

Original Article

The Unseen Struggle: Investigating The Barriers Behind Medical Students' Access To Mental Health Services

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Abstract

Objective: To determine the instrumental, stigma-related, and attitudinal barriers to seeking mental health support among medical students and examine variations between undergraduate and graduate levels.

Methods: In 2025, a cross-sectional study was conducted at the Pakistan Institute of Medical Sciences, Islamabad. The sample size was calculated to be 192. Undergraduate and postgraduate medical students above 18 years were included, while those with severe psychiatric disorders or prior mental health service use were excluded from the study. Data were collected via e-form using the *Barriers to Access to Care Evaluation (BACE v3)* questionnaire. Analysis was performed using SPSS 26, with independent sample t-tests applied ($p < 0.05$ considered significant).

Results: A total of 217 responses were analysed. The mean age was 27.2 years; 56.7% (N=123) were women and 43.3% (N=94) were men. Attitude-related barriers were the most reported (28.1%, N=61), including beliefs in self-resolution. Self-stigma concerns (25.3%, N=55) and time constraints were significant. The overall mean BACE score was 1.07, higher in postgraduates (1.11) than in undergraduates (0.966).

Conclusion: Access to mental health support is hindered by personal beliefs, workplace stigma, and structural constraints on nurses. Initiatives such as anti-stigma campaigns, confidential counselling services, flexible scheduling, and institutional support programs are crucial for encouraging help-seeking and improving medical students' well-being.

Keywords: Help-Seeking Behavior, Medical student, Mental health, Psychological Distress.

Introduction

A large percentage of healthcare professionals frequently overlook mental health, which is crucial for both general well-being and professional functioning.¹ This has resulted in a global epidemic of mental health issues among medical professionals, as evidenced by burnout, anxiety, and depression brought on by the demands of this line of work, some of which are unique to the medical industry, such as long workdays, stressful work environments, and constant exposure to patient suffering, and others that are typical of high-stress, highly skilled occupations.²

Ironically, medical professionals disregard their own mental health needs despite being expected to provide knowledgeable and compassionate patient care. Despite having access to healthcare services and expertise, many people are hesitant to seek support because of various systemic and personal obstacles.³

Recent studies have illustrated the extraordinary rates of mental suffering among healthcare workers. High levels of emotional exhaustion and negative help-seeking were found among doctors and nurses in China.⁴ Likewise, the U.S. Centers for Disease Control and Prevention (CDC) in 2023 also indicated that very few health workers who had experienced psychological distress sought support from professionals.⁵ Although these individuals recognise the presence of symptoms among them, they do not seek treatment because of the stigma linked with seeking support or fear of professional consequences, concerns about confidentiality, lack of taking time off work, and limited availability of mental health services.^{6,7}

These barriers are usually magnified among the populations of Pakistan and other developing nations. The stigma of mental illness in society is still rife, and seeking psychological assistance is linked to individual or professional incompetence.^{8,9} Institutional barriers, including the unavailability of in-house psychology services, clear referral procedures, and unsupportive cultures at work, dishearten the use of mental health services.^{10,11}

Stigma contributes significantly to mental health support-seeking, including both public and personalised or self-stigma, where professionals believe that acknowledging mental health challenges makes them vulnerable, undermining their credibility or strength.¹²

This reluctance has profound consequences, endangering patient safety and compromising the effectiveness of healthcare systems. Untreated mental health issues in healthcare professionals are associated with reduced job satisfaction, greater incidence of medical errors, absenteeism, and attrition from the workforce.⁸ Therefore, addressing these barriers is a critical public health priority.

This study explored the personal, professional, and organizational barriers that deter medical professionals from seeking mental health support services. By exploring the types and severity of these barriers within the Pakistani context, this study seeks to provide evidence-based recommendations that can guide institutional reforms, reduce stigma, and strengthen the mental well-being of healthcare workers.

Materials And Methods

A cross-sectional analytical study was conducted at a tertiary care hospital in Pakistan, where the participants included both undergraduate medical students and postgraduate trainees (FCPS, MD, MS) working or enrolled at the Pakistan Institute of Medical Sciences (PIMS), Islamabad. Attitudinal, stigma-related, and instrumental barriers that hinder healthcare professionals from seeking mental health services were evaluated. The prevalence of perceived barriers was studied while enabling comparisons between undergraduate and postgraduate students.

Responses from participants above 18 years of age were obtained after obtaining informed consent. Individuals diagnosed with severe psychiatric disorders, including generalised anxiety disorder and schizophrenia, those who had previously availed of mental health services, and those who declined or withdrew consent at any stage were excluded. Using the standard sample size formula for proportions with a precision of 7%, confidence interval of 95%, and a prevalence estimate of 42.5 percent from Al Salman et al.,¹³ the sample size was calculated to be 192 participants. A total of 217 fully completed responses were included in the final analysis. Data were collected using the “Barriers to Access to Care Evaluation (BACE v3) questionnaire”,¹⁴ developed by King’s College London. Perceived barriers were categorised into three domains: stigma-related, attitudinal and personal, and instrumental or structural barriers. The questionnaire was digitised using Google Forms, and the link was circulated electronically through institutional platforms and social media. Participation was voluntary, anonymous, and not incentivised by the researchers. Data collection was performed over four months.

Data analysis was performed by exporting the data to IBM SPSS Statistics, version 26. Detailed statistics (mean, standard deviation, range, frequency, and percentage) were calculated for all variables and BACE items. Domain scores were computed by averaging the responses within each conceptual domain (0 = not at all, 3 = very much). Independent sample tests were applied to compare the mean barrier scores between the undergraduate and postgraduate groups. Statistically significant results were considered if the p-value was < 0.05.

Results

A total of 217 completed questionnaires were included in the final analysis of this study. The mean age of the participants was 27.2 years (standard deviation = 4.3 years). The age range of the participants in this study was 18–41 years. Among the respondents, 56.7% (N=123) were female, and 43.3% (N=94) were male. Of the study population, 72.8% (N=158) were postgraduate trainees (FCPS, MD, MS), among whom 43.8% (N=95), 22.6% (N=49), 4.6% (N=10), and 1.8% (N=4) belonged to the medicine and allied, surgery and allied, diagnostic and basic sciences, and dental specialties, respectively, while 27.2 percent (n=59) were undergraduate medical students.

The Barriers to Access to Care Evaluation Questionnaire items were grouped into three conceptual categories: personal, social, and professional obstacles.

Attitudinal and personal barriers emerged as the most prominent, with respondents frequently preferring to manage problems on their own or believing that the issue would resolve without formal care. Stigma-related barriers included social and workplace problems. Instrumental barriers, such as difficulty in managing time to take off from work and financial limitations, were also reported by the participants.

Individual components of the Barriers to Access to Care Evaluation (BACE v3) questionnaire, rated as “quite a lot” or “a lot” by the respondents, are shown in Table 1.

Table 1: Proportion of Respondents who report Stigma, Attitudinal and Instrumental Barriers to Seeking Mental Health support as “quite a lot” or “a lot”

Stigma-Related Barriers	Count	Percentage
Not willing to report/mention a mental health problem in my medical records	85	39.20%
Concern that I might be considered crazy	79	36.40%
Concern about what other people at work might think, say, or do	71	32.70%
Concern that I might be considered weak for having a mental health issue	71	32.70%
Concern that what my family might think, say, do, or feel	64	29.50%
Concern that it might risk my chances when applying for jobs	53	24.40%
Concern about what my friends might think, say, or do	52	24.00%
Concern that I might be considered a bad parent	36	21.60%
Fear of being admitted to the hospital against my will	33	15.20%
Concern that my children may be taken into care or that I may lose access or custody of my children without my agreement	21	14.80%
Attitudinal Barriers		
Wanting to resolve the problem on my own	97	44.70%
Thinking the problem would get resolved by itself	97	44.70%
Preferring to get alternative therapies, e.g., traditional/ religious healing or alternative/complementary therapies	91	41.90%
Preferring to obtain help from family or friends	82	37.80%
Dislike talking about my feelings, emotions, or thoughts	75	34.60%
Thinking that I did not have a problem	50	23.00%
Concern that my acquaintances might find out	50	23.00%
Thinking that professional care probably would be useless	48	22.10%
Concern that people might not take me seriously in the future if they found that I was seeking professional care	46	21.20%
Feeling embarrassed or ashamed of seeking support	43	19.80%
Instrumental Barriers		
Difficulty managing time in taking time off from work	116	53.50%
Professionals are not available from my own ethnic and cultural background.	78	35.90%
Concerns about the adverse effects of available treatment	76	35.00%
Having issues with childcare while I receive professional care	41	27.90%
Non-affordability of the financial costs involved	60	27.60%
Problems with logistics, like transport or travelling for appointments	57	26.30%
Being unsure where to go to seek professional care	54	24.90%
Having no support who could help me get professional care	54	24.90%
Having had previous bad experiences with professional help for mental health	39	18.00%
Being too unwell to seek help	15	6.90%

Among the stigma-linked barriers, most (39.2%) reported “not wanting a mental health problem to be on my medical records” as a major obstacle to accessing care. The highest scoring attitudinal barriers were wanting to solve the problem on my own” and “thinking the problem would get better by itself”. A total of 97 respondents (44.7%) rated these as “quite a lot” or “a lot”. Preference for alternative and traditional care was also notable, with 41.9% indicating this as “quite a lot” or “a lot”. In the instrumental and structural category, “difficulty taking time off work” was prominent and was reported as “quite a lot” or “a lot” by 53.5 percent of respondents. Financial barriers were also relevant, with 27.6% of participants reporting “not being able to afford financial costs involved” at a high level. In contrast, some items were less frequently endorsed as severe barriers. Only 6.9% of participants reported a high level of “too unwell to seek help” Overall, the top 10 most frequently reported barriers are shown in figure 1.0.

Domain scores were calculated on a scale of zero to three, where zero represented “not at all” and three represented “a lot”. The mean score of each domain and the overall mean BACE score are summarised in Table 2.0. The overall mean BACE score across all items was 1.07, with a standard deviation of 0.51, indicating that respondents, on average, experienced barriers between “a little” and “quite a lot”.

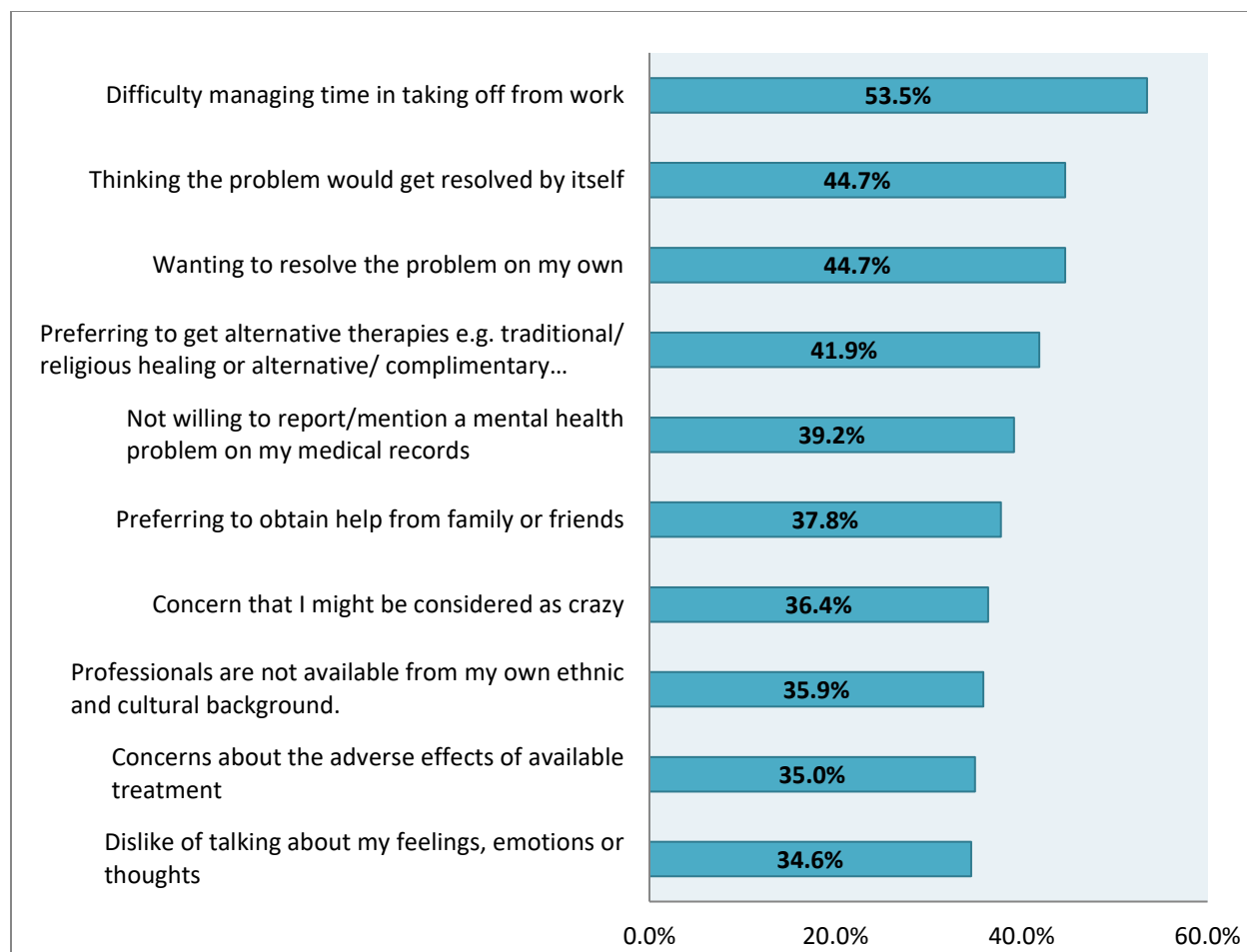


Figure 1: Top 10 barriers reported as “a lot” or “quite a lot”

Domain scores were calculated on a scale of zero to three, where zero represented “not at all” and three represented “a lot”. The mean score of each domain and the overall mean BACE score are summarised in Table 2.0. The overall mean BACE score across all items was 1.07, with a standard deviation of 0.51, indicating that respondents, on average, experienced barriers between “a little” and “quite a lot”.

Table 2: Descriptive Summary of Barrier to access to care evaluation (BACE) categories scores

	Mean	Std. Deviation	Minimum	Maximum	Range
Stigma-related Barriers	1.00	0.65	0	3	3
Attitudinal Barriers	1.18	0.50	0	2.8	2.8
Instrumental Barriers	1.04	0.54	0	2.56	2.56
Overall BACE	1.07	0.51	0	2.79	2.79

Of the participants, 28.1% (n=61) had an attitudinal domain score of at least 1.5, suggesting a substantial contribution of personal and belief-linked barriers to accessing mental health support services, while 25.3 percent (N=55) had stigma domain scores, and 18 percent (N=39) had instrumental domain scores at or above this threshold.

The mean overall BACE score and the mean among all three domains individually were slightly higher among males than females, but this difference was not statistically significant.

In terms of training level, the differences in stigma-related barriers between postgraduate and undergraduate trainees were not significant. However, although postgraduate respondents reported higher attitudinal, instrumental, and overall BACE scores than undergraduates, the differences were not statistically significant. The results are presented in Table 3.

Table 3: Comparison of Barrier domain scores by level of training

Barrier Domain	Level Of Training	N	Mean	Std. Deviation	p-value
Stigma Related	Postgraduate	158	1.0263	0.64201	0.286
	Undergraduate	59	0.9199	0.67606	
Attitudinal	Postgraduate	158	1.216	0.48726	0.053
	Undergraduate	59	1.0672	0.53461	
Instrumental	Postgraduate	158	1.0866	0.53186	0.022
	Undergraduate	59	0.899	0.54317	
Overall BACE	Postgraduate	158	1.1145	0.49564	0.055
	Undergraduate	59	0.9663	0.52356	

Discussion

The results highlighted that despite being more aware of mental health issues and direct exposure to psychological distress within clinical environments, many professionals still encounter significant barriers that prevent them from seeking help. These obstacles are a result of a combination of social expectations, workplace culture, personal beliefs, and structural gaps, consistent with the literature reporting a decline in the utilization of mental health support services by healthcare professionals globally.

The sample comprised mostly young health care professionals, predominantly postgraduate trainees, with a mean age of 27 years. A similar demographic pattern was observed in earlier studies showing that residents and junior doctors are particularly vulnerable to burnout and mental distress due to long working hours, high patient loads, and decision-making autonomy.¹⁵ Although both genders reported comparable levels of barriers to access to mental health support, males had slightly higher mean domain scores; however, the difference was statistically insignificant. Several recent studies have similarly reported minimal gender variation in help-seeking patterns among doctors, suggesting that systemic and occupational pressures may influence both genders similarly.¹⁶

Attitudinal and personal barriers emerged as the most prominent, followed by stigma-related and instrumental barriers, respectively. These findings align with global studies, highlighting that healthcare workers often prefer self-management, anticipate spontaneous symptom resolution, or seek alternative care over professional support.^{17,18}

The tendency to “solve the problem on my own” or assume that issues would resolve spontaneously was endorsed by nearly half (44%, N=97) of the respondents. Such self-reliance reflects a professional culture in which emotional vulnerability is often discouraged and stigmatised, and self-reliance is valued. Similar findings have been reported in the UK and Australia, where physicians tend to normalise their distress, rely on self-coping strategies, and underestimate the severity of their symptoms.^{19,20} In Pakistan, reliance on traditional or religious healing remains common, with 41.9% (N=91) of respondents preferring such alternatives. These results are in line with cultural studies showing that religious and community-based support systems are often prioritised over formal psychiatric care.²¹

Stigma also emerged as a major obstacle, with 39.2% (N=85) of respondents concerned about having a mental health diagnosis documented in their medical records. Other major factors leading to their reluctance included the fear of being considered weak or “crazy” and facing negative workplace judgment. These findings reflect the evidence worldwide that healthcare professionals experience heightened self-stigma and professional stigma due to expectations of emotional resilience and competence.²² Data from the National Mental Health Survey of Doctors and Medical Students, conducted in Australia, revealed a repeated association of stigma with hindrance to help-seeking, concealment of symptoms, and delays in access to mental healthcare among physicians.³ Another study has also supported this with evidence from multiple settings where concerns about confidentiality breach and fear of repercussions in professional life deter help-seeking.⁴

Many healthcare professionals are reluctant to seek mental health support because they worry about confidentiality and possible damage to their careers. Reflecting this concern, the CDC (2023) reported that only 38% of U.S. healthcare workers experiencing psychological symptoms reached out for help.⁵ In Pakistan, stigma is further enhanced by cultural perceptions associating mental illness with weakness or incompetence.^{23,24} A recent review emphasized that both public and self-stigma remain pervasive among Pakistani medical trainees, discouraging help-seeking.²³

Among the instrumental barriers, “difficulty taking time off work” was reported most frequently and was the most reported barrier overall, endorsed by 53.5% (N=116) of respondents. Similar findings have been documented in

studies elsewhere, where long working hours and understaffing significantly hinder healthcare professionals' ability to access mental health services.²³ Structural barriers such as transport issues, lack of healthcare providers from the same cultural background, financial constraints, and uncertainty about where to seek care have also been identified. These findings mirror recent studies in poorly resourced countries, where structural inefficiencies, such as limited mental health personnel, unclear referral mechanisms, and high service costs, contribute to unmet mental health needs among health workers.¹⁹

Postgraduate trainees demonstrated significantly higher attitudinal, instrumental, and overall barrier scores than their undergraduate counterparts. Postgraduate residents often experience greater workloads, longer shift hours, greater responsibility, and higher exposure to patient morbidity, which may intensify psychological strain while simultaneously limiting opportunities for self-care.²⁵ Several studies have shown that postgraduate trainees report more burnout, more difficulty allocating personal time, and a higher likelihood of dismissing their emotional needs than medical students.²⁶ The absence of significant differences in stigma scores suggests that stigma may be deeply embedded and not substantially influenced by the level of training.

The overall mean BACE score of 1.07 indicates that the study population reported barriers affecting access to care ranging from "a little" to "quite a lot". An amalgamation of stigma related to the workplace, personal attitudes towards help-seeking, and structural obstacles work synergistically to hinder access to support for mental health problems. While these challenges may not be severe, they are meaningful enough to impact timely access to mental health support.

The study results emphasise the need for targeted interventions, such as training sessions to counter stigma, institution-based mental health programmes, allocated time for consultations, counselling sessions, maintaining confidentiality, and integrating discussions on mental health into the medical education curriculum. Policy-level modifications are essential for creating a supportive environment in which seeking help is considered normal and overall well-being is actively endorsed.

Limited data from a single tertiary care hospital were included in this study, which is a major limitation in generalising the results to other healthcare settings and regions. The cause-and-effect relationships between the identified barriers and help-seeking behaviours cannot be determined with certainty because of the cross-sectional design. Therefore, further research using longitudinal designs and multicentre samples with a larger sample size is required to gain a more comprehensive understanding of the subject and help compare different populations working in government and private setups, and among doctors working in different specialties.


Conclusions

The study results indicate that access to mental health support services is impacted by significant barriers, including personal thoughts, structural constraints, and workplace-associated stigmas. The most prevalent obstacles included personal beliefs regarding self-management, fear of being judged, and workload-related limitations. A high level of this trend was noted among postgraduate trainees compared to undergraduates, reflecting the greater professional pressure. Initiatives to reduce stigma, targeted institutional support, and easily accessible mental health services are crucial for encouraging medical students and postgraduate trainees to seek help, improve their well-being, and safeguard the quality of patient care. An open culture where mental health concerns can be openly discussed is essential, particularly within hospitals and medical colleges, to promote help-seeking, protect healthcare workers' well-being, and ultimately provide safe and high-quality patient care by these health professionals.

The anonymised dataset generated and analysed during the current study (SPSS spreadsheet of BACE v3 responses) is not publicly available due to confidentiality restrictions, but it is available and can be accessed upon reasonable request from the corresponding author via email.

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