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ORIGINAL ARTICLE

Prevalence of Mental Health Stigma, Help-Seeking Behaviors, and Barriers to Seeking Assistance: A CERA Study of Family Physician Educators

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ABSTRACT

Background and Objectives: Mental health stigma remains prevalent in clinical practice, affecting even family physicians. Despite serving as frontline mental health providers, family physicians also face stigma and barriers to seeking care. Drawing on 2024 Council of Academic Family Medicine Educational Research Alliance study data, this study investigates family physician educators' perceptions of stigma, their help-seeking intentions, and the obstacles they encounter when pursuing mental health support.

Methods: This cross-sectional study drew responses from a 2024 survey of family medicine educators and practicing physicians between October 15 and November 22, 2024. Out of the initial pool of 4,844 participants completing the survey, our sample included 1,195 respondents. One-way analysis of variance and simple linear regression were performed in Stata 14.0 to test our hypotheses rigorously.

Results: Bivariate analyses identified statistically significant associations across five key relationships: years since degree completion and stigma score, age and stigma score, race and barriers to care, underrepresented in medicine status and barriers to care, and gender and barriers to care. Furthermore, linear regression models demonstrated that all three stigma categories (personal, perceived, and stigma of others) were significantly linked to higher barrier scores.

Conclusions: These findings underscore the pervasive nature of mental health stigma among family physicians, highlighting its detrimental impact on help-seeking and well-being. Targeted interventions are crucial for reducing stigma, addressing barriers to care, and protecting physicians' mental health, ultimately improving patient outcomes.

Globally, a growing body of evidence has documented high rates of burnout and suicide among medical professionals, highlighting the urgent need to protect and improve the psychological well-being of trainees, physicians, and physician educators. Mental health stigma is pervasive in medical education and the field of medicine, and it encompasses several psychological, structural, social, and cultural barriers to improving mental health.[1,2] Mental health stigma is defined as negative attitudes, beliefs, behaviors, stereotypes, prejudice, and discrimination that are exercised toward individuals with mental health conditions.[1,3] In the United States, barriers to help-seeking, such as fear of peer judgment, breach of confidence, and impact on licensure, can contribute to physicians' reluctance to disclose mental health challenges and further perpetuate mental health stigma.[4,5]

As first-line providers of mental health care, family physicians are at

significant risk for experiencing mental health stigma personally, professionally, and clinically. Delayed or absent treatment for burnout, depression, anxiety, and other mental health issues for physicians and patients is often the result of mental health stigma.[6] In a 2023 survey of physicians, 78% of physicians reported stigma related to seeking mental health treatment.[7] In that study, 83% of females reported higher perceived stigma levels than their male counterparts.[7] In addition to the deterrence of mental help-seeking for physicians, mental health stigma can influence clinical decision-making for patients with mental health needs. This influence can be translated into absent or suboptimal patient care, further perpetuating poor mental health outcomes. Thus, investigating mental health stigma in the context of help-seeking behaviors and help-seeking barriers in family physicians is critical.

A paucity of literature exists regarding mental health stigma and help-seeking intentions across a broad audience of family physicians, such as the general membership of the Council of Academic Family Medicine (CAFM) Educational Research Alliance (CERA). To date, one 2018 CERA study was conducted on mental health stigma regarding mental health stigma reduction programs. Thus, the purpose of this cross-sectional study was to examine the prevalence of and associations between mental health stigma (personal, perceived/anticipated, and stigma of others), help-seeking intention, and barriers to help-seeking in family physicians within the CERA general membership audience.

METHODS

Data Source

This study used data from the 2024 CERA study of family medicine educators and practicing physicians. CAFM is a joint initiative of four major academic family medicine organizations: the Society of Teachers of Family Medicine, the North American Primary Care Research Group, the Association of Departments of Family Medicine, and the Association of Family Medicine Residency Directors.

For our analysis, we used the following sections of the CERA survey: (1) Demographics, and (2) Mental Health Stigma, Help-Seeking Intentions, and Barriers to Seeking Mental Health. The study was approved by the American Academy of Family Physicians Institutional Review Board in October 2024. The survey was distributed to 5,168 candidates. Of these, 230 were returned as undeliverable email addresses, and 94 candidates who had previously opted out of receiving surveys from SurveyMonkey also were excluded. The survey was delivered to a final sample of 4,844 members of the CAFM organizations. The survey was conducted between October 15, 2024, and November 22, 2024.

Study Measures

Our questions were adapted from the peer-reviewed, validated stigma and help-seeking questionnaire, Stigma and Self-Stigma Scales.[8] We used data from the CERA recurring demographic questions, including age, race/ethnicity, gender identity, years since highest degree earned, and underrepresented in medicine (URiM) self-endorsement. These data assisted us in evaluating and investigating associations between the three types of stigmas, the relationships between mental health stigma types, and help-seeking intention and barriers to help-seeking.

Definitions

We used three categories to measure types of stigma: personal stigma, perceived/anticipated stigma, and stigma of others. Personal stigma, or self-stigma, is when individuals internalize negative perceptions, which may result in feelings of shame, lowered self-esteem, and reluctance to seek help.[9] Perceived/anticipated stigma is the belief that others hold negative views about individuals with mental health conditions, causing individuals to fear judgment or discrimination.[9] The stigma of others refers to the negative attitudes, beliefs, and stereotypes society holds about individuals with mental health conditions, including beliefs that they are incapable, unstable, dangerous, or weak.[8,10] We defined URiM status based on the definition of the Association of American Medical Colleges: "individuals from racial and ethnic populations who are underrepresented in the medical profession relative to their numbers in the general population (Black/African American, Hispanic/Latino/of Spanish Origin, American Indian/Alaska Native/Indigenous, Native Hawaiian/other Pacific Islander, and certain Asian ethnicities)."[11]

RESULTS

Study Sample

The survey was distributed to 4,844 respondents, with 1,195 completed responses and a response rate of 24.67% (1,195/4,844). For our selected sample, inclusion criteria included all individuals who reported themselves as one of the following: MD physician, DO physician, PhD/MD, or PhD/DO (N = 914). We established these criteria because the study focused primarily on practicing medical professionals.

Predictor Variables

The principal predictor variable involved the stigma score based on the five stigma questions presented in Table 1. The stigma score was the sum of all the responses across all five stigma items (ie, two personal, two perceived, and one stigma of others). We used the 5-point Likert-like scale for each item, with the following coding convention: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree. The higher the score, the greater the reported stigma; the lowest possible score was five and the highest possible score was 25. The other predictor variables included the following demographic variables: age, gender, race, URiM status, and years since degree completion.

TABLE 1. Principal Predictor and Outcome Variables

Principal predictor variables and questions		Responses
Personal stigma	1. If I had a mental health condition, I would question whether I am suitable for a career in medicine.	1 = Strongly disagree
	2. If I had a mental health condition, I would feel like a burden to others.	2 = Disagree
Perceived stigma	3. Important people in my life would think less of me if they were to find out that I was experiencing a mental health condition.	3 = Neutral
	4. If I had a mental health condition, I would worry that other people would think I was not equipped to work in my current career.	4 = Agree
Stigma of others	5. Physicians, residents, or medical students experiencing mental health conditions are less reliable than their counterparts without mental health conditions.	5 = Strongly agree
Principal outcome variables and questions		**Responses**
Help-seeking behavior: therapist	6. If I had a mental health condition and needed help, I would feel comfortable going to a therapist.	1 = Strongly disagree
Help-seeking behavior: mental health professional	7. If I had a mental health condition and needed help, I would feel comfortable going to a mental health specialist (eg, psychiatrist, family doctor) for medication.	2 = Disagree
Barriers to help-seeking: career	8. I believe that seeking help for mental health conditions could have negative repercussions for my current and/or future licensure or career.	3 = Neutral
Barriers to help-seeking: confidentiality	9. I would be uncomfortable seeking professional help for mental health conditions due to concerns about confidentiality.	4 = Agree
Barriers to help-seeking: time	10. My current schedule does not allow me the time to seek help for a mental health condition, if needed.	5 = Strongly agree

Outcome Variables

The principal outcome variables (shown in Table 1) were used to derive the following scores: help-seeking behavior and barrier scores. All items used the 5-point scale with the following coding convention: 1 = strongly disagree; 2 = disagree; 3 = neutral; 4 = agree; 5 = strongly agree.

1. **Help-seeking behavior score**. This score is the sum of all the responses across two health-seeking behavior items, which included therapist (ie, "*If I had a mental health condition and needed help, I would feel comfortable going to a therapist.*") and mental health professional ("*If I had a mental health condition and needed help, I would feel comfortable going to a mental health specialist (eg, psychiatrist, family doctor, etc.) for medication.*"). The higher the score, the greater the reported help-seeking behavior intention. The lowest possible score was 2, and the highest possible score was 10.
2. **Barrier score**. This score is the sum of all the responses across three barrier items, which included career (ie, "*I believe that seeking help for mental health conditions could have negative repercussions for my current and/or future licensure or career.*"), confidentiality (ie, "*I would be uncomfortable seeking professional help for mental health conditions due to concerns about confidentiality.*"), and time (ie, "*My current schedule does not allow me the time to seek help for a mental health condition if needed.*"). The higher the score, the greater the reported barriers to help-seeking behavior intention. The lowest possible score was 3, and the highest possible score was 15.

Analysis

The initial data manipulation to generate the desired sample frame and all subsequent data analyses were performed in Stata version 14.0.[12] We performed univariate descriptive analyses for all the predictor and outcome variables in this study.

The following analyses were performed:

- Descriptive analyses for demographic and outcome variables;
- Ten sets of one-way analysis of variance (ANOVA) tests examining bivariate relationships between each of the five demographic variables and the two outcome variables;
- Six sets of simple linear regressions modeling the relationship between each of the three stigma variables and two of the outcomes (ie, health-seeking behaviors score and barriers score); and
- Six sets of simple linear regressions modeling the relationship between each of the three combined URiM-stigma variables and two of the outcomes (ie, health-seeking behaviors score and barriers score).

A review of missing data for the mental health stigma items showed that less than 1% of data were missing for each of the 10 items. Little's test of data missing completely at random (MCAR) resulted in a fail-to-reject decision, thus indicating the data met the MCAR assumption, $\chi^2(106) = 160$, $P=0.056$. Given the small sample size impacted by the missing

data (ie, n = 24; 2.2%) and the MCAR result, listwise deletion was expected to yield unbiased parameter estimates.

RESULTS

The univariate analyses exhibiting the descriptive statistics for each predictor and outcome variable are presented in Table 2. A majority of the sample were MD physicians (82%), White (71%), female (63%), lived in an underserved area (69%), and earned their degree 16 or more years earlier (51%). The average age of the sample was 47, and 64% were between 25 and 55 years of age. Additionally, 19% of the sample designated themselves within the URiM status.

Regarding stigma, 34% of respondents reported experiencing at least one type of personal stigma, 44% reported experiencing at least one type of perceived stigma, and 11% reported experiencing stigma of others. For help-seeking behaviors, most respondents agreed to seek help from a therapist (84%) and help from a mental health professional (82%), if needed. For barriers to seeking assistance for mental health issues, 24% reported career, 20% reported confidentiality, and 32% reported time.

The bivariate analyses examining the relationship between the demographic variables and the outcome variables are presented in Table 3. The one-way ANOVA analyses indicated a statistically significant association between three different predictor variables and barriers score: gender, race, and URiM status. For gender, the barriers score for females was significantly higher than that of males (F 1,835) = 10.64, P=0.001). Those who endorsed being URiM had significantly higher barrier scores than those who did not endorse URiM status (F 1,851) = 4.79, P=0.03).

Linear regression analyses examining the three stigma variables and two outcomes—health-seeking behaviors and barrier scores—are summarized in Table 4. Personal stigma was significantly associated with lower health-seeking behaviors (β = −0.79; CI: [−1.06,−0.52]; P<0.001) and higher barrier scores (β = 1.63; CI: [1.19, 2.08]; P<0.001). Perceived stigma also was significantly associated with decreased health-seeking behaviors (β = −1.14; CI: [−1.39,−0.89]; P<0.001) and increased barriers (β = 2.78; CI: [2.40, 3.15]; P<0.001). Anticipated stigma was significantly associated only with higher barrier scores (β = 0.76; CI: [0.17, 1.35]; P=0.01), with no significant relationship to health-seeking behaviors (P>0.05). Combined URiM-stigma variables were not significantly associated with either outcome (P>0.017).

DISCUSSION

Our study is the first national study to assess the relationships between mental health stigma, help-seeking behaviors, and barriers to help-seeking in family physicians.

Mental Health Stigma

Our study revealed several important trends regarding mental health stigma in family physicians. Most striking was that 34% of our sample population endorsed perceived stigma and

TABLE 2. Demographic Characteristics of Sample

Demographic variable	
Age in years, mean (SD)	47.4 (11.9)
	n (%)
Type of professional	
Physician (MD)	744 (82)
Physician (DO)	121 (13)
Physician (MD/PhD or DO/PhD)	49 (5)
Sex	
Male	334 (37)
Female	558 (63)
Race and ethnicity	
White	620 (71)
Black	52 (6)
Asian	101 (12)
Hispanic	41 (5)
Multiple races	53 (6)
Years since earning degree	
Less than 5 years	76 (8)
5–15 years	370 (41)
16 + years	468 (51)
Self-identified as underrepresented in medicine (URiM)	175 (19)
From an underserved area	579 (69)
From a rural area	141 (15)
Personal stigma	
Strongly agree/agree	125 (15)
Neutral	141 (16)
Strongly disagree/disagree	590 (69)
Perceived stigma	
Strongly agree/agree	252 (29)
Neutral	218 (26)
Strongly disagree/disagree	384 (45)
Anticipated stigma	
Strongly agree/agree	145 (17)
Neutral	152 (18)
Strongly disagree/disagree	557 (65)
Seeking health from therapist	
Strongly agree/agree	718 (84)
Neutral	84 (10)
Strongly disagree/disagree	52 (6)
Seeking help from mental health	
Strongly agree/agree	699 (82)
Neutral	100 (12)
Strongly disagree/disagree	56 (6)
Barriers to seeking help: career	
Strongly agree/agree	209 (24)
Neutral	161 (19)
Strongly disagree/disagree	484 (57)
Barriers to seeking help: confidentiality	
Strongly agree/agree	167 (20)
Neutral	124 (14)

(*Continued*)

TABLE 2. Demographic Characteristics of Sample (Continued)

Demographic variable	
Strongly disagree/disagree	564 (66)
Barriers to seeking help: time	
Strongly agree/agree	273 (32)
Neutral	154 (18)
Strongly disagree/disagree	428 (50)

Abbreviation: SD, standard deviation

that they would feel like a burden to others if they had a mental health concern. Age, as a demographic, demonstrated a distinct and intriguing relationship with stigma scores; individuals aged 56 or older exhibited significantly higher stigma scores than those in the 25 to 40 age range. Furthermore, individuals with 16 or more years of postdegree experience exhibited substantially higher stigma scores than those with fewer than 5 years and 5 to 15 years postdegree experience. Gender, race, and URiM status did not correlate statistically with stigma score. Interestingly, when compared to those who did not report personal stigma, those who reported personal stigma exhibited the same odds of reporting health-seeking behaviors and barriers to health-seeking behaviors.

Help-Seeking Behaviors

Regarding help-seeking behaviors, most respondents agreed to seek help from a therapist (84%) and help from a mental health professional (82%), if needed. Race and years since degree completion were found to have a statistically significant association with help-seeking. Specifically, Asians exhibited significantly lower help-seeking scores than Whites; individuals with 5 to 15 years of postdegree experience exhibited significantly higher stigma scores than those with less than 5 years postdegree experience; and individuals with 16 or more years of postdegree experience exhibited significantly higher stigma scores than those with fewer than 5 years postdegree experience.

Barriers to Seeking Assistance

In terms of barriers to seeking mental health assistance, 24% reported career, 20% reported confidentiality, and 32% reported time as barriers. Females reported significantly higher help-seeking barrier scores than males. URiM-identifying participants had significantly higher barrier scores than non-URiM participants. However, age group, race, and years since degree completion did not correlate statistically with the barrier score. Notably, concerns regarding career impact, lack of time, and confidentiality continued to impede help-seeking for 20%–32% of respondents, indicating that much work still needs to be done on reducing barriers to help-seeking.

This study is critical because it sheds light on the real and complex challenges people, particularly family physician educators, face when dealing with mental health stigma and seeking care. The findings showed that many individuals

TABLE 3. One-Way ANOVA Results for Relationship Between Demographics and Outcome Variables

	Help-seeking score		Barrier score	
Demographic variables	***F* statistic**	***P* value**	***F* statistic**	***P* value**
Age group	0.02[a]	.98	0.28[f]	.75
Gender	2.02[b]	.16	10.64[g]	.001
Race	0.91[c]	.46	4.01[h]	.003
URiM status	1.43[d]	.23	4.79[i]	.03
Years since degree completion	0.38[e]	.69	0.76[j]	.47

[a]N = 856
[b]N = 837
[c]N = 820
[d]N = 853
[e]N = 856
[f]N = 837
[g]N = 820
[h]N = 853
[i]N = 856
[j]N = 914

Abbreviations: ANOVA, analysis of variance; URiM, underrepresented in medicine

experience personal, perceived, or stigma of others, which can create significant emotional and social barriers to help-seeking. The fact that stigma is influenced by factors like race and how long someone has been out of school highlights how deeply personal and cultural experiences shape these struggles. Our findings also demonstrated an association between reported perceived stigma and lower odds of seeking help from a therapist and significantly lower odds of seeking help from a mental health professional. Even when participants were open to seeking help from mental health professionals, practical barriers like lack of time, worries about confidentiality, and fear of career consequences remained obstacles.

Understanding these challenges helps spotlight the need for compassionate, culturally sensitive approaches to reduce mental health stigma and remove barriers to help-seeking to create supportive and nonjudgmental environments that encourage help-seeking. To address this dire need, solutions such as openly discussing personal lived experiences, engaging in advocacy at the state and local levels, including medical boards and hospital credentialing committees, promoting more inclusive perspectives on mental health conditions, and replacing stigmatizing language with person-centered terms are much needed.[2] While structural accommodations to promote physician well-being have been advocated for, cultural adjustments still need to be implemented. Accommodations such as providing virtual and evening mental health services and eliminating mental health history on licensing boards can increase accessibility, prevent worsening burnout, and promote physician well-being. However, decreasing stigmatization of mental health-related

TABLE 4. Simple Linear Regression ResultsModeling Relationship Between Stigma Types and Outcome Variables

	Outcome variables					
	Help-seeking score			Barrier score		
Predictor variable	β	CI	*P* value	β	CI	*P* value
Personal stigma & URiM combined	.09[a]	(−0.58, 0.76)	.80	−.06[g]	(−1.10, 0.98)	.91
Perceived stigma & URiM combined	.36[b]	(−0.23, 0.97)	.23	−.32[h]	(−1.13, 0.48)	.43
Anticipated stigma & URiM combined	.21[c]	(−0.88, 1.30)	.70	.03[i]	(−1.89, 1.84)	.98
Personal stigma	−.79[d]	(−1.06,−0.52)	<0.001	1.63[j]	(1.19, 2.08)	<0.001
Perceived stigma	−1.14[e]	(−1.39,−0.89)	<0.001	2.78[k]	(2.40,3.15)	<0.001
Anticipated stigma	−.21[f]	(−0.57, 0.15)	.26	.76[l]	(0.17,1.35)	.01

[a]N = 175
[b]N = 231
[c]N = 90
[d]N = 707
[e]N = 687
[f]N = 683
[g]N = 175
[h]N = 231
[i]N = 90
[j]N = 707
[k]N = 687
[l]N = 683
Abbreviations: CI, confidence interval; URiM, underrepresented in medicine; β, coefficient

services is the first step in encouraging physicians to act on these accommodations.

Study Strengths

Our study had several strengths that make our findings relevant. First, the CERA survey offered robust data regarding academic and clinical family physicians, which enabled us to comprehensively examine mental health stigma as aligned with current health care priorities. The instrument employed in the CERA survey was validated and reliable, ensuring the generalizability of the findings among physicians involved in family medicine practice or education. Next, this study examined a critical area in family medicine that focuses on the mental health stigma, help-seeking behaviors, and barriers to mental health care among family medicine professionals. These findings are necessary to inform researchers and professionals in this field about the need to address a critical public health burden in this specialty and improve access to mental health care.

Limitations

Nevertheless, our study encountered some limitations that could have impacted our findings. Ours was an observational hypothesis-generating study to assess multiple predictor variables. One of the study's limitations included a survey response rate of 24.67%, which is consistent with past CERA surveys.[13] Due to the cross-sectional nature of the CERA survey, our team was limited in the number of questions allowed for this study section and could not examine causal inference. Second, the CERA survey was self-reported, potentially introducing biases, including nonresponse bias, recall bias, and social desirability bias because of the topic's sensitivity, reflecting personal behavior and social stigma. Third, our findings may not apply to other medical specialties because their experiences might differ from those reported by the family physicians. Additionally, our study data were not primary; thus, findings could have been impacted by other confounding variables not accounted for in our analysis.

Future Directions

Given the significant findings of this study, future research should continue to explore and address mental health stigma in the medical profession, particularly among family physicians. A key direction for future studies is longitudinal research to better understand the causal relationships between mental health stigma, help-seeking behaviors, and career-related barriers over time. Additionally, while this study highlighted the role of perceived stigma and barriers to care, exploring the effectiveness of specific antistigma interventions within medical communities, particularly for URiMs, would provide valuable insight into actionable strategies to promote mental health care accessibility.[14] Further research also should investigate the intersection of race, gender, and mental health stigma to develop culturally tailored interventions.[2] Finally, examining trainees' experiences alongside practicing physicians could provide a more comprehensive view of stigma at various medical education and practice stages.[15]

CONCLUSIONS

This study contributes to the growing body of literature on mental health stigma and its impact on help-seeking behaviors in family physicians. Our findings demonstrate the pervasive nature of personal, perceived, and anticipated stigma and their significant impact on career concerns, confidentiality issues, and time limitations for seeking

mental health services. Despite a strong willingness to seek help, numerous barriers, particularly concerns over medical licensure and career progression, remain significant obstacles to accessing mental health care. The study highlights the importance of addressing these barriers, primarily through structural and cultural changes within medical institutions. Reducing mental health stigma will require continued efforts to advocate for mental health treatment, expand resources for mental well-being, and foster supportive environments that encourage physicians to prioritize their mental health.[4]

PRESENTATIONS

This study was presented at the Society of Teachers of Family Medicine Medical Student Education Conference, January 2026, in Charlotte, North Carolina.

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