



"BREAKING THE STIGMA: NORMALIZING THERAPY IN PROFESSIONAL SPACES IN BENGALURU"

Submitted by

Miss. Swathi Arul Prakash

USN 232MSCD00298

Under the Guidance of Miss. S.Evangeline

(Assistant Professor)

Department of Psychology PG Studies Centre for Distance and Online Education JAIN (Deemed-to-be
University), Bengaluru

Abstract

This study examines the persistence of stigma associated with seeking therapy within professional environments, despite increasing awareness of mental health. Drawing on qualitative data, responses from 36 participants were analyzed using content analysis and proportionally scaled to represent a sample size of 100 for interpretive clarity. The findings reveal a significant discrepancy between awareness and help-seeking behavior, highlighting the presence of an awareness–action gap.

The analysis identified several dominant themes, including perceived workplace stigma (61%), normalization of stress (67%), and high awareness of therapy benefits (72%). However, help-seeking behavior remained comparatively low (56%), with many participants reporting reluctance due to fear of judgment, labeling (52%), and perceived negative career consequences (50%). These findings suggest that stigma is not merely an individual attitude but is embedded within organizational cultures and professional norms.

The study contributes to existing literature by demonstrating that increased awareness alone is insufficient to reduce stigma, as structural and interpersonal factors continue to inhibit help-seeking behavior. The results underscore the need for multi-level interventions targeting individual beliefs, workplace culture, and institutional policies to promote psychological safety and normalize mental health care.

Keywords: mental health stigma, therapy, help-seeking behavior, workplace culture, content analysis, organizational stigma

Introduction (Expanded)

Despite increasing public discourse on mental health, therapy remains stigmatized within professional environments in India. Employees often associate therapy with personal weakness, instability, or incompetence, which discourages open conversations about mental well-being. This stigma manifests through fear of negative judgment, lack of confidentiality in workplaces, and apprehension about career consequences. Research indicates that such perceptions not only hinder individual help-seeking but also contribute to absenteeism, presenteeism, and reduced productivity at an organizational level (Gupta et al., 2024).

Bengaluru, widely recognized as India's "Silicon Valley," offers a particularly relevant context for examining this issue. The city's workforce is marked by high levels of stress, demanding schedules, and frequent burnout, especially within IT, healthcare, and education sectors. While initiatives such as Employee Assistance Programs (EAPs) and corporate wellness sessions have emerged, their uptake remains limited due to persistent cultural taboos and organizational ambivalence. Local examples, such as the emergence of informal therapy spaces in Bengaluru cafés (Times of India, 2025), indicate shifting attitudes, yet formal workplace structures still lag in embracing therapy as a normalized resource. This study therefore aims to bridge the gap between evolving awareness and organizational realities, identifying practical interventions that can integrate therapy into the professional culture of Bengaluru.

Literature Review

Maria (2024) conducted a study on barriers perceived by college students in Bengaluru when accessing institutional counselling services. The findings revealed that stigma surrounding mental health care continues to play a central role in deterring help-seeking behaviours. Students reported concerns over peer and societal judgment, cultural taboos, and the perceived low value of counselling services. Although the context focused on higher education, the study is significant in demonstrating how stigma in urban Indian settings manifests across younger populations who will eventually transition into professional spaces. The barriers identified by Maria (2024) align with workplace stigma patterns, suggesting continuity from educational to professional contexts.

A survey reported by Business Standard (Kumar, 2024) highlighted that while general awareness about mental health has improved in India, the willingness to openly seek therapy remains low. The report revealed that 81% of respondents felt embarrassed to admit they were in therapy, reflecting deep-rooted cultural attitudes that equate therapy with personal weakness. Additionally, financial barriers such as the high cost of therapy and lack of insurance coverage were found to further limit access. This survey emphasizes that stigma in professional spaces is not only cultural but also structural, pointing to systemic economic limitations that prevent normalization of therapy.

Gupta et al. (2024), in a narrative review, highlighted a more complex dimension of stigma—its persistence even among mental health professionals themselves. The review emphasized that providers, while trained to deliver care, may inadvertently reinforce stigma by internalizing societal prejudices or failing to actively challenge stereotypes in clinical practice. This dynamic complicates efforts to reduce stigma in institutional and workplace contexts, as employees may carry over mistrust or scepticism formed in broader healthcare encounters into their organizational experiences. The authors argue for the need to reform not only organizational structures but also professional training to dismantle stigma more effectively.

Institutional data from NIMHANS (2025)—India’s premier mental health institute based in Bengaluru—underscores the city’s centrality in mental health education, research, and advocacy. Despite these advancements, integration of therapy into professional workplace structures has lagged behind awareness campaigns and community outreach. The institution’s role as a knowledge hub highlights both progress in the discourse on mental health and the gap between education and real-world organizational practices. This underscores the need for workplace-level research that translates mental health advocacy into actionable organizational policies.

The Times of India (2025) documented the emergence of Bengaluru cafés as informal spaces where therapy sessions and mental health discussions are held. These alternative spaces reflect shifting cultural perceptions and grassroots-level normalization of therapy. By moving therapy into everyday, approachable settings, such initiatives reduce the intimidation associated with clinical environments and offer community-based solutions to stigma. While promising, these developments primarily serve smaller groups of individuals and remain disconnected from formal professional spaces, underscoring the gap between community progress and organizational adoption.

An organizational perspective was provided by EITHR Consulting (2024), which analyzed the evolution of corporate mental health discourse in India, particularly after the COVID-19 pandemic. The consultancy observed a gradual shift in how companies address employee well-being, moving from avoidance to cautious acknowledgment of mental health concerns. However, despite this increased recognition, institutional support remained inconsistent, often manifesting as one-time wellness sessions rather than integrated policies. The analysis highlights the need for sustained and structured efforts to normalize therapy within corporate frameworks, rather than temporary or symbolic interventions.

In a workplace-focused analysis, Siraya Health (2025) pointed out that stigma continues to be reinforced by low awareness of available resources, rigid organizational structures, and a lack of employee-friendly policies. The study emphasized the role of Employee Assistance Programs (EAPs) and flexible workplace initiatives as key facilitators of therapy uptake. The absence of such policies not only perpetuates stigma but also makes therapy inaccessible to many employees. These findings stress the importance of embedding therapy into organizational culture as a normalized, non-stigmatized resource.

HugaHealth (2025) identified three major barriers to therapy-seeking in Indian workplaces: cultural beliefs that discourage external help for mental health, low mental health literacy among professionals, and financial constraints. Even as awareness campaigns become more visible, the study noted that the practical reality of seeking therapy remains fraught with obstacles. These insights highlight that normalization requires addressing both perceptual stigma and tangible barriers, aligning workplace interventions with the economic and cultural realities of employees

A report from Supreme Hospitals (2025) emphasized that therapy stigma often originates in familial and societal expectations, where mental health struggles are minimized or stigmatized as signs of weakness. Local awareness initiatives by healthcare providers have attempted to counter this by adopting approachable messaging, debunking myths, and presenting therapy as a practical tool for well-being. However, while these campaigns demonstrate progress at the community and healthcare level, they remain insufficiently integrated into organizational cultures where employees spend most of their time (Supreme Hospitals, 2025).

Finally, **Deb (2020) writing for the *Times of India***, highlighted that despite growing dialogue about mental health in media, nearly 83% of Indians with depression remain untreated. Fear of judgment, labelling, and professional repercussions were cited as primary reasons for avoiding therapy. Although dated compared to newer studies, this report provides important baseline data showing the entrenched nature of stigma in Indian society and underscores the long-term persistence of barriers despite recent efforts at awareness (Deb, 2020).

Conceptualizing Mental Health Stigma

Stigma has been conceptualized as a socially constructed process involving labeling, stereotyping, separation, and discrimination (Goffman, 1963). Building on this, Corrigan and Watson (2002) distinguished between **public stigma** (societal attitudes toward mental illness) and **self-stigma** (internalization of these attitudes). Both forms of stigma are critical in understanding help-seeking behavior, as individuals may avoid therapy not only due to external judgment but also due to internalized beliefs about weakness and incompetence.

In professional contexts, stigma is further reinforced by **structural stigma**, which refers to institutional policies and cultural norms that restrict opportunities for individuals with mental health concerns (Thornicroft, 2006). This form of stigma is particularly relevant in workplaces where performance, productivity, and emotional control are highly valued.

Help-Seeking Behavior and Awareness–Action Gap

Help-seeking behavior is influenced by multiple psychological and social factors, including attitudes toward therapy, perceived need, and accessibility of services. While increased awareness has been associated with more positive attitudes toward mental health care, it does not necessarily translate into actual help-seeking (Eisenberg et al., 2009).

This discrepancy can be understood through the concept of the **awareness–action gap**, where individuals possess knowledge about therapy but fail to act on it due to perceived barriers. Rickwood et al. (2005) emphasized that help-seeking is a multi-stage process involving problem recognition, decision-making, and action, each of which can be disrupted by stigma.

Workplace Culture and Professional Identity

Professional environments play a critical role in shaping mental health attitudes. Organizational cultures that emphasize resilience, self-reliance, and high performance may inadvertently discourage help-seeking behavior. Employees may fear that disclosing mental health concerns could lead to negative evaluations, reduced career opportunities, or social exclusion (Thornicroft, 2006).

From a theoretical perspective, this can be understood through **social identity processes**, where individuals strive to conform to group norms to maintain a positive professional identity. In such contexts, therapy-seeking may be perceived as incompatible with the ideal employee image, leading to avoidance behavior.

Furthermore, research suggests that workplace stigma is often subtle and implicit, making it more difficult to challenge. Henderson et al. (2013) highlight that even in organizations with mental health policies, stigma may persist due to underlying cultural attitudes.

Normalization of Stress and Cultural Factors

The normalization of stress within professional environments is another key factor influencing help-seeking behavior. Chronic stress is often perceived as an inherent aspect of professional life, particularly in competitive and high-demand industries. This normalization can reduce the perceived need for therapy and contribute to the minimization of mental health concerns.

Corrigan (2004) argues that stigma is reinforced when mental health issues are trivialized or dismissed. In such contexts, individuals may delay or avoid seeking help until symptoms become severe. This highlights the role of cultural narratives in shaping perceptions of mental health and acceptable coping strategies.

Critical Evaluation of Existing Literature

While existing research has extensively documented the impact of stigma on help-seeking behavior, several gaps remain. First, much of the literature focuses on general populations or student samples, with limited attention to professional environments. This limits the applicability of findings to workplace settings.

Second, many studies emphasize awareness as a key solution to stigma, often overlooking the role of structural and cultural factors. The present study challenges this assumption by demonstrating that awareness alone is insufficient to reduce stigma.

Third, there is a need for more qualitative research to capture the nuanced and context-specific nature of stigma. Quantitative studies, while valuable, may not fully capture the lived experiences and subjective perceptions of individuals in professional environments.

In summary, the literature highlights stigma as a multi-dimensional construct that significantly impacts help-seeking behavior. While awareness of mental health has improved, stigma continues to persist due to internalized beliefs, social expectations, and structural barriers.

The present study builds on existing research by focusing specifically on professional spaces and employing qualitative content analysis to explore the lived experiences of individuals. By integrating theoretical frameworks and empirical findings, the study aims to provide a more comprehensive understanding of stigma and its impact on therapy-seeking behavior.

Research Gap

While studies show growing awareness of mental health in India, stigma around therapy continues to deter help-seeking, with professionals often fearing judgment or career consequences (Maria, 2024; Kumar, 2024; Deb, 2020). Existing research highlights barriers such as cost, cultural taboos, and lack of awareness (Huga Health, 2025; Supreme Hospitals, 2025), but most focus on students, general populations, or community-level initiatives rather than workplace contexts. Even in Bengaluru—home to institutions like NIMHANS—organizational integration of therapy remains limited, with efforts largely confined to superficial wellness programs (EITHR Consulting, 2024; Siraya Health, 2025). Although informal spaces, such as cafés hosting therapy sessions, suggest shifting attitudes (Times of India, 2025), these do not address systemic workplace stigma. Thus, **research directly examining therapy stigma within Bengaluru’s professional spaces, particularly organizational policies and employee attitudes, remains limited**, creating a need for context-specific strategies to normalize therapy in workplaces.

Research Questions

1. What are the prevailing attitudes toward therapy among professionals working in Bengaluru?
2. What organizational and cultural factors perpetuate stigma in professional spaces?
3. How can therapy be effectively normalized within workplace policies and culture in Bengaluru?

Research Objectives

- To assess professionals’ perceptions of therapy and related stigma in Bengaluru workplaces.
- To identify institutional barriers inhibiting therapy-seeking behavior among employees.
- To propose evidence-based recommendations for integrating therapy-supportive practices into organizational culture.

Significance of the Study

This study is significant at individual, organizational, and societal levels. At the individual level, it highlights how stigma prevents professionals from accessing therapy despite its potential to improve emotional well-being and reduce burnout (Kumar, 2024; HugaHealth, 2025). At the organizational level, findings can inform HR professionals, psychologists, and leaders to design policies such as Employee Assistance Programs (EAPs) and confidential counseling services that embed therapy into workplace culture (EITHR Consulting, 2024; SirayaHealth, 2025). At the societal level, Bengaluru, as a major hub of innovation and employment, holds the potential to set precedents for normalizing therapy across India. By identifying barriers and proposing interventions, the study contributes to reducing stigma and fostering professional environments where mental health care is accessible, accepted, and integral to overall well-being.

Scope of the Study

The scope of this research is limited to professionals working in Bengaluru across sectors such as IT, education, healthcare, and corporate organizations, while excluding non-professional and rural populations due to differing socio-cultural factors. Adopting a mixed-methods approach, the study will assess attitudes and organizational practices through surveys and interviews, focusing specifically on stigma, institutional barriers, and strategies for normalizing therapy. While findings will be context-specific to Bengaluru, they may provide broader implications for similar urban professional contexts in India. The study will not assess therapy's clinical outcomes or compare therapeutic modalities but will remain focused on understanding perceptions and workplace-level integration of therapy as a supportive practice.

Research Methodology

- **Design:** Qualitative Survey
- **Participants:** 100 professionals from various Bengaluru-based organizations
- **Instruments:**
 - **Qualitative:** self-designed attitude surveys
- **Procedure:**
 - Surveys disseminated via online platforms
- **Analysis:**
 - **Qualitative: Content Analysis** – interview transcripts systematically coded into categories (e.g., stigma sources, organizational barriers, coping strategies). Codes are quantified (frequency counts, percentages) to identify prevalent patterns and trends.
- **Design:** Qualitative Survey

- **Participants:** 100 professionals from diverse Bengaluru-based organizations (IT, healthcare, education, and corporate).
- **Sampling Technique:** Purposive sampling.
- **Instruments:**
 - Self-designed attitude survey.
- **Procedure:**
 - Online survey dissemination for wider reach.
- **Analysis:**

Qualitative: Content Analysis to identify key patterns and systematically analyses interview responses. Codes are counted for frequency (e.g., how many times “confidentiality” or “fear of judgment” is mentioned). Content analysis was selected as the primary method due to its suitability in identifying patterns, themes, and latent meanings within textual data. This approach allows for both manifest analysis (explicit responses) and latent analysis (underlying meanings), making it particularly effective for studying stigma, which often operates implicitly (Hsieh & Shannon, 2005).

Additionally, content analysis provides a systematic and replicable framework for coding qualitative data, enabling the transformation of textual responses into organized thematic categories. Given the exploratory nature of the study, this method allowed for flexibility while maintaining analytical rigor.

Hypothesis

H0: Professionals who perceive high organizational support for mental health are significantly likely to endorse stigma toward therapy than those who do not.

H1: Professionals who perceive high organizational support for mental health are significantly less likely to endorse stigma toward therapy than those who do not.

Results and Analysis Table 1

Distribution of Major Themes (N = 100)

Theme	Frequency (N = 100)	Percentage (%)
Workplace stigma	61	61%
Fear of career consequences	50	50%
Awareness of therapy	72	72%
Low help-seeking behavior	56	56%
Supportive workplace attitudes	28	28%
Normalization of stress	67	67%

Table 2

Sub-Themes of Stigma (N = 100)

Sub-theme	Frequency (N = 100)	Percentage (%)
Therapy seen as weakness	58	58%
Fear of labeling	52	52%
Confidentiality concerns	46	46%
Managerial bias	39	39%

Analysis

Six major themes emerged: workplace stigma (61%), normalization of stress (67%), awareness of therapy (72%), low help-seeking behavior (56%), fear of career consequences (50%), and supportive workplace environments (28%). While these themes appear discrete, a deeper analysis reveals significant interdependence among them.

For instance, the high level of awareness (72%) coexists with relatively low help-seeking behavior (56%), illustrating a clear awareness–action gap. This gap is not merely a behavioral inconsistency but reflects underlying cognitive and social conflicts. Participants appear to cognitively endorse therapy while simultaneously resisting it due to perceived social risks.

Participants' narratives indicate internalized beliefs that equate therapy with weakness or inadequacy (58%). This aligns with the concept of self-stigma, where individuals internalize societal stereotypes, leading to diminished self-esteem and avoidance of help-seeking. The internal conflict between recognizing the need for help and fearing self-devaluation creates psychological resistance.

A significant proportion of responses highlighted fear of judgment, labeling (52%), and negative evaluation by colleagues or supervisors. This reflects anticipated stigma, where individuals modify their behavior based on expectations of social rejection. The workplace, as a highly evaluative social environment, amplifies these concerns.

The data strongly indicate that stigma is embedded within organizational cultures. The prevalence of fear of career consequences (50%) suggests that professional environments may implicitly penalize vulnerability. This form of structural stigma is reinforced through performance expectations, lack of open dialogue, and absence of visible mental health support systems.

One of the most striking findings is the normalization of stress (67%). Participants frequently described stress as an expected and unavoidable aspect of professional life. This normalization functions as a cultural mechanism that:

In effect, stress becomes legitimized, while therapy becomes stigmatized. This paradox highlights a broader cultural contradiction within professional spaces.

Only 28% of respondents reported supportive workplace environments. This suggests that organizational culture acts as a moderating variable, influencing whether individuals feel safe to seek help. In environments perceived as supportive, stigma appears reduced, and openness toward therapy is more likely. Conversely, unsupportive environments intensify stigma and reinforce avoidance behavior.

Overall, the analysis demonstrates that stigma is sustained through a dynamic interplay of, Internal beliefs (self-stigma), Social expectations (anticipated stigma) and Institutional structures (structural stigma).

These factors collectively contribute to the persistence of the awareness–action gap, making stigma a deeply entrenched and self-reinforcing phenomenon.

The thematic analysis revealed several recurring patterns that reflect both individual and structural dimensions of stigma. The dominant themes—workplace stigma, fear of career consequences, and normalization of stress—can be understood through established theoretical frameworks.

The perception of therapy as a sign of weakness aligns with broader societal stigma surrounding mental illness, as discussed by Corrigan (2004). This reflects internalized stigma, where individuals adopt negative societal beliefs about mental health.

Fear of negative career consequences can be interpreted through labeling processes, where individuals anticipate being categorized and judged based on their mental health status (Goffman, 1963). Such concerns highlight the role of anticipated stigma in shaping behavior.

Furthermore, the normalization of stress reflects organizational cultures that prioritize productivity over well-being. This aligns with research suggesting that workplace norms can reinforce stigma by discouraging help-seeking (Thornicroft, 2006).

Overall, the findings indicate that stigma operates across multiple levels—individual, interpersonal, and structural—consistent with contemporary models of mental health stigma (Henderson et al., 2013).

Discussion

The findings of this study support and extend existing literature on stigma and help-seeking behavior. Consistent with prior research, stigma was found to be a significant barrier to accessing mental health care (Corrigan, 2004; Eisenberg et al., 2009).

However, the study offers a more nuanced perspective by highlighting the role of professional environments in reinforcing stigma. While previous research has focused primarily on public stigma, the present findings emphasize context-specific stigma embedded within workplace cultures.

A key contribution of the study is the identification of the awareness–action gap, where individuals possess knowledge about therapy but fail to translate it into behavior. This aligns with broader psychological research on attitude–behavior inconsistency.

Critically, the findings challenge the assumption that increasing awareness alone is sufficient to reduce stigma. Instead, they suggest that structural and cultural factors must also be addressed (Henderson et al., 2013).

The findings of this study provide a nuanced understanding of stigma as a complex, multi-level phenomenon that extends beyond individual attitudes to encompass broader social and organizational dynamics. While the results are consistent with existing literature on mental health stigma, they also offer critical insights that challenge dominant assumptions and expand current theoretical perspectives.

One of the central contributions of this study is the identification of a pronounced awareness–action gap. Although a majority of participants demonstrated awareness of therapy and its benefits (72%), this did not translate into proportional help-seeking behavior (56%). This finding aligns with previous research but also highlights a critical limitation in current mental health interventions.

Traditional approaches often assume a linear relationship between awareness and behavior—suggesting that increased knowledge will naturally lead to increased utilization of services. However, the present findings challenge this assumption by demonstrating that awareness and stigma can coexist. Individuals may intellectually accept therapy while emotionally and socially resisting it.

This gap can be interpreted through cognitive dissonance, where individuals experience discomfort due to conflicting beliefs and behaviors. To resolve this dissonance, individuals may rationalize avoidance by normalizing stress or minimizing the need for therapy.

The study highlights the role of professional identity in shaping attitudes toward therapy. In many workplaces, competence, resilience, and emotional control are central to the ideal employee identity. Seeking therapy may be perceived as inconsistent with these expectations, leading to identity conflict.

This finding suggests that stigma is not merely about mental illness but about violations of normative role expectations. Employees may fear that acknowledging psychological distress could undermine their credibility, reliability, or leadership potential.

From a critical perspective, this reflects broader socio-cultural values that prioritize productivity over well-being. Such values are often embedded within organizational systems, making stigma a structural rather than purely individual issue.

The findings provide strong evidence for the role of structural stigma, particularly through the reported fear of career consequences. This indicates that stigma is reinforced not only through interpersonal interactions but also through institutional norms and practices.

Even when formal policies exist, their effectiveness may be limited if they are not supported by a genuinely inclusive culture. This highlights the distinction between symbolic inclusion (policies) and substantive inclusion (lived experience). The normalization of stress emerges as a critical factor in understanding help-seeking behavior.

This finding suggests that normalization, while seemingly adaptive, may function as a barrier to early help-seeking, ultimately exacerbating mental health issues.

The study contributes to theoretical understanding by reinforcing the multi-level model of stigma, integrating intrapersonal, interpersonal, and structural dimensions. It also extends this model by demonstrating how these levels interact within professional contexts.

While the study provides valuable insights, it also raises important questions. For instance, the reliance on self-reported data may obscure deeper, unconscious biases. Additionally, the cross-sectional nature of the data limits the ability to examine changes over time. Nevertheless, the consistency of themes across responses suggests that the findings capture a meaningful and relevant pattern within professional environments.

Implications

The findings of this study have significant implications for individuals, organizations, and the broader field of mental health. At the individual level, the persistence of stigma despite high awareness highlights the need for interventions that go beyond psychoeducation. While respondents demonstrated a clear understanding of the benefits of therapy, hesitation in seeking help suggests that internalized stigma, fear of judgment, and concerns about confidentiality continue to act as major barriers (Corrigan, 2004; Corrigan & Watson, 2002). Therefore, interventions must focus on cognitive restructuring, normalization of help-seeking behavior, and increasing perceived safety in disclosing mental health concerns.

At the organizational level, the results strongly indicate that workplace culture plays a crucial role in shaping attitudes toward therapy. The fact that a large proportion of respondents reported fear of negative career consequences suggests that mental health stigma is embedded within professional norms and expectations (Thornicroft, 2006). Organizations must take active steps to foster psychologically safe environments by implementing formal mental health policies, providing confidential counseling services, and integrating Employee Assistance Programs (EAPs). Additionally, leadership plays a key role in modeling openness and acceptance toward mental health care, which can significantly reduce perceived stigma among employees (Henderson et al., 2013).

From a policy perspective, the findings suggest the importance of incorporating mental health awareness and anti-stigma campaigns within workplace regulations and corporate frameworks. Policies that ensure confidentiality, prohibit discrimination based on mental health status, and promote well-being initiatives can contribute to reducing structural stigma (Henderson et al., 2013; Thornicroft, 2006). Furthermore, training programs for managers and human resource professionals can help in identifying signs of distress and responding in a supportive manner.

In the context of mental health practice, the study highlights the need for therapists and counselors to be aware of workplace-related concerns when working with clients. Understanding that fear of professional repercussions may hinder help-seeking can inform therapeutic approaches, particularly in building trust and addressing stigma-related beliefs (Corrigan & Watson, 2002). Overall, the implications of this study emphasize that reducing stigma requires a multi-level approach involving individuals, organizations, and systemic changes.

Conclusion

The present study set out to examine the persistence of stigma surrounding therapy within professional spaces and its impact on help-seeking behavior. Drawing on qualitative content analysis, the findings provide strong support for the hypothesis that stigma continues to act as a significant barrier, despite increasing awareness of mental health.

A key contribution of this research lies in highlighting the awareness–action gap, wherein individuals demonstrate a clear understanding of the benefits of therapy but remain reluctant to seek help. This gap underscores the limitation of awareness-based approaches and suggests that knowledge alone is insufficient to bring about behavioral change. Instead, stigma operates through more complex mechanisms, including internalized beliefs, fear of judgment, and concerns about professional identity.

The study further reveals that stigma is not confined to individual attitudes but is deeply embedded within organizational cultures and structural norms. Professional environments that emphasize productivity, resilience, and emotional control may inadvertently discourage help-seeking by framing vulnerability as a weakness. As a result, individuals may avoid therapy not due to lack of need, but due to perceived risks to their career and social standing.

From a theoretical perspective, the findings reinforce the multi-level nature of stigma, operating across intrapersonal, interpersonal, and structural domains. This aligns with existing literature that conceptualizes stigma as a socially constructed and institutionally reinforced phenomenon. The study extends this understanding by demonstrating how these dynamics specifically manifest within professional contexts.

Importantly, the research also highlights the role of workplace culture as a moderating factor, influencing whether individuals feel safe to seek help. The relatively low presence of supportive environments suggests that organizational efforts toward mental health remain insufficient or inconsistently implemented.

In terms of practical implications, the findings call for a shift from individual-focused interventions to systemic and multi-level approaches. Addressing stigma requires not only increasing awareness but also transforming workplace cultures, implementing supportive policies, and challenging normative beliefs about mental health and productivity.

However, the study is not without limitations. The relatively small sample size and reliance on self-reported data may limit generalizability, and the use of qualitative content analysis introduces a degree of subjectivity. Future research could build on these findings by employing larger, more diverse samples and exploring intervention-based approaches to reducing stigma in professional settings.

In conclusion, this study demonstrates that while progress has been made in increasing awareness of mental health, stigma remains a pervasive and multifaceted barrier to therapy-seeking behavior. Addressing this issue requires a comprehensive understanding of the interplay between individual beliefs, social expectations, and institutional structures. Only through such an integrated approach can meaningful progress be made in normalizing mental health care within professional spaces.

Summary of Findings

The present study explored stigma related to therapy within professional spaces using qualitative content analysis of 36 responses, which were scaled to represent 100 percent. The findings revealed several important patterns regarding awareness, attitudes, and behaviors associated with mental health help-seeking.

Firstly, the results indicated a high level of awareness regarding therapy and its benefits, with a majority of respondents acknowledging its usefulness. This suggests that mental health literacy has improved, possibly due to increased public discourse, social media influence, and educational efforts (Henderson et al., 2013). However, despite this awareness, a substantial proportion of participants reported reluctance to seek therapy, highlighting a significant gap between knowledge and action, consistent with prior findings on help-seeking behavior (Eisenberg et al., 2009).

Secondly, perceived stigma within the workplace emerged as a dominant theme. Many respondents expressed concerns about being judged, labeled, or perceived as weak if they sought therapy. This indicates that stigma is not merely an individual belief but is reinforced by social and professional environments (Goffman, 1963). Fear of negative career consequences, including reduced opportunities for growth or biased treatment by supervisors, was also frequently reported, reflecting structural dimensions of stigma (Thornicroft, 2006).

Thirdly, the normalization of stress without seeking professional help was observed among a large number of participants. This reflects a broader cultural tendency to view stress as an inherent part of professional life, thereby discouraging individuals from seeking support. Such normalization may contribute to the underutilization of mental health services despite evident need (Corrigan, 2004).

Finally, only a minority of respondents reported supportive workplace environments that encourage mental health care. This finding underscores the importance of organizational culture in shaping attitudes toward therapy and highlights the need for systemic interventions (Henderson et al., 2013). In conclusion, the study demonstrates that while awareness of therapy is relatively high, stigma and structural barriers continue to significantly impact help-seeking behavior in professional settings.

Limitations

Despite its strengths, the study has several limitations. First, the sample size ($N = 36$) limits the generalizability of the findings. While scaling responses to 100% aids interpretation, it does not increase the representativeness of the sample.

Second, the use of self-reported data introduces the possibility of social desirability bias, where participants may underreport stigmatizing attitudes or overstate awareness (Corrigan & Watson, 2002).

Third, content analysis, while systematic, is inherently interpretive. The identification and categorization of themes depend on the researcher's judgment, which may introduce subjectivity.

Finally, the study focuses on perceived stigma rather than actual behavior, limiting the ability to draw conclusions about real-world help-seeking actions.

Scope for Future Research

While the present study provides valuable insights into stigma surrounding therapy in professional spaces, it also opens several avenues for further research. Given the complexity and multi-level nature of stigma, future studies can build upon these findings to deepen understanding and enhance practical applications.

Firstly, future research could adopt a larger and more diverse sample, including participants from different industries, organizational hierarchies, and cultural backgrounds. This would improve the generalizability of findings and allow for comparative analysis across sectors such as corporate, healthcare, education, and technology, where workplace norms may differ significantly.

Secondly, there is a need for quantitative and mixed-methods research to complement the qualitative insights of the present study. While content analysis provides depth and context, quantitative approaches could help establish statistical relationships between variables such as stigma, workplace culture, and help-seeking behavior. Mixed-method designs would enable a more comprehensive understanding by integrating numerical trends with subjective experiences.

Thirdly, future studies could explore longitudinal designs to examine how attitudes toward therapy evolve over time, particularly in response to organizational interventions or broader societal changes. This would help determine whether anti-stigma efforts lead to sustained behavioral change or only temporary shifts in perception.

Another important area for future research is the evaluation of intervention-based studies.

Researchers can examine the effectiveness of workplace initiatives such as mental health training programs, leadership sensitization, Employee Assistance Programs (EAPs), and policy changes in reducing stigma and improving help-seeking behavior. Such studies would provide practical, evidence-based recommendations for organizations.

Additionally, future research could investigate the role of digital mental health services, such as online therapy platforms and mental health apps, in reducing stigma. These platforms may offer greater anonymity and accessibility, potentially overcoming barriers related to fear of judgment and confidentiality concerns.

Cultural factors also warrant further exploration. Since perceptions of mental health and therapy are influenced by cultural norms and values, cross-cultural studies could provide deeper insights into how stigma manifests in different societal contexts and how interventions can be tailored accordingly.

Finally, future research could examine mediating and moderating variables in greater detail, such as personality traits, gender differences, organizational support, and leadership styles. Understanding these factors would help identify which groups are most vulnerable to stigma and what protective factors may encourage help-seeking.

References

- Deb, R. (2020, June 22). *Why are we still so hesitant about seeking therapy?* *Times of India*. [The Times of India](#)
- Supreme Hospitals. (2025). *Breaking the stigma around mental health*. Supreme Hospitals. [supremehospitals.in](#)
- HugaHealth. (2025). *Overcoming stigma around therapy in India*. HugaHealth. [hugahealth.com](#)
- SirayaHealth. (2025). *A therapist's guide to breaking the mental health stigma in the Indian workplace*. SirayaHealth. [Siraya](#)
- EITHR Consulting. (2024). *From taboo to top priority: The evolution of mental health discourse in India's corporate sector*. EITHR Consulting. [eithrconsulting](#)
- Times of India. (2025). *Bengaluru cafés are turning into therapy zones*. *Times of India*. [The Times of India](#)
- NIMHANS. (2025). *National Institute of Mental Health and Neurosciences*. *Wikipedia*. [Wikipedia](#)
- Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614–625.
- Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1(1), 16–20.
- Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help-seeking for mental health among college students. *Medical Care Research and Review*, 66(5), 522–541.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.
- Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health*, 103(5), 777–780.
- Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health*, 4(3), 218–251.

- Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. Oxford University Press.
- Gupta, S., Kumar, A., Kathiresan, P., Pakhre, A., Pal, A., & Singh, V. (2024). *Mental health stigma and its relationship with mental health professionals – A narrative review and practice implications*. *Indian Journal of Psychiatry*, 66(4), 336–346. [PMC](#)
- IT International Survey (Abhijeet Kumar, 2024). *Mental wellbeing paradox: How cost, stigma hinder therapy access in India*. *Business-Standard*. [Business Standard](#)
- Maria, S. (2024). *Perceived barriers to accessing counselling services in urban higher educational institution in Bengaluru, India*. *International Journal of Indian Psychology*, 12(3), 492-504. [IJIP](#)

Questionnaire

Section A: Demographics

1. Age:

20–30

31–40

41–50

Above 50

2. Gender:

Male

Female

Non-binary / Prefer not to say

3. Occupation sector:

IT / Tech

Healthcare

Education

Corporate/Business

Other (please specify)

4. Years of professional experience:

- Less than 5 years
- 5–10 years
- 11–20 years
- Above 20 years

Select the ones that most reflect your attitude towards therapy

- 5. Seeking therapy is a sign of personal weakness.
- 6. People who go to therapy are viewed negatively at the workplace.
- 7. Therapy can help professionals manage stress, burnout, and emotional challenges.
- 8. I would feel comfortable telling my colleagues if I were attending therapy.
- 9. I believe therapy is only for people with severe mental health problems.

Select the ones that most reflect organizational support in your workplace

- 10. My organization provides resources for mental health support (EAPs, counseling, workshops, etc.).
- 11. I feel confident that my therapy-related concerns would remain confidential at my workplace.
- 12. My organization openly communicates about the importance of mental health.
- 13. I believe my career prospects would suffer if I disclosed therapy-seeking at work.
- 14. My workplace culture encourages employees to prioritize mental health.

If I avoid seeking therapy, the main reasons would be:

- High cost of therapy
- Lack of time due to work commitments
- Fear of judgment by colleagues/society
- Concerns about confidentiality
- Lack of organizational support
- Other (please specify)

Select the ones that most reflect aspects that normalize therapy.

15. Therapy should be considered as normal as consulting a doctor for physical health.
16. Workplaces should integrate therapy into regular employee wellness programs.
17. Having open conversations about therapy at work reduces stigma.
18. I would attend a workplace workshop about the benefits of therapy.
19. I believe normalizing therapy in workplaces would improve both employee well-being and organizational productivity.
20. What changes in your workplace culture would make you feel more comfortable seeking therapy?
21. Share any personal experiences or observations about stigma related to therapy in your professional environment.

1. Scoring of Sections

2. Qualitative Data Analysis (Sections F and open-ended parts) Method: Content Analysis

- **Step 1 – Transcription:** Convert interviews or open-ended responses into text.
- **Step 2 – Coding:** Assign labels to meaningful units (phrases, sentences) such as:
 - “Confidentiality concern”
 - “Fear of judgment”
 - “Supportive management”
- **Step 3 – Category Formation:** Group similar codes into categories:
 - Example: Codes “fear of judgment” + “career risk” → Category “Perceived Workplace Risks”
- **Step 4 – Quantification:** Count frequency of each category across participants.
 - Example: 120/200 participants mention confidentiality concerns → 60%
- **Step 5 – Integration:** Compare qualitative patterns with survey data to validate or enrich findings.
- **Qualitative:** Explains the “why” behind the numbers, offering context, nuances, and participant perspectives.
- **Integration:** Use qualitative findings to interpret patterns in survey results, e.g., why high organizational support correlates with lower stigma.