve it. Mental health knowledge can be viewed as the single most important factor that influences stigma, referral patterns and health care seeking behavior, subsequently improving treatment outcomes. Certain cultural beliefs, accessibility, and preference still play a major role for faith healers. The popular choice of first contact (faith healers) and origin of most referrals to psychiatrist (by medical practitioner) gives us the direction on planning our awareness programs.

Recommendations:

Our study highlights the critical need for community stigma reduction programs, especially for susceptible groups of disorders, mental health training for primary care providers, and targeted rural service expansion to address treatment gaps and improve early intervention.

Future research could adopt longitudinal designs to explore how mental health literacy and internalized stigma evolve over time and how they influence the timing and pattern of care-seeking across different stages of illness. Qualitative approaches could elucidate nuanced psychosocial barriers, particularly in rural/underserved populations. Additionally, technology-based interventions (e.g., telepsychiatry, digital campaigns) warrant investigation for their potential to improve mental health awareness and reduce stigma, especially among youth and hard-to-reach groups.

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