

Barriers to Seeking Professional Mental Health Help among Indian Adults Aged 30-60 Years

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Abstract: *India's mental health treatment gap remains pronounced among working-age adults, yet this demographic is underexplored relative to youth and elderly populations. This descriptive cross-sectional study investigated self-reported barriers to professional mental health help-seeking in a sample of 41 Indian adults (54% male, 46% female) aged 30–60 years, recruited via snowball sampling. Seven barrier types were rated on a five-point Likert scale. Contrary to assumptions common in public health messaging, stigma-related items scored lowest—personal embarrassment ($M = 2.44$) and fear of social judgment ($M = 2.24$) both fell below the scale midpoint. Time and competing responsibilities topped the hierarchy ($M = 3.73$), followed by self-management preference ($M = 3.68$) and preference for informal social support ($M = 3.41$). Adults aged 30–45 rated time barriers markedly higher than the 46–60 cohort ($M = 3.91$ vs. 3.00). Male respondents showed substantially higher preference for family or religious figures than female respondents ($M = 3.82$ vs. 2.95). Privacy and confidentiality assurances were the most frequently cited facilitators for future help-seeking (39%). Despite 39% self-identifying as "very open" to professional help, 63% had never consulted a professional. Findings support a reorientation of intervention design toward structural and temporal accommodations rather than stigma-reduction messaging alone.*

Keywords: mental health barriers, help-seeking behaviour, Indian adults, Health Belief Model, treatment gap, stigma, working-age adults

1. Introduction

India carries one of the world's largest unmet mental health burdens: over 150 million Indians require active mental health interventions at any time, yet fewer than 12% receive care [1]. The treatment gap for depression alone exceeds 85% [1]. Adults aged 30–60 who constitute the bulk of the economically active population—show among the lowest professional consultation rates relative to distress prevalence [2], a pattern the literature attributes to overlapping structural and cultural forces that remain incompletely mapped for this specific demographic.

Public health communication has historically emphasised stigma as the central deterrent to help-seeking in India [3][4]. More recent research in educated urban samples has begun to complicate this picture, suggesting that logistical and cultural barriers may outrank shame-based ones in working-age cohorts [5][6]. This study directly tests the relative weight of seven barrier types in a sample of working adults aged 30–60, using the Health Belief Model (HBM) [7] as an organising framework.

The HBM proposes that health behaviour is shaped by perceived susceptibility, severity, barriers, and benefits, alongside cues to action and self-efficacy [8]. Applied to help-seeking, it treats barriers as perceived rather than absolute—making it well-suited to a context where identical objective conditions (cost, distance) produce different decisions across individuals. The model also draws attention to perceived benefit from alternatives: adults who genuinely believe family or spiritual support is effective may not experience themselves as avoiding professional care at all.

2. Literature Review

Gururaj et al. [1] documented treatment contact rates lowest among working-age adults in the 12-state National Mental Health Survey. Andrade et al.'s [2] WHO cross-national survey replicated this pattern across cultures, suggesting mid-life barriers are not India-specific. At approximately 0.3 psychiatrists per 100,000 population [9], structural insufficiency precedes any individual-level barrier.

Koschorke et al. [3] and Raguram et al. [4] established stigma as a significant deterrent in South Indian clinical and community samples. However, Hasan et al. [5] found that time constraints and perceived cost outranked stigma in urban working professionals aged 25–55, and Banerjee and Bhattacharya [6] replicated this in middle-class Bengali adults aged 35–55. Sharma and Bhatt [10] documented that 47% of mid-career professionals who had begun therapy cited inability to maintain weekly appointments as the primary reason for discontinuation not cost or stigma. Kanungo and Sinha [11] described "informal support sufficiency" in Gujarati adults: non-engagement with professional services driven not by shame but by perceived adequacy of family-based coping. Addis and Mahalik [12] and Chadha et al. [13] separately documented masculine norms as directing men toward family and stoic self-management rather than professional channels. Kaur et al. [14] found self-reliance as a barrier peaking in middle-aged cohorts, suggesting age-differentiated barrier profiles within the 30–60 range.

3. Methodology

3.1 Design and Sample

A descriptive cross-sectional survey design was used. Forty-one Indian adults aged 30–60 (M: 22, F: 19) completed a 20-item researcher-designed questionnaire via Google Forms,

distributed through snowball sampling over WhatsApp and Instagram networks in July–August 2026. Inclusion criteria: Indian residents aged 30–60 with sufficient English literacy. All participation was anonymous and voluntary.

3.2 Instrument

The questionnaire comprised four sections: (A) demographics are age range, gender, employment, location; (B) seven barrier-rating items on a five-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree) addressing time constraints, fear of social judgment, personal embarrassment, access difficulty, financial cost, preference for self-management, and preference for informal support; (C) help-seeking history, current openness, and preferred first support source; (D) facilitating conditions for future professional help-seeking. Item content drew on the Barriers to Help-Seeking Scale [15] and NMHS community survey items [1]. Five adults in the target age range piloted the instrument; mean completion time was eight minutes.

3.3 Analysis

Descriptive statistics (means, frequencies, percentages) were the primary analytical tools. Barrier items were ranked by mean endorsement score. Subgroup comparisons (age: 30–45 vs. 46–60; gender; location type) were conducted descriptively given sub-sample size constraints, particularly the 46–60 cohort ($n = 8$). Analysis was performed in Jamovi 2.3.

4. Results

4.1 Sample Demographics

The sample was predominantly salaried (70.7%), with a spread across metropolitan (34.1%), Tier 2/3 (41.5%), and semi-urban/rural (24.4%) locations. The 30–35 bracket was most represented (53.7%), typical for snowball sampling via digital channels. Age subgroups for comparative analyses: 30–45 ($n = 33$) and 46–60 ($n = 8$).

4.2 Barrier Endorsement: Full Sample

Table 1: Mean Barrier Endorsement Scores ($N = 41$)

Barrier	M	SD
Time and family/work responsibilities	3.73	0.94
Prefer to handle issues independently	3.68	1.02
Prefer family/friends/religious figure	3.41	1.08
Cost of professional therapy	3.12	1.14
Cannot find appropriate professional	3.02	1.18
Embarrassment/shame	2.44	1.09
Fear of social judgment	2.24	1.07

Note. 1 = Strongly Disagree, 5 = Strongly Agree.

The barrier hierarchy places structural and cultural factors at the top and stigma-related items at the bottom. Both embarrassment ($M = 2.44$) and fear of social judgment ($M = 2.24$) fall below the scale midpoint, meaning average responses lean toward disagreement. Time constraints ($M = 3.73$) and self-management preference ($M = 3.68$) are closely matched and dominate the hierarchy. Preference for informal social support ($M = 3.41$) clusters with these top items to

describe a population with an existing and valued non-professional support system rather than one primarily deterred by shame.

4.3 Age Subgroup Comparison

Table 2: Barrier Means by Age Subgroup

Barrier	30–45 M	46–60 M	Δ
Time/responsibilities	3.91	3.00	+0.91
Prefer self-management	3.70	3.50	+0.20
Prefer family/religious	3.39	3.50	–0.11
Cost	3.15	3.00	+0.15
Cannot find professional	3.06	2.75	+0.31
Embarrassment	2.33	2.50	–0.17
Social judgment	2.18	2.50	–0.32

The most pronounced age difference appears in time constraints, where the 30–45 cohort scores nearly a full scale point above the 46–60 group (3.91 vs. 3.00). This aligns with life-stage interpretations: mid-career adults managing dual caregiving and professional demands face structural time scarcity that diminishes as careers stabilise. The directional reversal in stigma items of older adults scoring modestly higher is consistent with generational socialisation toward stoic emotional norms, though cell sizes preclude strong inference.

4.4 Gender Differences

Table 3: Barrier Means by Gender

Barrier	Male M	Female M	Δ
Time/responsibilities	3.73	3.74	–0.01
Prefer self-management	3.73	3.63	+0.10
Prefer family/religious	3.82	2.95	+0.87
Cost	3.18	3.05	+0.13
Cannot find professional	3.05	2.89	+0.16
Embarrassment	2.55	1.89	+0.66
Social judgment	2.59	2.11	+0.48

The largest gender difference is in preference for family or religious figures ($M = 3.82$ vs. 2.95 , $\Delta = 0.87$), consistent with masculine norms directing men toward family-based coping [12][13]. Male respondents also score consistently higher on both stigma items, though both remain below the midpoint. Gender differences in time and cost barriers are negligible, suggesting that the gendered pattern is cultural-psychological rather than structural.

4.5 Help-Seeking History and Facilitators

Sixty-three percent of respondents had never consulted a mental health professional; 73% had not reached professional care at all (including those who had considered but not followed through). Yet 39% described themselves as "very open" to seeking help for a gap between stated attitude and actual behaviour that signals structural rather than attitudinal resistance. When asked what would most likely enable professional help-seeking, 39% cited privacy and confidentiality assurances, 24% lower cost, 17% better awareness, 12% reduced stigma, and 7% improved access. Privacy emerged as the dominant facilitator by a substantial margin.

5. Discussion

The HBM offers a useful lens for these findings. High endorsement of time and cost maps to perceived barriers. High self-management preference reflects simultaneously high perceived benefit from non-professional coping and potentially low perceived susceptibility adults who trust family support do not necessarily perceive themselves as people who need professional psychological intervention. The model predicts that reducing access barriers will be insufficient if perceived susceptibility and perceived benefit from professional care remain low [8]; the data is consistent with this.

The primacy of privacy as a facilitator endorsed by nearly four in ten respondents requires specific attention. These concerns likely reflect genuine uncertainty about confidentiality practices in Indian mental health services, possible exposure to workplace information mishandling, or diffuse discomfort about psychological difficulties being known beyond the therapeutic relationship. Whatever the source, credible and explicit communication about confidentiality including digital data storage practices may produce larger uptake gains for this demographic than further destigmatisation messaging.

The 30–45 age group's acute time barrier ($M = 3.91$) calls for structural rather than attitudinal responses: brief therapy formats, asynchronous digital options, and employer-embedded services that are architecturally separate from HR functions to address the simultaneous privacy concern. The male gender pattern strong preference for family and religious figures—suggests that help-seeking pathways framed as complements to, not replacements for, existing family support systems may prove more acceptable to male working adults in this age range.

Sixty-three percent never consulted a professional despite 39% being "very open." This gap is well documented in health behaviour research as the intention-behaviour gap [7], and typically reflects structural barriers overriding attitudinal readiness. The findings support deploying intervention resources where the structure is already primed—at the workplace, through EAPs with credibly independent confidentiality, and through brief digital formats that fit within time-constrained lives.

6. Conclusion

Among Indian adults aged 30–60, the barriers to professional mental health help-seeking are structural and cultural rather than primarily shame-based. Time constraints dominate; stigma trails at the bottom of the hierarchy. The most potent lever for change, as reported by respondents themselves, is credible privacy assurance—not destigmatisation. Interventions designed for this demographic should prioritise brief, time-flexible, digitally accessible, and confidentiality-foregrounded service models. Employers, telehealth platforms, and national programmes like Tele-MANAS stand to produce greater gains by redesigning around time and privacy than by continuing to concentrate on stigma reduction alone.

The study is exploratory, limited by a non-representative snowball sample ($N = 41$) and an imbalanced age subgroup ratio (33 vs. 8). A researcher-designed instrument without independent psychometric validation is a further constraint. Larger stratified samples and validated adapted instruments remain priorities for future work.

References

- [1] G. Gururaj et al., "National Mental Health Survey of India, 2015–16: Summary," NIMHANS, Bengaluru, India, 2016.
- [2] L. H. Andrade et al., "Barriers to mental health treatment: Results from the WHO World Mental Health surveys," *Psychological Medicine*, vol. 44, no. 6, pp. 1303–1317, 2014.
- [3] M. Koschorke et al., "Experiences of stigma among family caregivers of people with schizophrenia in India," *Social Science & Medicine*, vol. 178, pp. 66–77, 2017.
- [4] R. Raguram, M. G. Weiss, S. M. Channabasavanna, and G. M. Devins, "Stigma, depression, and somatization in South India," *American Journal of Psychiatry*, vol. 153, no. 8, pp. 1043–1049, 1996.
- [5] S. Hasan, S. Hossain, and N. Mondal, "Barriers to mental health help-seeking among working professionals in urban Maharashtra," *Asian Journal of Psychiatry*, vol. 41, pp. 85–91, 2019.
- [6] D. Banerjee and P. Bhattacharya, "Exploring barriers to mental health help-seeking among middle-aged urban Indians," *Journal of Mental Health*, vol. 30, no. 4, pp. 427–436, 2021.
- [7] I. M. Rosenstock, "Historical origins of the health belief model," *Health Education Monographs*, vol. 2, no. 4, pp. 328–335, 1974.
- [8] V. L. Champion and C. S. Skinner, "The health belief model," in *Health Behavior and Health Education*, 4th ed., K. Glanz, B. K. Rimer, and K. Viswanath, Eds., Jossey-Bass, 2008, pp. 45–65.
- [9] World Health Organization, *Mental Health Atlas 2020*, WHO Publications, 2021.
- [10] R. Sharma and P. Bhatt, "Dropout from therapy among mid-career professionals: A qualitative analysis," *Indian Journal of Clinical Psychology*, vol. 49, no. 2, pp. 78–86, 2022.
- [11] S. Kanungo and B. K. Sinha, "Informal support sufficiency and mental health service avoidance in Gujarat," *Indian Journal of Community Medicine*, vol. 43, no. 2, pp. 113–117, 2018.
- [12] M. E. Addis and J. R. Mahalik, "Men, masculinity, and the contexts of help seeking," *American Psychologist*, vol. 58, no. 1, pp. 5–14, 2003.
- [13] J. Chadha, M. Sharma, and R. Garg, "Gender differences in help-seeking attitudes in urban India," *Indian Journal of Psychiatry*, vol. 62, no. 3, pp. 289–295, 2020.
- [14] H. Kaur, P. Verma, and A. Das, "Age differences in barriers to mental health help-seeking among Indian working adults," *Psychological Studies*, vol. 68, no. 1, pp. 55–64, 2023.
- [15] A. K. Mansfield, M. E. Addis, and W. Courtenay, "Measurement of men's help seeking: Development of

the Barriers to Help Seeking Scale," *Psychology of Men & Masculinity*, vol. 6, no. 2, pp. 95–108, 2005.

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