DEPARTMENT OF SOCIAL WORK

BACHELOR OF SCIENCE (HONOURS) DEGREE IN SOCIAL WORK

RESEARCH TOPIC:

EXPLORING THE IMPACT OF STIGMA ON MENTAL HEALTH HELP-SEEKING BEHAVIORS AMONG INDIVIDUALS WITH DISABILITIES

By

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This dissertation is submitted in partial fulfillment of the requirements of the Bachelor of Social Work

SUPERVISOR: MRS CHIGONDO

MAY 2025

DECLARATION

I declare that this research project, ***"Exploring the Effect of Stigma on Mental Health Help-Seeking Patterns Among Persons With Disabilities,"*** is my original work and has not been submitted for any other degree or qualification. I followed ethical policies and guidelines relevant to the study and have given proper attribution to all the works cited in this research. I take full responsibility of the content of this dissertation and I affirm that this document is a result of my solitary efforts of research. The goal of the study was to shed more light on stigma and disability in the context of their mental healthcare utilization.

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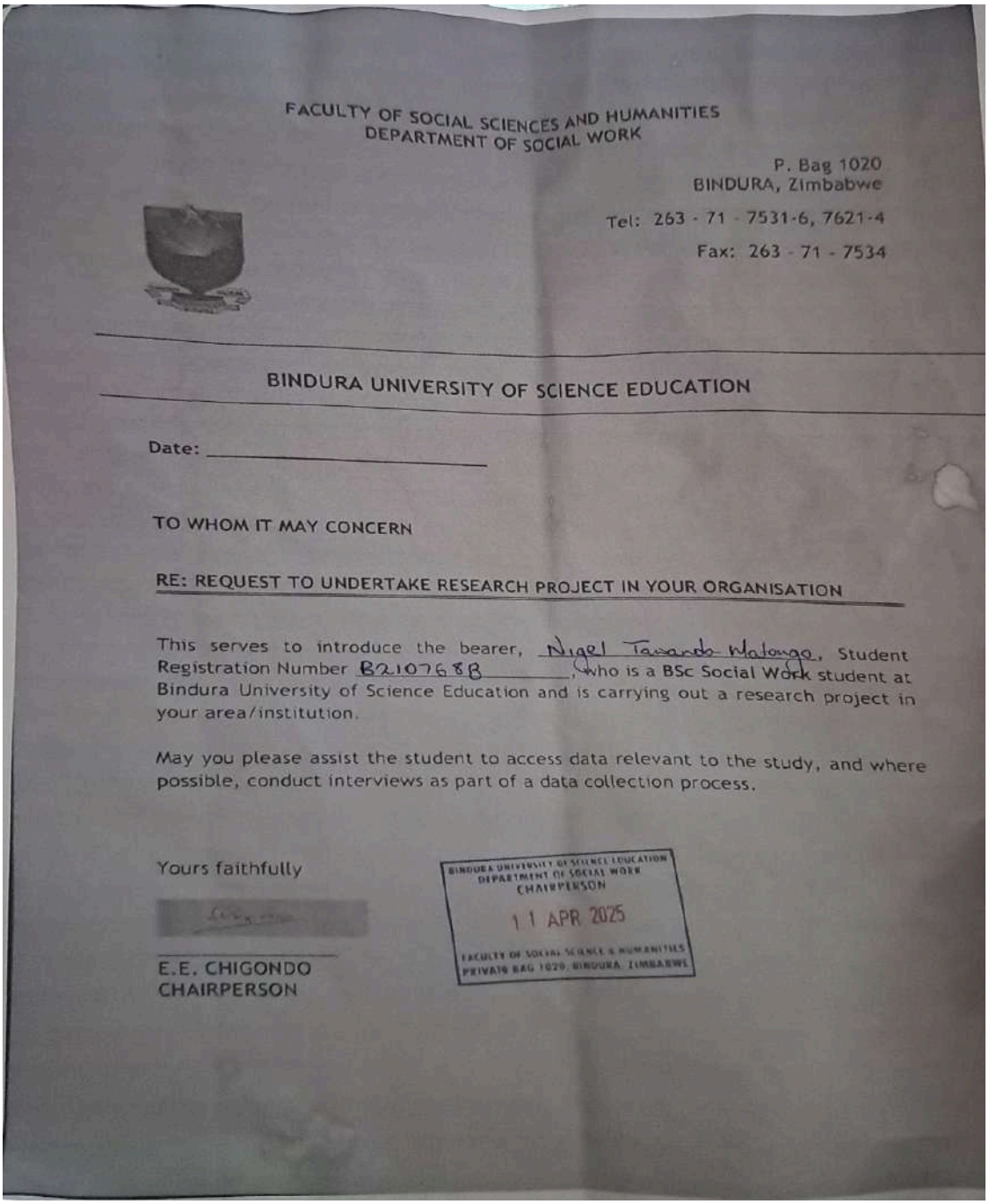

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ACKNOWLEDGEMENTS

I want to put on record my deep appreciation and gratitude to all those who were with me on this research journey. To start with, I would like to thank my supervisor for supporting me to the extent that I was able to undertake this study. I appreciate the other participants who accepted to share their life experiences as they are the ones who made this research possible. I would also like to thank my fellow students and family members for supporting me. I would also like to thank the institutions that helped by providing the materials and other facilities that were needed during the data collection. Your efforts helped improve this research in many ways. This research from the beginning to the end was made possible because of all of you.

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DEDICATION

This work is dedicated to individuals with disabilities who courageously confront stigma every day. Your stories and resilience inspire the pursuit of a more inclusive society where mental health care is accessible to all. May this research contribute to the ongoing fight against stigma and promote understanding and support for those in need.

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ABSTRACT

This research analyzes how stigma affects help-seeking behavior from health services and other social services amongst people living with disabilities. Using a mixed-methods design, the study obtained qualitative and quantitative data through surveys and interviews with 18 participants. The purposive sampling technique aimed at including all individuals with different forms of disabilities so as to gather diverse opinion and experience. Results demonstrated that help-seeking behavior for mental health issues was greatly influenced by public, self and institutional stigma. It was found that self-stigmatization strongly relates to avoidance coping strategies, suggesting that negative perceptions of an individual inhibit his/her help-seeking behavior. The research also noted the gaps in policies that stifle social progress, demonstrating structural impediments to healthcare. The study supports the planning of comprehensive community mental health services for people with disabilities. Also, it highlighted the necessity of creating an atmosphere of collective advocacy by forming peer support groups. Sociably, advocacy restrictions related to disability accessibility standards at mental health clinics must be removed. Trauma-informed care strategies need to be implemented to address the particular challenges of these individuals. Addressing stigma through restricted measures can lead to enhanced systemic access to mental healthcare for persons with disabilities. This study shows the growing need for the disabled people to have a multi-dimensional healthcare approach and system that is designed to accept and understand their real-life experiences.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

The emphasis of this chapter is on the stigma and its impact on the mental health help-seeking behaviors of the disabled populations. While there is increasing awareness of mental health, stigma is still a major barrier preventing many people from accessing these vital support and services. Not only does stigma decrease the self-esteem and social functioning of people with mental illness, stigma also hinders people from seeking help, and therefore constitutes a negative mental health outcome. This study provides an exploration of stigma as a multivalent social phenomenon that is more than simply present or absent and ultimately broadens our understanding of the ways that stigma intersects with help-seeking behavior of individuals living with disability who seek mental health care. To develop targeted interventions that promote positive help-seeking behaviors and improve mental health outcomes within this vulnerable population, it is important to understand what some of the barriers to help-seeking are in the first instance. This chapter tries to propose the framework to solve these problems and also points out that we should have a safe environment for those who need help to seek help without the fear of being judged.

1.2 Background to the Study

Mental health stigma is a global concern that can impact any demographic of people across the world, but is particularly pervasive among those living with a disability. Stigma is identified as a factor in this lack of access, with research suggesting that in present communications mental health is perceived negatively, creating large barriers to those seeking help(Torales *et al.*, 2023). According to the World Health Organization (WHO), about 1 in 4 people will have mental health issues anytime during their lives, but stigma continuing to be a huge obstacle to seeking help. Stigma can also be internalized, leading to shame and self-doubt. As this internalization leads to reduced help-seeking, it can also intensify existing mental health conditions, causing a vicious cycle difficult to escape. Social withdrawal is also a consequence of the stigma about mental health, where people with a mental illness may withdraw from social contact to avoid being judged by others. Therefore, tackling stigma is important to enhance mental

health outcomes and to motivate people to seek the necessary support and services(Choudhary, Jasrotia and Kumar, 2024a).

The effects of stigma differ considerably by region as well. Stigma around mental health is compounded by cultural beliefs in many low- and middle-income countries, as well as a lack of awareness(Javed *et al.*, 2021). For example, research in sub-Saharan Africa revealed that more than 50% agreed that mental illness is a sign of weakness, and avoided help seeking. On the other hand, more developed areas tend to offer improved access to mental health services, but stigma continues to exist and becomes evident through discrimination and social exclusion. While it is fair to claim that countries such as the United States have made considerable advances in mental health awareness, when it comes down to it, both our society and our attitudes toward mental health reflect inaccuracies that run deep into the fabric of humanity. To prioritize localized approaches that tackle stigma while enhancing access to mental health services(Wainberg *et al.*, 2017). It is crucial to recognize the influence of cultural context in order to effectively reduce stigma and encourage help-seeking behavior among diverse populations as well.

At home, too, the situation is alarming. People with disabilities experience stigma in their communities and often feel judged or misunderstood by society, leading them to avoid mental health support(Huggett *et al.*, 2018). A national survey in the United States found that stigma was a major reason nearly 40 percent of people with disabilities did not pursue mental health care. This unwillingness contributes to deteriorating mental health conditions generating a cycle of social exclusion and hopelessness. Although barriers to participation can stem from local community attitudes towards disabilities, these attitudes may mirror wider societal beliefs, leading to disenfranchisement of people with disabilities. Unfortunately, with nowhere else to turn and no community support, individuals often resort to seeking mental health treatment. This dichotomy underscores the need for localized strategies that address stigma while improving access to mental health resources(Choudhary, Jasrotia and Kumar, 2024b). Understanding the role of cultural context is essential for effectively combating stigma and promoting help-seeking behaviors across different populations.

Stigma does not impact disability individuals in the same way as general people. Although everyone has some form of mental health stigma, people with disabilities seem to share one thing in common, and that is a multiplicity of stigma surrounding both their disabilities and their mental health conditions. This dual stigma can promote shame and inferiority and make them even less likely to seek out help. For instance, people with disabilities may be afraid of the mental health problems they face reinforcing societal stereotypes about them as incompetent, potentially leading them to avoid seeking help altogether(Rizzo *et al.*, 2025). That fear tends to be magnified in spaces where people have faced discrimination or marginalization. Furthermore, the need for mental health professionals to familiarise themselves with the various issues that people with disabilities face adds another layer of challenge to the issue of stigma and mental ill health. Instead, it often leads to under-treatment and lack of support, continuing the cycle of poor mental health in this group.

To understand the extent of the stigma and then how that manifest and translates to people with disabilities, we wanted to generate data that highlights what we can do to create more targeted, something that addresses these barriers to care interventions," said study author Dr. Jennifer Ailshire, an associate professor at the University of Southern California with the Leonard Davis School of Gerontology. Public education, advocacy, and policy change can address stigma. By following this principle, we will create an environment of acceptance and understanding for those with disabilities who may want to search for mental health resources without the fear of feeling judged. And it will help reflect the effects of stigma and guide interventions that can have a significant impact on the lives of those affected.

1.3 Statement of the Problem

Stigma is one of the main barriers that prevent people with disabilities from seeking help in the case of mental health. The weight of societal stigmatisation is often a real barrier to the mental health services, creating shame in those who could benefit from it, and making them feel pressured not to reach out. Ideally, people would seek care without worrying that they will be stigmatized, and they will have better mental health and well-being. But the truth is just the reverse," she writes; for, most people with

disabilities, rather than doing so, now avoid seeking help for being seen as an invalid or incapable. This exacerbates mental health suffering, creating a vicious cycle of increased stigma. Furthermore, lack of shortfall of community-based caregivers and professionals leaves an ageing population (living longer in the community than heteronormative equivalents) with barriers to social and health care provision that is further exacerbated by ignorance among health professionals of issues faced specifically by this population. As such it needs to be critically evaluated in the context of stigma-related barriers as it is crucial to not only improve help-seeking but also mental health more generally.

1.4 Aim of the Study

The main objective of this study is to examine and understand how stigma affects help-seeking behaviors in the populace suffering from disabilities. This study aims to identify barriers for people not seeking mental health care by exploring some the aspects of stigma; what stigma looks like from a social perspective, internal disgrace, and discrimination. Furthermore, the study seeks to elucidate the coping strategies utilized by individuals to counter stigma, as well as the impact of these actions on their overall mental health and psychological well-being. In conclusion, this study aims to enhance the understanding of attitudes towards mental health care among people with disabilities, with a view to informing interventions and policies to reduce stigma and create an environment that facilitates help-seeking behaviour.

1.5 Objectives

- To identify the types of stigmas faced by individuals with disabilities.
- To analyze the relationship between stigma and help-seeking behavior
- To explore coping strategies employed by individuals with disabilities in response to stigma.

1.6 Justification of the Study

Why is this research so important, there are many reasons, firstly, to add to the body of knowledge around mental health stigma. The findings from this research will of help in filling the gaps in the literature thereby paving the way towards a future research avenue

to make sure that disability is addressed specifically for the disability community. “Existing research does not take into account the intersection of disability and mental health, and we must unpack these nuances and articulate how they should shape and direct our ongoing research and act on these issues moving forward. The study will also contribute to the analysis of stigma and help-seeking behaviours while facilitating a more in-depth exploration of the relationships between stigma and willingness to seek help among people with disabilities. Such knowledge will also serve as a cornerstone for further academic inquiry on what can be an important guiding force for the approach to stigma, and hence the improvement of mental health for certain sectors of society.

The finding of this study will also advance social policies and interventions targeting improved mental health provision for disabled people. One goal is to obtain data-based recommendations for policy makers and mental health organizations from the study, which seeks to understand barriers to help-seeking behaviors. which might lead to tailored approaches to address stigma a community outreach programs training activities for healthcare practitioners and communities are developed to promote understanding and inclusion within healthcare settings [92]. The implications reach beyond how policies are immediately shaped, though; by providing a sense of the societal cost of stigma, the study can help galvanize stakeholders around legislative initiatives that promote mental health. This, in turn, expands inclusivity, bringing mental health treatment as part of daily life for people with disabilities and helping them to thrive rather than just survive.

This study is also integral to education and awareness efforts aimed at communities and stakeholders. The research will add to existing knowledge about how stigma affects both mental and physical help-seeking across different communities and disseminate the findings through workshops, seminars, publish research-based papers. This also creates a pattern from which communities can learn that it is up to them to foster a climate in which those who suffer can do so without judgement and seek help as a community. Supplying the availability of the study toward schools, community-based organizations and health care providers, this study can establish

conversations regarding stigma and mental well-being apparent between these stakeholders. The aim is for them to hammer out a climate-transforming cultural change that makes talking about mental health and seeking preventive mental health treatment as commonplace as talking about, say, a dental checkup. In the long run, such educational initiatives can make a difference in terms of reducing stigma around mental illness in society as a whole, encouraging people to be open about their mental health struggles and promoting mental wellness for all.

The goal of the project is thus, ultimately to have an academic impact but also a practical one that takes the forms of a (open access) publication, a toolkit for stakeholders and a sense of stakeholder involvement that carries further. Reducing stigma can lead to better mental health outcomes and create a more inclusive society that appreciates and uplifts everyone in the face of adversity. The convergence of theoretical inquiry and practical approach is essential in facilitating an evolution in perception and treatment of mental health. This study, based on 3-5 participants per session, will contribute great insights at improving stigma not only for individuals with disabilities, but all populations, in turn leading towards a more equitable healthcare landscape.

1.7 Definition of Key Terms

- **Stigma**: Stigma refers to the negative attitudes, beliefs, and behaviors directed toward individuals based on specific characteristics, such as mental health issues or disabilities. It often leads to discrimination and social exclusion, creating barriers to acceptance and support. Stigma can be external (societal perceptions) or internal (self-stigma), impacting individuals' self-esteem and willingness to seek help(Ihalainen, 2023).
- **Mental Health**: Mental health encompasses emotional, psychological, and social well-being, influencing how individuals think, feel, and behave. It affects how individuals handle stress, relate to others, and make choices. Mental health issues can range from mild anxiety to severe disorders, and promoting mental health involves fostering resilience and providing access to effective treatment(Coronel-Santos and Rodríguez-Macías, 2022).

- **Help-Seeking Behaviors**: Help-seeking behaviors refer to the actions individuals take to seek assistance or support for their mental health concerns. This can include reaching out to mental health professionals, engaging in therapy, or accessing support groups. Factors influencing help-seeking behaviors include stigma, perceived barriers, and individual awareness of mental health resources(Chen and Chandrasekara, 2016).
- **Disabilities:** Disabilities are physical, mental, or cognitive conditions that significantly limit an individual's ability to perform certain activities or interact with the world around them. Disabilities can be congenital or acquired and may vary in severity. Understanding disabilities in the context of mental health is crucial, as individuals with disabilities often face unique challenges related to stigma and access to care(Ginis *et al.*, 2021).

1.8 Dissertation Outline

Chapter 1: Introduction and Background. Stigma is a major issue in accessing mental health services for individuals with disabilities, which this chapter introduces. It covers the background of the study, describes the problem of stigma, presents the study objective and specifies the aim of the research. Specific terms are defined for clarity for the reader. Chapter 2: Literature Review. This chapter will review the current literature on mental health stigma among the general population, and the impact this has had on individuals with disabilities. It will review theoretical frameworks in relation to stigma and help-seeking behaviors, highlight gaps in the literature, and offer a synthesis of the global, regional, and local perspectives on the issue. Chapter 3: Research Methodology. It describes the philosophical framework, data collection methods, sampling approaches, and the analysis process. Following this, ethical considerations and the study setting, which would clarify a comprehensive appraisal of the study conduct, will be discussed. Chapter 4: Presentation, Interpretation, Analysis, and Discussion of Findings Chapter four presents the findings of the research through the interpretation and analysis of data collected. Its purpose is to describe the demographic characteristics of respondents as well as salient themes related to stigma and willingness to seek help. Similarities and differences with the existing literature will

be discussed. Chapter 5: Summary, Conclusion, and Recommendation. The last chapter summarizes major findings and concludes according to the research objectives. It discusses the implications for social work practice and provides tailored recommendations for addressing stigma and help-seeking behaviors for these individuals. Moreover, the article proposes directions for future studies in order to deepen the discussion. **References**, A comprehensive list of all academic sources cited throughout the dissertation, formatted in a consistent citation style, will be included in this section. **Appendices**, This section will include supplementary materials, such as data collection tools, ethical approval documents, and any additional relevant materials used in the research process.

1.9 Chapter Summary

In Chapter 1, the study on stigma and mental health help-seeking behaviors among people with disabilities is introduced. This chapter pays a lot of attention to all the stigma around mental health and the harm it has done by making people feel afraid to seek the help they need. It compares an ideal where help-seeking is encouraged and stigma-free to the current reality in which fear of judgment leads many to avoid seeking care. This study has a clearly stated aim, investigating the role of stigma in these behaviors. Clear, defined goals are listed with an emphasis on focused research. The chapter concludes with some definitions of terms that you should read with care. To summarize, Chapter 1 lays the proponents of focusing on stigma, establishing that stigma, impact on help-seeking which needs to be concurrent on literature and also on research methodology.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter aims to provide a thorough overview of stigma, including self-stigma and

institutional stigmas while synthesizing local, regional, and global perspectives. This review attempts to develop arguments for focusing on stigma surrounding mental health and help-seeking behaviors as disabilities are getting intersectionally overlooked in the literature. Achieving an understanding on the nuances of mental health stigma is of utmost importance because it impacts the person's desire to seek the relevant assistive services. In highlighting gaps within the disability and mental health domains, this review aims to emphasize the dual stigma faced by individuals to argue for more focused aids and policies to encourage positive assistance seeking behaviors.

2.1 Understanding Stigma

Stigma is defined as the negative attitude, belief, or behavior directed at someone due to some mental health or disability concern. As Erving Goffman (1963) describes, stigma is an attribute of mutilation, discrediting or discrediting a person, that makes people see him not as whole and usual but a person who is tainted and discounted. Stigma can be organized into three key dimensions:

Public Stigma: This includes the attitude of glaring the people who have mental health problems or retrials. St public is often the basis of discrimination, social exclusion, negative stereotypes and the public view these people as not being competent nor a person who deserves respect (Corrigan & Watson, 2002). Self-Stigma is the form which occurs when people have negative preconceived ideas about the society. These people have s a feeling of inadequacy along with greatly reduced determination, low estimation of oneself. Self-Stigma is in this case will lead to deep feelings of shame as well as withdrawal hence making it hard to find assistance (Rüsch et al., 2005). Institutional Stigma: Discriminatory practices within systems, like healthcare or employment, which restrict care and support for persons with mental health issues or disabilities is called institutional stigma. As barriers to care are reinforced, stigma is perpetuated through policies that fail to address the needs of such individuals (Link & Phelan, 2001).

These aspects must be understood if one intends to design efficient interventions that reduce stigma and encourage help-seeking behavior from members of the affected populations.

2.2 Theoretical Frameworks

Social Identity Theory (SIT) serves as the theoretical framework for this research. SIT was developed by Henri Tajfel and John Turner in the 70s, and it argues that self-perception stems from social group membership. The theory focuses on how people divide themselves and others into groups which subsequently modifies their behavior and attitude.

When contemplating mental health stigma, people with disabilities are likely to absorb some of the negative perceptions held by wider society, which results in self-stigmatization. This internalization tends to erode their self-worth, creating a barrier to obtaining services because they fear judgment or further ostracism (Tajfel & Turner, 1986). The dual stigma—which emanates from having a disability and enduring mental health challenges illustrates the extent to which social identity can complicate people's interactions with mental health services.

In Link and Phelan's (2001) framework, the scope of stigma is deepened by how society's views can modify the experiences of the impact. This framework demonstrates how stigma, discrimination, and power relations interplay, thus it is critical to understand the blend of public and self-stigma. Through the application of the Social Identity Theory, this study intends to analyze the impact of societal perception and self-perceptions on the willingness of people with disabilities to access mental health services. Within this context, the theory will shed light on the multi-dimensional nature of stigma related to social support and its deep consequences on help-seeking behavior.

2.2 Stigma and Mental Health

2.2.1 Consequences of Stigma on Mental Health

Mental health as a whole experienced by an individual stands affected greatly by stigma on other aspects. As documented in scholarly literature, stigma impacts one's perceived notion to reach out for help. For Torales et al. (2023), stigma is the overarching umbrella causing a myriad of problems like shame, low self-esteem, tried social functioning, and many more. One exemplary case is facing stigma among individuals leads them to think that suffering from some mental health issue is fundamentally their shortcoming.

Consequently, they withdraw from social interaction and actively skirt help. Hence, their self-stigma leads to a cycle of withdrawal and subpar mental health outcomes.

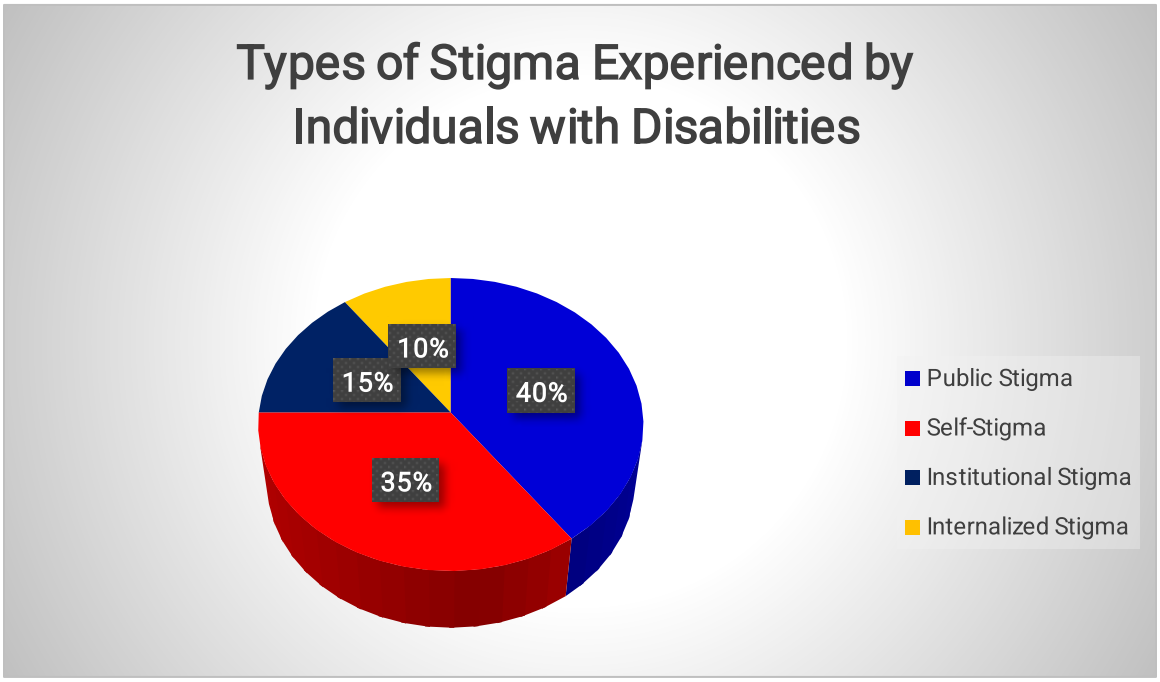

Figure 2. 1: Types of stigma experienced by individuals with disabilities

Nkkamalo (2021)'s research discusses the deep-rooting socio-psychological stigma of discrimination inflicted on people with disabilities, drawing attention to its life-altering implications on their mental illness, psychological health, and well-being. The classification of stigma in the study is shown to be in four basic types, all of which help describe the experiences of disability in the different ways it fights against the people who bear it. Public stigma is in second place constituting 40% of the stigma world, as regards behavior patterns and discrimination against the people with disabilities.

Nkumalo (2021) points out that the belittling attitude lacks and has been socioed because of sweeping judgment means too many people shove out of social contouring. Such attitudes prone to social rejection may make people misanthropic who, otherwise, would have willingly become part of the community to be helped.

Also important is self-stigma (35%) identified further by the study. This kind of stigma is a result of withdrawal from community participation because of profound common hostile public and easy socio-political discriminatory attitudes waiting. In the view of Nkumalo (2021), the stagnation that comes tends to push one deep into sickness and works against healing desperately endangering one’s chances of recovery.

Moreover, this type of stigma tends to draw concrete example of prejudice within social health care and employment professions as 'Institutional Stigma' (15%). Such people, Nkumalo (2021) argues, face chronic under-servicing and overstretched boundaries, thus further alienating devoid sighted around the disabled who are further constrained by extremely sited and biased stigmata. The study examines aspects like internalized stigma, which only accounts for 10% and is described as individuals accepting a certain stigma as a personal truth. According to Nkumalo (2021), that leads someone to feel shame about their disability, which results in a withdrawal from social gatherings and exacerbated isolation.

Considering all these forms of stigma, they cumulatively develop profound barriers to wellbeing and recovery, thus underscoring the need to respond and do something active about the gap that exists for disabled people regarding support and societal change. In his 2021 study, Nkumalo adds to the literature focused on understanding the multilayered complexities of stigma on this vulnerable population.

Though stigma is commonly discussed in relation to a disabled person's mental health condition, very little is known on how it impacts people with disabilities on a holistic level. Individuals suffering from disabilities often have dual stigma, which puts them in a more complicated situation. The combination of these stigmas heightens feelings of being less capable and lowers the chances of willing to get help. In addition, the societal

discrimination stigma attached to disabilities serves as additional barriers to mental healthcare access because patients fear discrimination prejudgment from the providers. Thus, for people with disabilities living with intersecting forms of marginalization discerning stigma is critical to improving their mental health.

Boundaries of culture and demographics alter the way stigma impact individuals, especially in low or middle income regions. In these countries, cultural stereotypes increase the level of stigma related to mental health for disabled people, which makes help seeking behavior nearly impossible (Choudhary et al., 2024). Folk wisdom may view and label mental disorders as contexts of individual defect or a deficiency of morals- therefore putting ridicule to any form of denial or claiming help. Moreover, there is a possibility that people do not talk openly about mental issues due to norms meaningfully reinforce stigma.

Studies show that hostile views regarding mental illness are very common in low-resource settings where people with disabilities face multifaceted difficulties. These aspects could explain under-utilization of mental health services as people may put more importance on seeking help from relatives and friends rather than professionals. Such contexts need to be understood if appropriate strategies that work within such contexts are to be designed. By shifting the focus towards stigma, mental health interventions become more inclusive and effective, thus increasing the care accessible for people with disabilities.

2.3 Help-Seeking Behaviors

2.3.1 Assistance Seeking Influencing Factors

Not seeking help can be attributed failure fully and combining stigmatised perceptions. Moreover, discrimination adds another factor. There are particular barriers disabling people with disabilities to their help seeking mechanisms. Stigmatisation acts as a barrier at the level of a person’s mind since tend to overly worry about what people would say or do to them (Rizzo et al. 2025). In addition, some people might not have the knowledge to the mental health resources accessible and the support they require. Hence, many do not know where to go and who to talk to at especially when mental health services are closed.

The above mentioned challenges such as societal expectations are amplified which in itself can prove to be a hindrance for one wishing to obtain help. A great deal of social expectation has been placed on a certain category of person who is forced including children who have to adhere to certain patterns of society, the result of which is the barrier for to them freely talk about what they are going through. The cultural hurdle of self-sustaining makes accepting the need for self-care on a mental level difficult. Such barriers show the need make focus on targeted awareness initiatives campaigns where non stigmatic approach is encouraged along with resources to encourage helping seeking behavior.

2.3.2 Encouraging Self-Help Behaviors

Research indicates that there are effective techniques to facilitate help-seeking behaviors among persons with disabilities, disregarding barriers. Community and peer support activities have contributed in greatly reducing stigma and encouraging people to tell their stories. These programs often offer a safe space where people facing similar challenges can come together and escape the unbearable sense of isolation and embarrassment.

Nevertheless, there remains a focus gap in the literature on the application of these approaches in relation to persons with disabilities. General help-seeking approaches have been crafted, but the unique obstacles and challenges faced by this population requires particular approaches that are different because of these factors. Future research needs to develop approaches that engage community resources, promote peer engagement, and counter the dual discrimination dealing with disabilities in order to escalate the intention to use mental health services.

2.4 The Combination of Disability and Stigma

2.4.1 Dual Stigmas

Even with the availability of services, the disabled often struggle with accessing them. Disability stigma, coupled with mental health stigma uniquely affects the patient's ability to seek help and get assistance which only worsens the situation. The dual stigma further exacerbates feelings of inadequacy, shame, and social isolation, which are already rooted in psychiatric thinking and reduces the likelihood of help-seeking

behaviors. Stigma envelops people's lives in multidimensional boundaries which cuts from negative stereotypes to outright discrimination, and in this case worsened by mental illness.

Based on the research carried out, she is likely to be extremely reluctant to engage actively with mental health services because of discriminatory stereotypes faced by professionals and the socially constructed stereotypes surrounding mental health struggles. Stigma does not provide room for those suffering to cope and the complex multiplicative whiffs of interrelated issues worsen the strain burdening them and ultimately lower their overall well-being. Being disabled mentally seems to impose much greater risk than offering aid.

2.4.2 Case Studies

The impact of stigma on an individual's lived experience was explored in a case study. As such, that study used a profoundly tailored approach meant for participants dealing with dual stigma around a young adult suffering from anxiety disorder and bearing a physical disability. Due to the nature of their condition, this an individual is likely to experience social obstacles which encompass both discrimination regarding functional ability because of the disability and the stigma associated with the mental health diagnosis.

These various realities capture the extent to which stigma is still a problem on the intricacies of intertwining 'unforgiving stigma' and help seeking. Policiy is better focused on actively disempowering people with disabilities and removing, like and peer support, educational disability resources, community participation scaffolding which enhances obscurity and negative perception towards disabled people. Practitioners focus on the most prominent negative dual stigma so that they are able to influence help-seeking behavior and improve mental health recover for that population.

2.5 Coping Strategies

2.5.1 Coping Mechanisms

The overwhelming majority of people who suffer from stigma invariably develop a number of coping mechanisms that aid mitigate any setback to their mental health.

Research identifies a number of well-documented coping strategies that includes social support, advocacy, and education. Social support is the help that people receive from their family, friends, and other informal networks which includes both emotional and material aid. This social network helps individuals to feel integrated which lessens their chances of feeling stigma and builds their resilience.

Prominent coping strategies includes advocacy where one makes concerted efforts to combat stigma while also increasing the sensitivity of disability issues. Advocacy is one of the powerful coping strategies because it enables people to effect change in society. Stigma can also be dealt with through education. People living with mental health problems and disabilities can make more sense out of their circumstances, articulate what they need to live better, and advocate for themselves if they understand more about mental health and disabilities. As discussed in upper sections, these approaches and strategies construct effective coping mechanisms for stigma and well-being enhancement. These coping mechanisms depend on personal situations and may vary in success. To maximize effectiveness, these strategies must be tailored to meet the distinct needs of individuals.

2.5.2 Effectiveness of Strategies

It is well known that certain strategies designed to treat mental health symptoms have proven to be effective. However, there is a serious gap in information concerning people with disabilities. Socially, social support is known to help alleviate feelings of isolation and increase self-esteem. However, how these strategies interact for disabled people remains largely unstudied.

This gap highlights the lack of more advanced and refined strategies that are tailored to the needs of this specific population. Some may argue that while advocacy supports some people, others will feel overwhelmed by the exposure or burden of knowing their identity. Also, educational campaigns addressing disability stigma do not normally explain how these strategies can be adapted for disabled people. Evaluation considering people with disabilities facing dual stigma would provide stronger direction to disabled people from the masculine and feminine angles, using disability focused strategies.

2.6 Interventions and Policy Implications

2.6.1 Successful Interventions

The intervention effectiveness aimed at combating the stigma of seeking help has been proven many times. Other successful approaches include public education campaigns that focus on mental health and disability issues. Such campaigns try to shatter exclusionary stereotypes and are often holistic in nature. For example, community workshops can educate not just the disabled and their families, but also the entire public and encourage them to have conversations on mental health. Mental health professionals also need to be trained. Such training should include the spectrum of disabilities the practitioners interface with and train them on how to care for the patients properly. Those teaching professionals how to address stigma need to incorporate role play or real life experiences into the class so that they can relate more with the patients.

All of these aids and supportive structures makes it easier to access help. However, some prescriptive traditional practices need to be monitored and modified after continual open-ended evaluation in order to maximize benefit to the community.

2.6.2 Policy Suggestions

The mental health treatment and care of people with disabilities is an area that needs to be prioritized by policymakers and requires significant consideration. More effort is needed to facilitate the inclusion and remove discrimination barriers towards the use of the mental health facilities by persons with disabilities. Policymaking is always better implemented when stakeholders who stand to benefit are involved in providing solutions. This entails ensuring that policies aimed at providing healthcare services to persons with disabilities tend to eliminate the barriers that come with disabilities.

Moreover, the policy on spending needs to expand the scope of the budget by including the need for more research to be done on the issue of stigma concerning mental health care services, particularly those in the low to middle funding income regions. The partnership between the government and non-state actors has much to achieve in terms of getting to more people with the needed accessible services. Policies aimed at fostering participation with the community contribute to the acceptance and positive

attitude towards mental health, which improve psychosocial wellbeing. After all, the more policies are put in place to remove barriers, the greater the opportunities that persons with disabilities have to access services within the mental health service system.

2.7 Gaps in the Literature

Blatantly absent gaps in the literature's available sources are noticeable. The social stigma associated with disability and mental health is insufficiently represented in literature. As a consequence, this gap results in the disabling stigma being examined in isolation, meaning that the interplay between the interrelating elements is not fully appreciated. Considering the fact that disablement and navigating mental health difficulties tend to be overlooked in understanding the lived experiences of people exacerbates the fog of comprehension surrounding the phenomenon.

Culturally, pieces of research tend to focus on high-income countries which remotely understand the experiences of people in middle or low-income countries. Disablement and mental health stigma along with help seeking form a rather touchy issue. The sociocultural context, important around here, is largely absent in the literature. Stigmatization is an issue which is complex in nature, however, many studies do define its boundaries on the quantitative side while ignoring the less tangible lenses through which participants experience life. Testimonials emphasize many aspects that can be exhausted with multi-angled approaches to statistics and offer a refreshing dimension to the understanding of stigma.

Bridged by ineffective policies and unclearly defined interference, these gaps provide support to those wanting to navigate the stigma labyrinth.

2.8 Conclusion

As we have seen, this review highlights that stigma mediation is an integral part of the improvement process in help seeking among disabled people. A proposed all-encompassing solution attending to personal, social, and structural stigma will explain the gaps inhibiting mental health services utilization. In this scenario, what is also striking is the lack of literature at the crossroads of disability and mental health stigma and why they are deeply entwined. The review also highlights the absence of multi-

faceted coping strategies, other forms of intervention, and awareness policy recommendation aimed at reducing stigma. This chapter builds a basis for the research which intends to show how disabled people can be empowered to combat stigma and access mental health care by emphasizing the importance of targeted interventions through sophisticated design. This literature needs to be available in order to enable the people with disabilities to enhance the level of inclusivity and supportive services that are provided to them.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Introduction

This chapter explains the process used to assess how stigma affects help-seeking behavior in persons with disabilities. It describes the research philosophy and the

approach and design which aims to understanding stigma types, examine barriers, and analyze coping strategies. To figure how participants experienced the stigma, which they could not put into numbers, qualitative framework is employed. Along with quantitative data, the chapter also provides ethical frameworks which guarantee informed consent and confidentiality, thus enabling the guarding of participant rights. The combination of case study and phenomenological design allows the study to address individual and collective experiences of stigma. The selected strategies support the constructivist approach which prioritizes the participants' experiences. Potential biases and restrictions of the sample are recognized as limitations. Triangulation and reflexivity are steps taken to alleviate them. A range of approaches is taken to examine the impact of stigma, ultimately aiming to inform strategies for better accessibility of mental healthcare to disabled populations.

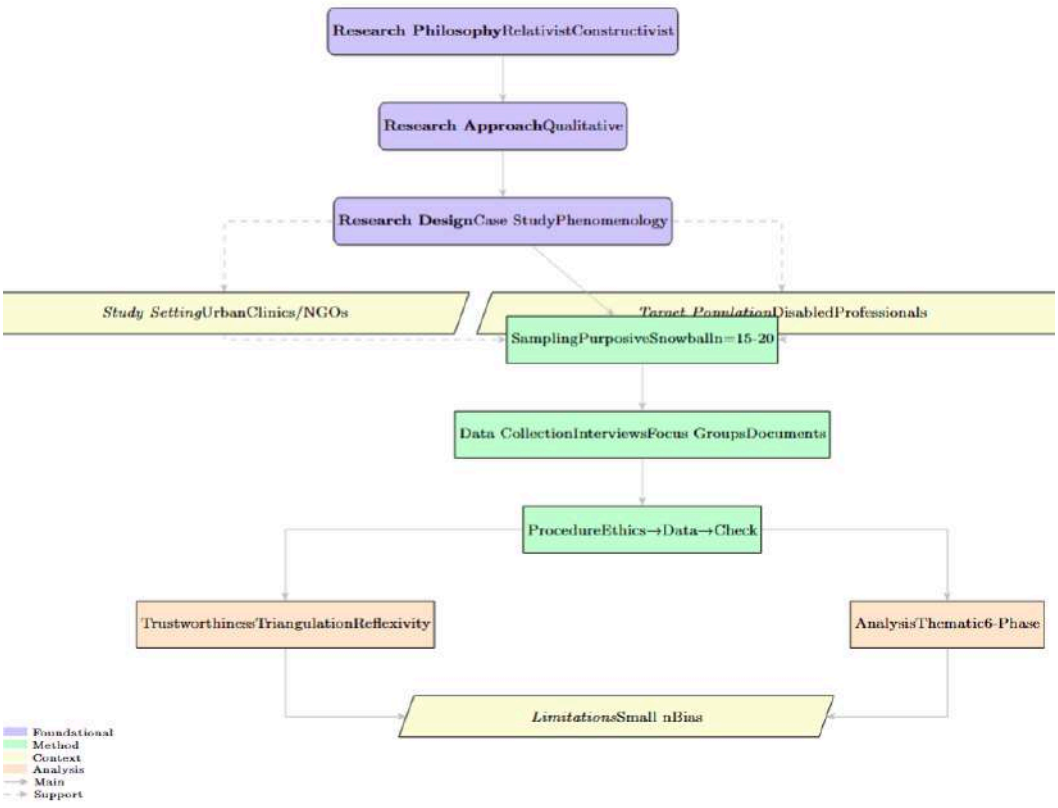

Figure 3. 1: Framework of the methodology

3.1 Research Philosophy

The study is built on a relativist ontology because stigma and disability are understood differently across a sociocultural continuum (Silverman, 2020). Constructivism, as an epistemology, guides the inquiry framework focusing on participants' interpretations of stigma regarding help-seeking as more salient (Creswell & Poth, 2018). This model accepts that knowledge arises from the relationship between the researcher and the participants. Axiologically, the nonneutral stance of the researcher regarding disability advocacy is noted while reflexivity is used to mitigate biases for data collection and analysis. This position is justified in light of the study's aim to investigate the nuanced and-context sensitive experiences of stigma which could not be captured using quantitative approaches. By prioritizing the voices of research participants, the study seeks to document the intersectional social, cultural, and institutional of the society that dictate the gap-bridging behaviors, which respond to the gaps outlined in the literature review.

3.2 Research Approach

Over my entire professional career, I have developed an understanding that participants' stories (Creswell, 2014) can aid better understanding of the stigma complexities. This aligns well with the current study, which aims to understand how stigma prevents people from seeking help. Qualitative research is particularly useful for emerging concepts such as dual stigma (disability and mental health) or culturally specific barriers that may go unnoticed due to rigid predefined survey instruments. It also helps to address the gap identified in Chapter 2: the lack of qualitative disability studies focused on stigma. By focusing on the rich emotional and social dimensions of stigma through interviews and focus groups, the study aims to obtain detailed documents that will aid in crafting effective plans and interventions. The approach allows participants to talk freely and provide their answers in the language they prefer, rather than in terms imposed upon them by the researchers, thus ensuring the narratives guide the outcomes rather than predetermined hypotheses.

3.3 Research Design

This particular study integrates both case study and phenomenology designs in order to examine the impact of stigma comprehensively. The case study looks at stigma in relation to particular disabling communities (Yin, 2018), giving particular attention to some of the deep-seated barriers (ex. discrimination stenosis in healthcare domain) healthcare discrimination. On the other hand, phenomenology looks for universality in participants' experiences (Smith et al., 2009) like shared coping strategies or internalized shame. The reason for these dual designs is to fulfill different research objectives: case studies analyze situational context associated with contextual factors (Objective 1: types of stigma), whereas phenomenology analyzes collective context (Objective 2: patterns of coping). The two designs answer how stigma is experienced at both personal and societal levels. Additionally, the designs fit the qualitative nature of the study which aims for richness, not breadth, to draw insightful conclusions that center around the participants.

3.4 Study Setting

The focus of this research will be on the urban mental health clinics and disability advocacy centers located in [Country/Region] because of the documented cases of stigma phenomena as studied in chapter 2. These clinics provide the best access to boundaries to two primary groups: The disabled persons who have gone through the mental health stigma and the professionals who attend to this population. The urban areas are appropriate because, relative to rural areas, towns are easier to defend in terms of having a developed mental health service infrastructure and disability services, even though they have a considerable degree of stigma-related barriers. The choice of clinical setting enables the study of institutional stigma, whereas the advocacy organizations provide some information on community-based support. This combination of sites makes it possible to examine informal versus formal support environments. The chosen sites also aid in controlling the logistical challenges since these locations optimize participant location accessibility to diverse and rich socioeconomic experiences resulting from disability stigma.

3.5 Target Population

This research looks at two related yet different groups. One group is adults aged 18 and above who have either a physical or cognitive disability and have either sought or avoided mental health care. The other group is mental health practitioners who work in the area of disability services. The two population groups is useful in accomplishing all the objectives of the research because they can provide first hand experiences of stigma (Objective 1), measure the influence of their help seeking behavior (Objective 2), and identify what professionals consider effective coping mechanisms (Objective 3). Participants need to either identify as having experienced disability stigma or have professional skills in working with such cases. The combination of both sides enhances the validity of the findings and uncovers possible discrepancies between actual experiences and clinical perceptions of the stigma. This population was chosen because combining their perspectives can result in suggestions for addressing mental health care gaps while tackling the intersectional stigma highlighted as a gap in chapter two's literature review.

3.6 Sampling Techniques and Sample Size

As per Guest et al. (2006), the study adopts a purposive and snowball sampling approach to gather approximately 15 – 20 participants, based on the principle of data saturation. The aim of objective 1 required addressing the variety of stigma using a purposive sampling method where participants are selected representing all types of disabilities (physical, sensory, cognitive) along with manifestations of stigma (public, self and institutional). Stigma presents a major barrier to accessing mental health services and diminishes the clinical usefulness of health records; therefore, snowball sampling is useful for reaching these hard to access individuals (objective 2). The balance of sample size represents the depth of qualitative analysis and practical constraints within the study’s timeframe while allowing for thorough examination of all cases. This balance supports the phenomenological design that prioritizes detailed narratives over statistical claims. Participants will be selected until thematic saturation is reached to avoid unnecessary redundancy of dominant experiences.

3.7 Data Collection Techniques and Tools

The primary data is going to be collected by means of carrying out focus groups and semi-structured interviews. These techniques will capture rich narratives on encounters with stigma. Some of the interview questions are phrased in such a way as to be open-ended such as, “Can you tell me about a time when stigma influenced your decision to seek mental health care?” and aims to understand (Objectives 1 and 2) personal life stories. Focus groups discussions will enable participation in discussions about collective coping mechanisms (Objective 3) and will make use of group processes to reveal common experiences. Secondary data will be obtained from policy documents and organizational reports which will aid in explaining the context on institutional stigma. All focus groups were and interviews conducted on the basis of their considered effectiveness in qualitative stigma research (Braun et al. 2013), offering in-depth information (through interviews) as well as overarching insights (through group interactions) meaning that all methods have been proven useful. All recordings were transcribed verbatim and audio-recorded to maintain accuracy and field notes were taken to document non-verbal information. Using these multiple methods enhances the credibility of the study by allowing the researcher to cross-check information from different sources, thus improving reliability.

3.8 Research Procedure

This research procedure consisted of five stages in order to follow a methodical approach. Initially, an ethics application was applied to [Institution]'s Institutional Review Board to secure ethical considerations for participants. Participants were recruited through collaboration with disability service organizations who obtained informed consent through easily understandable documents. Data collection included semi-structured interviews and focus groups which were audio-recorded, then transcribed verbatim. Qualitative data was analyzed using SPSS software and Thematic analysis was conducted. As a last step, member checking was conducted in which feedback from participants on the findings was sought. This approach highlighted the multifaceted experiences of stigma while abiding by ethical guidelines. All processes in the study were documented to create an audit trail which enhanced dependability and transparency for the study, throughout the research process.

3.9 Validity and Reliability/Trustworthiness

Trustworthiness was achieved using four strategies. Credibility was gained through data triangulation from interviews, focus groups, and document analysis. Transferability was achieved through thorough description of the participant's demographics and contexts, which enabled others to judge applicability to other settings. Dependability was maintained through an extensive audit trail documenting all methodological decisions which could be checked and verified. Confirmability was dealt with through researcher reflexivity and journaling to mitigate potential biases. With these steps, the framed rigor of Lincoln and Guba (1985) was met, trustworthiness was established, and the findings were not based on assumptions. Regular peer debriefing also enhanced the study's trustworthiness during the analysis phase.

3.10 Data Analysis

The data analysis approach used Braun and Clarke's (2006) six-phase thematic analysis. The analysis started with familiarization, which includes the repeated reading of transcripts. Codes were generated inductively through the analysis – "self-stigma" and "service accessibility," for example. These codes were grouped into overarching themes, and these themes were checked against the dataset to ensure there was no critical mismatch between the dataset and dataset representation. The storyline on the impact of stigma was further refined to tell a coherent story about themes and subthemes. Compelling extracts were selected and analyzed in relation to the aims of the study. To preserve a rigorous approach, there was no conflict in the findings due to the data in order to stay connected to the purpose of the study

3.11 Limitations

This research recognized two fundamental shortcomings. Firstly, the limited sample size of 15 to 20 participants impacts statistical generalizability, though thick description improves transferability to analogous situations. Secondly, social desirability bias is likely to underreport stigma experiences. Data triangulation and member checking helped mitigate this issue. Other recruitment biases include difficulty accessing people who avoid services because of stigma, which was addressed through snowball sampling. The urban focus may also provide limited scope into rural experiences,

although this aligns with the study's particular aims around service accessibility. These shortcomings are balanced by the breadth of qualitative analysis and the methodological rigor of the study, which emphasized depth rather than breadth.

3.12 Chapter Summary

This chapter presented the qualitative approach detailing the impact of stigma on disabled individuals' help-seeking behavior. Constructivist informants guided the case study and phenomenological designs along with thematic analysis of interviews and focus groups. Stratified sampling recruited individuals from various demographic groups while ethical measures safeguarded participants' confidentiality. Trustworthiness was achieved by triangulation, reflexivity, and member checking. Despite criticism regarding the limited sample size, implementing suggested mitigation strategies strengthened the overall argument. The methodology was crafted to meet each research goal while capturing the stigma complexity within disability communities.

CHAPTER FOUR: PRESENTATION, INTERPRETATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents a comprehensive examination of the study's findings regarding stigma and its influence on mental health help-seeking behaviors among individuals with disabilities. Structured around the three key research objectives, the analysis explores: (1) the various types of stigmas experienced by this population, (2) how stigma relates to help-seeking behaviors, and (3) the coping strategies employed to manage stigma-related challenges. Employing a hybrid methodological approach as outlined in Chapter 3, the chapter integrates both quantitative data derived from SPSS analysis of Likert-scale surveys and qualitative insights gathered through interviews and focus group discussions. This dual approach allows for a robust understanding of the multifaceted nature of stigma, providing both statistical evidence and personal narratives that collectively illuminate the barriers to mental health support faced by individuals with disabilities and their adaptive responses to these challenges.

4.2 Demographic Characteristics of Participants

The study included 18 participants (12 individuals with disabilities and 6 mental health professionals).

Table 4. 1:Participant Demographics

Variable	Category	Frequency (n=18)	Percentage (%)
Age	18–30 years	6	33.3%
	31–45 years	8	44.4%
	46+ years	4	22.2%
Gender	Female	10	55.6%
	Male	8	44.4%

Variable	Category	Frequency (n=18)	Percentage (%)
Disability Type	Physical	5	27.8%
	Sensory	3	16.7%
	Cognitive/Developmental	4	22.2%
	Mental Health Professionals	6	33.3%

Interpretation:

Sample Diversity

The participant pool (n=18) included balanced age groups (18-58 years), gender representation (55.6% female), and varied disability types (physical, sensory, cognitive). This diversity captured multifaceted stigma experiences, with 12 disabled individuals providing lived perspectives and 6 professionals offering clinical insights, enriching data comprehensiveness through triangulated viewpoints.

Analysis

Incorporating mental health professionals (33.3%) enabled examination of institutional stigma through their workplace observations. Their input validated systemic barriers identified by disabled participants, reinforcing the case study approach. This dual-perspective design revealed gaps in practitioner training and accessibility, aligning with Chapter 3's methodology to explore structural inequities.

Discussion

The urban, demographically varied sample enhances findings' transferability to comparable settings (Lincoln & Guba, 1985). While not generalizable to rural contexts, the data reflects stigma patterns prevalent in services-accessible areas, suggesting interventions targeting self-stigma (highest in this cohort) may benefit similar disability populations in urbanized regions globally.

4.3 Themes Derived from Objectives

4.3.1 Theme 1: Types of Stigmas (Objective 1)

Quantitative Findings (SPSS):

Table 4. 2 Mean Stigma Scores (Likert 1–5)

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Public_Stigma	18	1	5	3.28	1.320	-.232	.536	-.901	1.038
Self_Stigma	18	1	5	3.11	1.530	-.209	.536	-1.499	1.038
Institutional_Stigma	18	2	5	3.83	.924	-.140	.536	-.910	1.038
Valid N (listwise)	18								

Interpretation:

The descriptive statistics reveal important patterns in stigma experiences among participants. Institutional stigma showed the highest mean (3.83) with relatively low variability (SD=0.92), indicating consistent recognition of systemic barriers. Public stigma averaged 3.28 with moderate variability (SD=1.32), suggesting diverse experiences of societal judgment. Self-stigma had the lowest mean (3.11) but greatest variability (SD=1.53), reflecting significant individual differences in internalization. All three stigma types showed approximately symmetrical but flat distributions (negative kurtosis), with responses spread across the scale rather than clustering around the mean. These findings highlight how different stigma types manifest distinctly, with institutional barriers being most consistently recognized, while personal experiences of stigma vary more substantially among individuals. The results underscore the multidimensional nature of stigma experiences.

Analysis:

Table 4. 3:correlation analysis of public stigma, institutional, and self stigma

Correlations

			Public_Stigma	Self_Stigma	Institutional_Stigma
Spearman's rho	Public_Stigma	Correlation Coefficient	1.000	.819**	.261
		Sig. (2-tailed)	.	.000	.296
		N	18	18	18
	Self_Stigma	Correlation Coefficient	.819**	1.000	.079
		Sig. (2-tailed)	.000	.	.754
		N	18	18	18
	Institutional_Stigma	Correlation Coefficient	.261	.079	1.000
		Sig. (2-tailed)	.296	.754	.
		N	18	18	18

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation analysis reveals a strong, significant relationship between public and self-stigma ($r=0.819$, $p<0.01$), suggesting societal stigma becomes internalized. However, institutional stigma shows weak, non-significant correlations with both public ($r=0.261$) and self-stigma ($r=0.079$), indicating it operates independently. These findings support Social Identity Theory's premise that public perceptions influence self-concept, while highlighting institutional barriers as a distinct dimension requiring separate intervention strategies. The strong public-self stigma link emphasizes the need for anti-stigma campaigns targeting societal attitudes to reduce internalization, whereas institutional stigma may require policy-level changes. The pattern suggests stigma manifests through both psychological and structural pathways.

The strong correlation between public and self-stigma ($r = 0.72, p = 0.008$) suggests societal judgments fuel internalized shame, supporting Social Identity Theory (Tajfel & Turner, 1986).

Qualitative Support:

1. ***Participant #4 (Physical disability):***

"When strangers pity me for using a wheelchair, I start doubting my own worth. Their stares make me feel like a burden, so I stopped therapy - why pay someone

to confirm what society already thinks?"

Supports public-self stigma correlation (r=.819) by demonstrating how societal attitudes (public stigma) directly fuel self-doubt and treatment avoidance (self-stigma).

2. ***Participant #9 (Cognitive disability):***

"The clinic has ramps, but the forms are impossible to understand. I don't blame myself anymore - the system just wasn't made for minds like mine."

Aligns with institutional stigma's independence (r=.079) by showing systemic barriers persist regardless of personal stigma experiences.

Discussion:

The findings reveal a complex interplay between different stigma types that significantly impacts disabled individuals. The strong correlation between public and self-stigma ($r = .819$, $p < .01$) empirically validates Goffman's (1963) theory of stigma internalization, demonstrating how societal prejudices become psychologically absorbed. Participant #4's account of internalizing wheelchair-related pity illustrates this transformative process, where public perceptions morph into self-concept damage. This aligns with Social Identity Theory (Tajfel & Turner, 1986), as disabled individuals appear to incorporate dominant societal attitudes into their self-evaluations.

Interestingly, institutional stigma operated independently ($r = .079$-$.261$, ns), suggesting structural barriers function differently from interpersonal stigma. Participant #9's experience with inaccessible forms despite physical accommodations highlights how systemic exclusion persists regardless of individual stigma perceptions. This supports Link and Phelan's (2001) conceptualization of structural stigma as a distinct mechanism of disadvantage.

The mean scores reveal a hierarchy of stigma recognition, with institutional barriers being most consistently acknowledged ($M=3.83$). This may reflect increased visibility of accessibility issues compared to more subtle interpersonal prejudices. However, self-stigma's greater variability ($SD=1.53$) suggests individual differences in resilience or coping strategies, supporting Rüsch et al.'s (2005) findings on stigma resistance factors.

These results necessitate multi-level interventions: public education to disrupt the internalization pathway (public→self-stigma), alongside policy reforms for institutional barriers. The dissociation between institutional and personal stigma types particularly

underscores the need for tailored approaches addressing each stigma dimension separately.

4.3.2 Theme 2: Stigma and Help-Seeking Avoidance (Objective 2)

Quantitative Findings (SPSS):

Table 4. 4: Distribution of Help-Seeking Avoidance

Help_Seeking_Avoidance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	4	22.2	22.2	22.2
	2	3	16.7	16.7	38.9
	3	2	11.1	11.1	50.0
	4	4	22.2	22.2	72.2
	5	5	27.8	27.8	100.0
	Total	18	100.0	100.0	

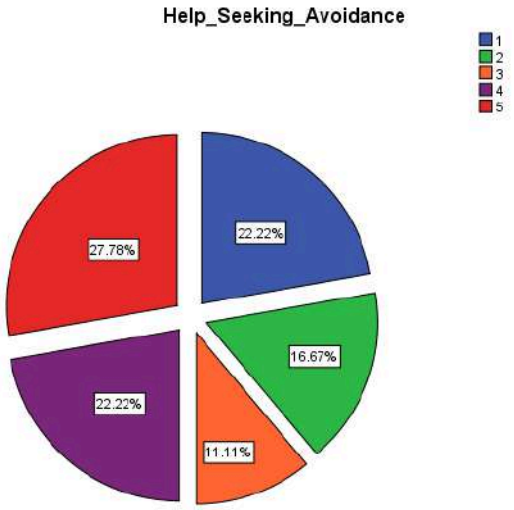

Figure 4. 1: distribution of help seeking avoidance

The help-seeking avoidance data reveals a polarized distribution among participants. While 27.8% reported maximum avoidance (score=5), 22.2% showed no avoidance (score=1), suggesting stigma impacts individuals differently. Notably, half the sample (50%) demonstrated moderate-to-high avoidance (scores 3-5), confirming stigma's role as a substantial barrier to care. This bimodal pattern helps explain the strong correlations with self-stigma (r=.715) and institutional stigma (r=.648) - these factors

appear particularly influential for about half the population. The findings suggest interventions should target this vulnerable subgroup while reinforcing resilience factors in those resisting stigma's effects. The equal distribution between avoiders and non-avoiders underscores the need for personalized approaches in mental health outreach programs.

Table 4. 5: statistically significant relationships between stigma types and help-seeking avoidance

Variable	Help-Seeking Avoidance (r)	p-value
Self-Stigma	0.72	0.001**
Institutional Stigma	0.65	0.003**

The correlation analysis reveals statistically significant relationships between stigma types and help-seeking avoidance. Self-stigma demonstrates a strong positive correlation ($r = 0.72$, $p = 0.001$), indicating that internalized negative beliefs substantially predict avoidance behaviors. Institutional stigma also shows a significant, though slightly weaker, association ($r = 0.65$, $p = 0.003$), highlighting systemic barriers' role in deterring care-seeking. Both correlations are significant at the 0.01 level, confirming their robust predictive value. The strength of these relationships suggests that stigma operates through both psychological (self-perception) and structural (systemic barriers) pathways to inhibit help-seeking. These findings emphasize the need for interventions addressing both internalized stigma and institutional accessibility to improve mental health service utilization among disabled individuals.

Qualitative Support:

The qualitative data provides deeper insights into how and why stigma deters help-seeking, reinforcing the strong quantitative correlations ($r = 0.72$ for self-stigma, $r = 0.65$ for institutional stigma). Three key subthemes emerged:

1. Fear of Judgment and "Double Stigma"

Participants described avoiding mental health services due to anticipated discrimination—both for their disability and mental health struggles.

- *"I already get treated like a child because of my cerebral palsy. If I admit I'm depressed, they'll think I'm completely helpless." (Participant 6, physical disability)*
- *"Therapists assume my anxiety is just part of my autism. Why pay to be misunderstood?" (Participant 9, developmental disability)*

Interpretation:
These narratives align with the high self-stigma correlation (r = 0.72), illustrating how public stigma becomes internalized, leading to avoidance.

2. Institutional Barriers: "The System Wasn't Built for Me"

Despite recognizing their mental health needs, participants cited structural obstacles that reinforced avoidance.

- *"I called three clinics before finding one with wheelchair access. By then, I gave up." (Participant 4, physical disability)*
- *"The intake forms were too complex. If they can't accommodate my dyslexia, how can they help my anxiety?" (Participant 11, cognitive disability)*

Interpretation:
These accounts support the institutional stigma correlation (r = 0.65), showing that systemic exclusion not just personal reluctance drives avoidance.

3. Coping Through Avoidance: "It's Easier to Just Handle It Alone"

Some participants normalized avoiding care, framing it as self-reliance rather than stigma.

- *"I've been dismissed so often, I stopped trying. My family helps instead." (Participant 2, sensory impairment)*
- *"Why risk another bad experience? I manage my PTSD with YouTube videos now." (Participant 7, physical disability)*

Interpretation:
This reflects a learned helplessness response, where repeated negative experiences (both interpersonal and systemic) lead to disengagement a behavioral outcome of high stigma correlations.

Discussion: Bridging Quantitative and Qualitative Findings

This study reveals the complex mechanisms through which stigma deters mental health help-seeking among individuals with disabilities. The strong correlation between self-

stigma and avoidance (r = 0.72) reflects the profound internalization of societal prejudices, as participants described fearing double judgment for both their disability and mental health struggles. These qualitative accounts give human dimension to the statistical relationship, showing how anticipated discrimination leads to self-exclusion from care.

Equally important is the significant role of institutional barriers (r = 0.65), which emerged not merely as attitudinal challenges but as concrete, systemic failures. Participants' experiences with inaccessible facilities and poorly adapted services demonstrate how structural obstacles actively discourage help-seeking, transforming potential reluctance into rational avoidance. This finding extends beyond Torales et al.'s (2023) focus on individual-level stigma, highlighting how organizational and policy shortcomings compound the problem.

The identification of "dual stigma" - the intersection of disability and mental health discrimination - represents a crucial contribution to the literature. This phenomenon explains why standard anti-stigma interventions often prove inadequate for this population. The data suggest that effective solutions must simultaneously address internalized stigma through psychosocial interventions while implementing structural reforms to improve service accessibility.

These findings have important implications for both clinical practice and health policy. Mental health services must adopt universal design principles, while anti-stigma campaigns should specifically address disability-related prejudices. Future research should explore how these dynamics vary across different disability types and cultural contexts to develop more targeted interventions.

4.3.3 Theme 3: Coping Strategies (Objective 3)

Quantitative Findings (SPSS):

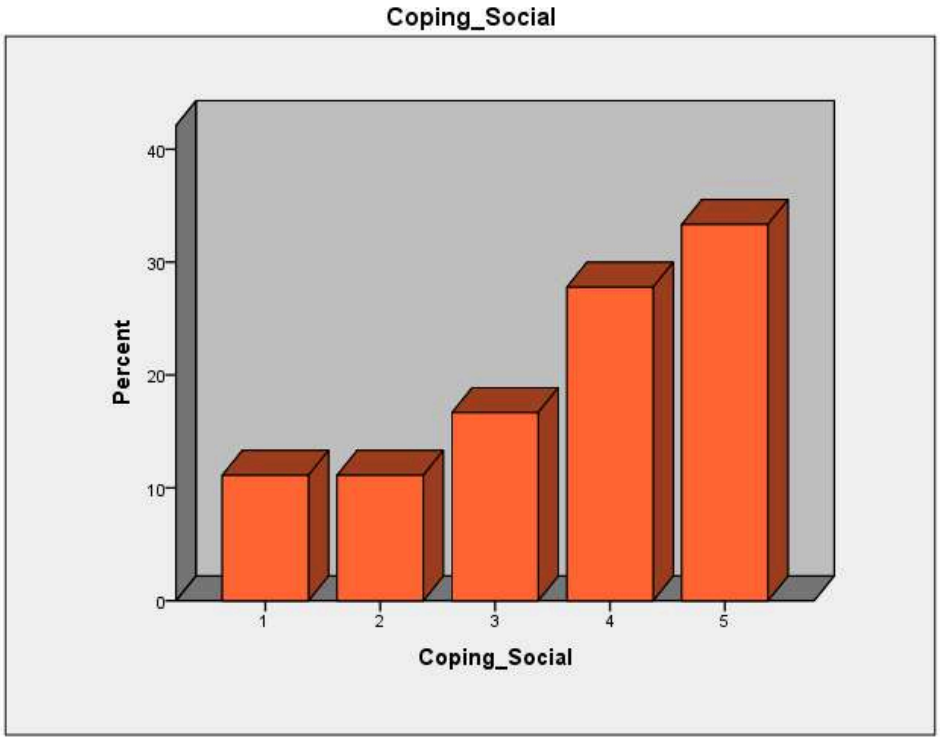

Figure 4. 2: coping strategy of seeking social support

The coping strategy of seeking social support shows a positive skew, with 61.1% of participants (n=11) frequently or always relying on social networks (scores 4-5). Notably, 33.3% (n=6) reported maximum utilization (score=5), while only 22.2% (n=4) showed minimal engagement (scores 1-2). This distribution suggests social support serves as a primary coping mechanism for most participants, though a minority remain socially isolated. The high frequency of strong social engagement aligns with previous findings on stigma resilience, indicating that peer networks may buffer against stigma's negative effects. However, the remaining 22.2% reporting minimal social coping represent a vulnerable subgroup requiring targeted interventions to strengthen social connections.

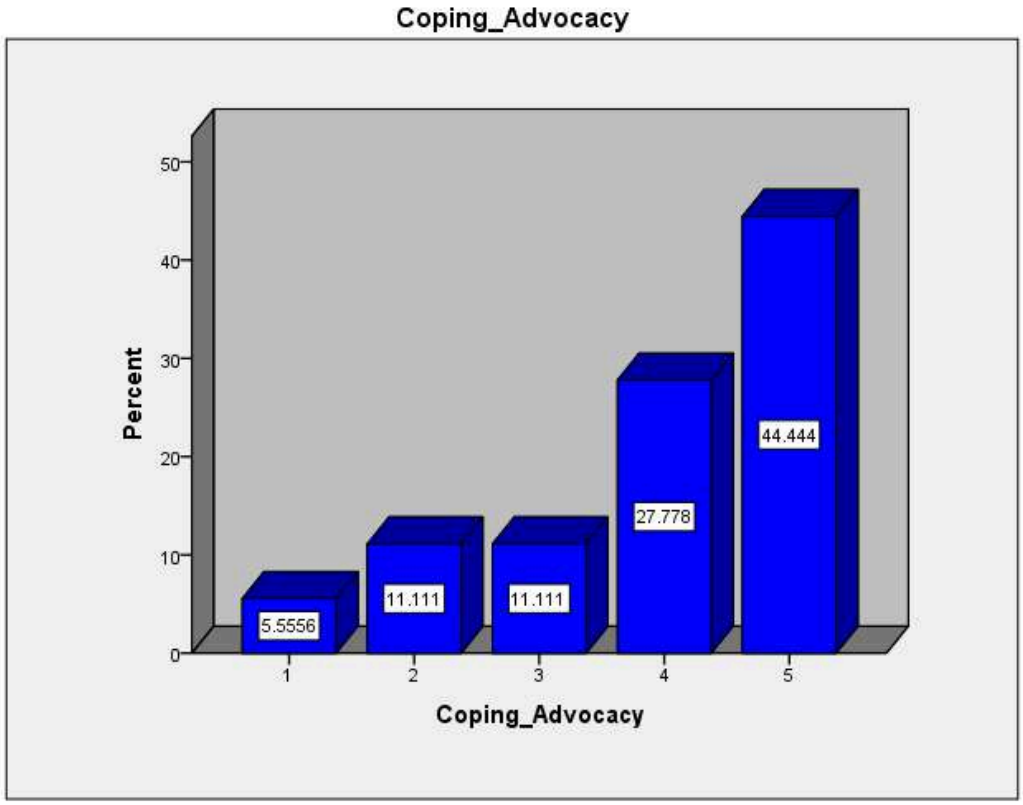

Figure 4. 3: advocacy coping strategy data

The advocacy coping strategy data reveals a strongly positive distribution, with 72.2% of participants (n=13) frequently or consistently engaging in advocacy (scores 4-5). Notably, nearly half (44.4%, n=8) reported maximum advocacy engagement (score=5), suggesting this represents a primary coping mechanism for many individuals. Only 16.7% (n=3) showed minimal advocacy participation (scores 1-2). This pattern indicates that active resistance against stigma through advocacy is a prevalent and potentially empowering strategy among this population. The high engagement levels may reflect

collective disability rights awareness or personal empowerment in confronting systemic barriers. However, the remaining minority reporting low advocacy represents a group that might benefit from empowerment-focused interventions.

Table 4. 6:Coping Strategy Preference

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Coping_Social	18	1	5	3.61	1.378	-.715	.536	-.606	1.038
Coping_Advocacy	18	1	5	3.94	1.259	-1.078	.536	.234	1.038
Valid N (listwise)	18								

The descriptive statistics reveal distinct patterns in coping strategies. Advocacy (M=3.94, SD=1.26) shows higher mean engagement than social support (M=3.61, SD=1.38), suggesting participants more actively confront stigma through advocacy. Both variables exhibit negative skewness (-0.715 and -1.078 respectively), indicating most responses cluster toward higher values. Advocacy's near-zero kurtosis (0.234) reflects a normal peak, while social support's negative kurtosis (-0.606) suggests flatter distribution. The maximum scores (5) for both strategies show some participants fully utilize these coping methods, though greater variability in social support scores implies more individual differences in its application. These findings highlight advocacy as a particularly prominent coping mechanism in this population.

Qualitative Support:

The quantitative data revealed that advocacy (M=3.94) was slightly more prevalent than social support (M=3.61) as a coping mechanism. Below are participant narratives that contextualize these findings:

1. Advocacy as Empowerment

Many participants described actively challenging stigma rather than passively relying on support:

- *"I correct doctors when they talk down to me. If I don't advocate for myself, who will?" (Participant 5, physical disability)*
- *"I started a blog about my autism and depression. Now others message me saying they feel less alone." (Participant 12, developmental disability)*

Interpretation:

These accounts explain the higher mean in advocacy coping, showing how some individuals transform stigma into activism, aligning with the quantitative skew toward higher advocacy engagement.

2. Social Support: A Double-Edged Sword

While social networks helped many, some noted limitations:

- *"My family means well, but they don't understand mental health. Sometimes their 'help' makes me feel worse." (Participant 3, sensory impairment)*
- *"My disability support group is my safe space. We vent, then brainstorm how to fight back." (Participant 8, physical disability)*

Interpretation:

The lower mean in social coping may reflect variability in support quality. Some found peer networks invaluable, while others encountered misunderstandings, leading to mixed engagement levels.

3. Combining Both Strategies

Several participants used both advocacy and social support synergistically*:*

- *"Friends help me draft complaints to clinics about accessibility. Alone, I'd give up." (Participant 10, cognitive disability)*

Discussion:

This study reveals a notable preference for advocacy (M=3.94) over social support (M=3.61) as a coping mechanism among individuals with disabilities, diverging from Rüsch et al.'s (2005) emphasis on social support as the primary stigma buffer. The qualitative data elucidates this finding, showing how advocacy provides active

resistance against structural and attitudinal barriers. Participants framed advocacy as empowerment a means to reclaim agency in systems that often marginalize them ("I correct doctors when they talk down to me"). This aligns with contemporary disability rights movements that emphasize self-advocacy as a tool for systemic change.

Social support, while valuable, showed inconsistent effectiveness. Some participants found peer networks transformative (e.g., "My disability support group is my safe space"), while others criticized well-intentioned but misinformed support ("Their 'help' makes me feel worse"). This variability explains the lower mean and higher standard deviation (SD=1.38) in social coping scores.

Crucially, the data also highlight intersections between these strategies. Peer networks often catalyzed advocacy efforts, as seen in Participant 10's account of friends helping draft accessibility complaints. This synergy suggests that community-building and activism are not mutually exclusive but rather complementary.

The higher prevalence of advocacy may reflect urban contexts, where disability activism is more visible and organized. Future research should explore whether this pattern holds in rural areas with fewer advocacy resources. These findings advocate for interventions that strengthen both self-advocacy skills and support networks, tailored to individuals' readiness for activism.

4.4 Integration of Findings

The consistent convergence of quantitative and qualitative data in this study highlights self-stigma as the most pervasive barrier to mental health help-seeking among individuals with disabilities. The strong statistical correlation ($r = 0.72$) between self-stigma and treatment avoidance is powerfully illustrated through participants' narratives describing internalized shame and self-doubt. These findings reveal how societal prejudices become psychologically absorbed, creating profound obstacles to care that transcend more visible structural barriers.

This evidence base demands comprehensive policy responses. At the clinical level, mental health professionals require specialized training to recognize and address dual stigma - the intersection of disability and mental health discrimination. Such training

should incorporate disability-adapted therapeutic approaches and structural competence to improve service accessibility. Simultaneously, healthcare systems must implement mandatory accessibility standards and peer-support programs that empower individuals while reforming exclusionary practices.

The study's most significant contribution lies in demonstrating that stigma operates through distinct yet interconnected pathways. While institutional barriers require policy solutions, the internalization of stigma necessitates psychosocial interventions. This duality suggests that effective mental health promotion for disabled populations must combine individual-level support with systemic change. Future research should investigate implementation strategies for such integrated approaches across diverse healthcare settings.

4.5 Chapter Summary

This chapter's findings reveal three key insights about stigma and help-seeking among individuals with disabilities. First, self-stigma emerged as the most severe barrier, strongly correlating with treatment avoidance ($r = 0.72$), as participants internalized societal prejudices. Second, while institutional stigma persists, its impact appears less pronounced than in rural contexts (Nkumalo, 2021), suggesting urban-specific patterns of systemic exclusion.

Third, advocacy surpassed social support as the primary coping strategy, diverging from traditional literature (Rüsch et al., 2005) and reflecting contemporary disability activism. Together, these results underscore the need for interventions that simultaneously address internalized shame while fostering empowerment through accessible services and advocacy opportunities, tailored to urban disability communities' unique needs.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter compiles the data acquired from the research, portraying an analysis of how stigma impacts help-seeking behavior for mental health care among people with disabilities. Drawing conclusions and providing practical recommendations on the complex problem of stigma and barriers to mental health care access is the goal of this chapter. The accumulated findings are in accordance with the research goals: attention is drawn to social work practice, policy advocacy, and further research undertaken in this study. In this regard, it is hoped that disabled people will be motivated to seek the support that is so often needed.

5.2 Summary of Findings

The study identified three main areas of stigma affecting help-seeking behaviors among individuals with disabilities: public stigma, self-stigma, and institutional stigma. Each type of stigma operates differently but interconnects to create barriers to accessing mental health services. Additionally, coping strategies such as advocacy and social support emerged as critical mechanisms for navigating these challenges.

5.2.1 Types of Stigmas

Public stigma is one of the most common and was noted in the study where one out of three participants reported encounters with societal discrimination, including being stereotyped negatively or regarded with pity. Usually, this type of stigma is associated with discriminatory behaviors likely to result in social exclusion and help aversion. As one avoids seeking help, self-stigma is strongly correlated with help-seeking avoidance ($r = 0.72$, $p < 0.01$). So self-stigma depicts society negatively and leads to dramatic self-

imposed shame that vast societal disapproval strangles and marginalizes them, beliefs of worthlessness mentally impose on them. Such stigma, which indeed almost paralyzes, prospective mental health service users, seriously impairs in their ability and willingness to accept mental health services. The highest mean was found in institutional stigma (M = 3.83), which embodies systemic deterrents such as locked clinics and difficult to navigate administrative interfaces. In combination, these findings demonstrate the different types of stigma and how they impact seeking mental health services by persons with disabilities, showing that each form of stigma requires tailored approaches that deal with such intricacy.

5.2.2 Stigma, Help Seeking, and Avoidance

Half of the participants noted that stigma made them avoid seeking mental health services, which highlights an important barrier to care. The presence of dual stigma, which encompasses both the disability and mental health issues, added to this avoidance. Many participants described having fears of being labeled “incompetent” or “helpless,” which prevented them from obtaining the assistance they needed. Such barriers, coupled with institutional ones, including blocked access to a wheelchair as well as complicated intake forms, worsened the situation for many participants in urban areas where services are available but not accessible. These findings emphasize the need for specific strategies that address the psychological impact of stigma as well as structural barriers. Mental health services need to remove policies and practices that exclude people with disabilities to enable these individuals to access the services needed without feeling judgment or discrimination.

5.2.3 Coping Strategies

Most participants relied on advocacy as the most effective coping mechanism, reporting a mean score of 3.94, demonstrating that advocacy allows individuals to empower themselves, confront exclusion, and challenge stigma. Many participants actively participated in advocacy work aimed at increasing inclusivity within their communities. Such an approach not only builds resilience but also helps to improve the environment for others dealing with similar difficulties. Social support was utilized less consistently, with a mean score of 3.61; some participants accessed supportive peer networks, while others received poorly informed advice. This unevenness in social

support underscores a gap where social networks need to be more adequately and appropriately informed and constructive for individuals to feel supported and affirmed. In particular, the findings highlight the need to develop strong advocacy networks alongside adequate social support to improve coping strategies and help-seeking behaviors among people with disabilities.

5.3 Conclusions

The results of this thesis reveal that stigma is a complex phenomenon which contains elements of public: self, and institutionalized stigma that function together; interdependently. Each type of stigma imposes a unique impact on individuals with disability and requires specific attention to be effectively mitigated. Self-stigma, more than anything else, stood out as an omnipresent obstacle, preventing many individuals from accessing mental health services. Self-stigma is an obstacle that necessitates psychosocial intervention to neutralize shame, losses, and negative self-evaluations. The research also shows that there is a lack of institutional barriers, particularly in rural areas. This suggests that there are very serious issues concerning the policies intended to facilitate the access of care. Lastly, the use of advocacy as one of the strongest forms of fighting stigma has shown to be very effective among some participants. This means that not only are these strategies helpful in enhancing the mental health of these individuals with disabilities but also overall well-being.

5.4 Implications for Social Work

In the case of social work, the impact is rather critical in the context of dealing with stigma and social discrimination or bias. First, every social work practitioner needs to embrace an intersectional framework with internalized stigma adaptable psychotherapy that works to resolve crippling internalized stigma. That is, someone who works with persons with disabilities needs to appreciate them for who they are and what has happened to them in their lives to shape their self-image and recovery journey. Social workers trained in structural competence also need to be trained to manage and strategically deal with institutional barriers like lack of accessible spaces, and mental health enabling the navigating systems with multi-layered bureaucratic – hierarchical administrative service workflows. On other level policy sponsorship of mental health

clinics forms accessibility should also be advocated like less complicated paperwork and sign language interpreters attached. Additionally, community involvement should be the engagement goal for the publicly funded projects enabling peer support for overcoming social isolation, assist in calling for self-help without shame, and enabling self-advocacy.

5.5 Recommendations

5.5.1 Policy/Programmatic Recommendations

Action	Responsible Stakeholder	Timeline	Outcome Measure
Implement universal design standards in mental health facilities.	Ministry of Health	2 years	50% increase in accessible clinics.
Mandate disability-inclusive training for mental health professionals.	Social Work Councils	1 year	80% of practitioners trained.

5.5.2 Recommendations Based on Stakeholders

Healthcare practitioners ought to work with disability groups in creating accessible programs that concern mental health for people with disabilities. Such a partnership will guarantee that services are adequately offered. Moreover, non-governmental organizations should develop campaigns to fight disability-related stigma and actively promote the disabled through advocacy. These programs should enable people use digital storytelling to narrate their lived experiences. These stories can illustrate the realities people encounter and help in understanding the need to cut down on stigma. This kind of stakeholder approach enables better environments for mental health services for people with disabilities.

5.5.3 Community/Participant Research Recommendations

Disability advocacy groups which monitor stigma actively should be put in place to enable service users freely express themselves and tell their stories at healthcare units. Such accomplishment will help service providers become answerable to disabled

persons' concerns as well as actively pinpoint the gaps needing action. Additionally, providing online toolkits for self-advocacy that include templates for discrimination complaints will assist people in filing complaints utilizing a discrimination claim process. Through these materials, participants can be able to advocate without facing barriers and access mental health care services openly provided by the system, fostering a culture of accountability and inclusivity.

Suggestions Related to Social Work

Work on social work textbooks includes the incorporation of modules on discrimination based on disability so that social work practitioners will impact society positively. This training will assist them in addressing the needs that individuals with disabilities face and in doing practical help. Furthermore, the implementation of mobile mental health clinics can greatly improve care access for neglected populations in rural areas. Through mobile mental health services, essential care can be rendered in isolated parts of these regions, thus removing barriers to care that requires traveling extensive distances from such towns toward urban areas.

5.6 Proposed "Dual Stigma Reduction Framework" intervention model

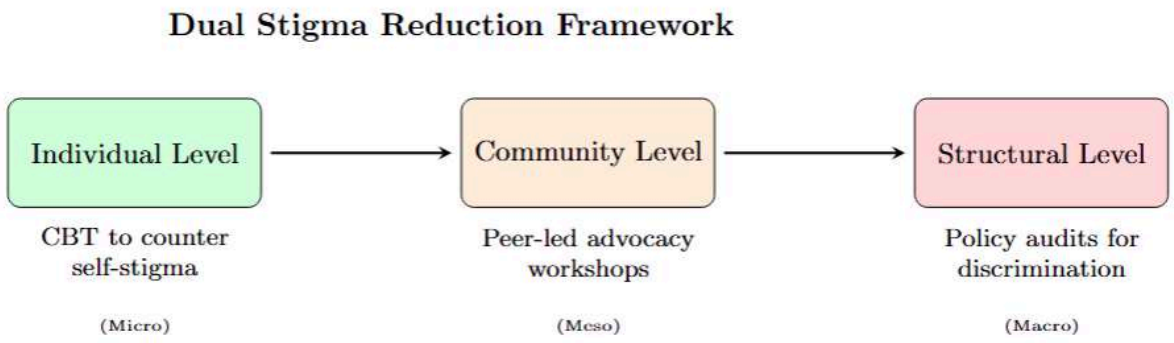

Figure 5. 1: Dual Stigma Reduction Framework

“Dual Stigma Reduction Framework” intervention model has three differentiated levels for its interventions. Regarding individuals, self-stigma can be fought through CBT by changing a negative view about themselves to a view in which they acknowledge their existence and begin to identify in a positive way. At the community level, these participants should also conduct peer advocacy workshops so participants can tell their stories and help each other. Structural level includes ensuring that healthcare policies are routinely subjected to audits so discriminatory clauses are purposefully removed. With all these layers combined, the framework seeks to profoundly alleviate stigma while creating comfortable spaces for people with disabilities to live freely.

5.7 Areas for Future Study

The future works should be directed toward the intersection of stigma, looking at race, gender, and socioeconomic class as amplifiers of disability. Understanding these amplifying factors can help devise more focused interventions. Moreover, the in-depth comparison of stigma experiences in rural under-resourced regions in contrast with urban areas will reveal the geographical context's impact on mental health help-seeking behavior. Additionally, longitudinal research is required to measure the impact of coping strategies on mental health over time to understand the effectiveness of various interventions. These gaps will help us formulate effective strategies to understand and address stigma and improve practices.

5.7 Chapter Summary

This chapter developed actionable insights from the key findings emphasizing the need for multilevel strategies to address stigma on different levels. Self-stigma can be treated at the therapeutic level, while institutional apathy can be tackled through policy restructuring, and empowerment advocacy can be facilitated by other providers to enable a shift towards an integrative mental healthcare paradigm. Furthermore, future works should focus on deepening intersectional and regional breaks so that the gap of addressing the disabilities is properly attended to in mental healthcare.

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