

Stigmatic Beliefs about Depression and Attitude toward Seeking Professional Help among Doctors: Mediating Role of Depression

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ABSTRACT: Doctors are often known for the stressful nature of their work, particularly when they have to frequently provide best care for their patient while working in high stress environments. The purpose of this study was to assess the relationship between stigma beliefs and attitudes to seeking professional help, controlling for depression. 200 samples were taken from the targeted population of nine hundred doctors in public sector hospitals of Rawalpindi. The results revealed a significant positive correlation between depression and self-stigma (.242). There was a low correlation between depression and perceived stigma (.078). Self-stigma was found to be significantly negatively correlated with attitude toward seeking help (-.454) and depression was slightly negatively correlated with attitude toward seeking help (-.232). The study focused on depression as a mediator between self-stigma, perceived stigma and attitudes towards the use of professional help. The results showed that self-stigma significantly affected depression and attitudes toward seeking help but not so much for predicting depression and attitudes toward treatment. Finally, the study concludes that the three factors, i.e., stigma, depression and attitudes towards seeking help, are interrelated among doctors in the tertiary care hospitals of Rawalpindi.

KEYWORDS: Stigma, Depression, Attitude toward Seeking Help, Doctors, Mental Health

Introduction

Mental health is a state of wellbeing that enables people to cope with stress, to be able to use their abilities, to learn, to function at work and to participate in their community. (WHO). Stigma is closely-related to mental health and has been examined in psychology, psychiatry and sociology. According to this definition, stigma is a negative attribute that can be seen as deeply discrediting, a way in which stigmatized people are treated as less than what is considered normal. The stigma of mental illness has the potential to harm reputations and create negative attitudes. These negative perceptions can also impact those associated with a person with a mental health issue, such as family members and mental health providers (Zayts-Spence et al., 2023).

Stigma is defined as a social process of rejection, exclusion, negative social judgements, negative perceptions, and adverse experiences. Can increase social isolation, delay help-seeking and restrict opportunities in life. The public portrayal of mental illness, interpersonal interaction, access to social roles, and structural discrimination are considered as different dimensions. Prejudice, ignorance and discrimination are all linked to the stigma of mental

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health. Mental health issues can be regarded as a disadvantage of a doctor's career and it may be the first choice of the suffering doctor to self-diagnose and treat the problem (Eissa et al., 2020).

Link and Phelan (2001) identified three mechanisms of stigmatization based on direct discrimination, structural discrimination and social psychological processes. Self-stigmatization can contribute to self-devaluing behaviors and interconnected systems can intensify the effects of self-devaluation. Stigma also involves stereotyping, prejudice and attitudes. Stereotypes are generalizations about people with mental illness; prejudice is an emotional response to the stereotype; attitudes are feelings that can influence behavior.

Physicians are required to make critical decisions under stress and significant pressure as a result of the challenging work environment. The thesis has linked doctors' burnout and mental health issues to medical errors, poor quality care, provider dissatisfaction, isolation, low self-esteem and depression (Ventriglio et al., 2020). Research in other populations has likewise examined problematic digital behaviors in relation to psychological and behavioral outcomes, including aggression and emotion regulation (Shahid & Yaseen, 2025; Shahid et al., 2025). A systematic review also found that resident physicians were reporting a significant depression burden and depressive symptoms (Mata et al., 2015). Medical students' depression, stigma and suicidal ideation have also been investigated (Schwenk et al., 2010).

In Pakistan, mental health problems have been reported among healthcare professionals. The thesis mentions the study conducted on dentists in Karachi, Rawalpindi, and Islamabad which reported anxiety, depression, stress, and burnout. Studies have found variations in occupational stress and depression among hospital practitioners by specialty and higher stress among younger doctors in Germany (Bernburg et al., 2016), while Occupational stress and coping of physicians has been studied in India but not in the context of this study (Rashid & Talib, 2015).

There has been a lot of stigma attached to mental health, and this has been referred to as a major barrier to care. The professional culture of the hospital setting can reflect the stigma of society and result in treatment delay of physicians (Brower, 2021). Doctors and medical students might hide their mental health treatment due to anticipated judgment. Other concerns or stigmas among professionals, including researchers, have been found as barriers to help-seeking (Clough et al., 2019). A survey of medical students in Karachi, Pakistan, revealed moderate levels of stigma with regard to seeking professional mental health care (Zafar et al., 2024).

The barriers to mental health care identified in the thesis are: stigma, fear of negative social perceptions, social isolation, lack of awareness, high cost, scarcity of mental health professionals, conservative attitudes and perception that discussing mental health is taboo. These barriers can be knowledge barriers, structural barriers and attitudinal barriers. Recent quantitative research has also highlighted the relationship between addictive behaviors and mental health outcomes, further supporting the need to examine behavioral and psychological factors together (Shahid et al., 2025). Physician self-stigma can be driven by duty, self-sufficiency and perfectionism, and manifest as shame, self-doubt, self-medication, withdrawals, and avoidance of professional help-seeking.

Depression is characterized as a mental health disorder with a sad mood, guilt and worthlessness, helplessness and hopelessness, psychomotor slowing, loss of appetite and sleep disturbance (Bernard, 2018). It's also connected to negative thinking patterns that include negative thoughts about self, the world, and future. Repeated studies have reported higher levels of depressive symptoms at the end of medical education than at the beginning. Recent research has also examined depression alongside behavioral and psychological difficulties in young adults, highlighting the broader relationship between mental health symptoms and problematic technology-related behaviors (Shahid et al., 2024). Stigma may also play a role in delayed mental health treatment, and self-stigma can have a negative impact on self-esteem, self-efficacy and a desire to seek help.

Help-seeking is low as doctors and medical students only go to help in crisis situation. The thesis includes statements about concealment of symptoms due to fear of stigma, and the fear of confidentiality, licensure, and career advancement can further complicate the issue of public stigma. Recent research has similarly examined psychological distress in relation to problematic social media use, demonstrating the importance of understanding psychological difficulties alongside maladaptive behavioral patterns (Shahid et al., 2026). Interventions to address self-stigma have been explored in medical students and doctors, with education and contact interventions being explored, and recommendations suggesting normalizing mental health conversations and fostering supportive work contexts through access to services and peer support (Bannatyne et al., 2023).

This study is guided by Corrigan's theory of self-stigma. The theory explains the processes by which stigma against mental illness is internalized and becomes a form of self-stigma, which impacts self-esteem, self-worth and willingness to seek help (Corrigan & Rao, 2012). Public stigma is negative stereotypes that are held by society, and self-stigma is when the negative stereotypes are internalized and applied to oneself. There are three components of the internalization process as described in the thesis: stereotype awareness, stereotype agreement, and self-concurrence. This can lead to decreased self-esteem, decreased self-efficacy, avoidance of behaviors and reluctance to accept professional help. The theory thus offers a structure in which to view the connection among stigma, personal beliefs and help-seeking.

The thesis correlates various mental health problems among doctors with demanding work environments, working long shifts, and emotional and physical duties of the medical profession. Whilst under such pressure, doctors may be reluctant to take the step to care for their own mental health. This reluctance can be added to by the stigma attached to depression. Though significant research has been undertaken in the West, the field of mental health awareness is still in its early stages in other parts of the world, and especially in South Asian contexts where mental health responses may be highly stigmatizing and acceptance of seeking help may be perceived as a failure of a person. The thesis suggests depression can help to connect stigmatic beliefs and reluctance to seek help. The current study, therefore, explored stigmatic beliefs about depression, depression and attitudes of doctors towards seeking health professionals' help in doctorates hospitals of Rawalpindi.

Objectives

1. To investigate the relationship between self-stigma and perceived stigma and attitude toward seeking professional help among doctors working in tertiary care hospitals of Rawalpindi.
2. To investigate the relationship between self-stigma and perceived stigma and depression among doctors working in tertiary care hospitals of Rawalpindi.
3. To investigate the relationship between depression and attitude toward seeking professional help among doctors working in tertiary care hospitals of Rawalpindi.
4. To examine the mediating role of depression between self-stigma and perceived stigma and attitude toward seeking professional help among doctors working in tertiary care hospitals of Rawalpindi.

Hypotheses

1. There will be a negative relationship between self-stigma about depression and attitude toward seeking professional help among doctors.
2. There will be a positive relationship between self-stigma about depression and depression among doctors.

3. There will be a negative relationship between depression and attitude toward seeking professional help among doctors.
4. Depression among doctors will partially or fully mediate the relationship between self-stigma, perceived stigma, and attitude toward seeking professional help among doctors.
5. Gender differences will show variability in scores of depression, self-stigma, perceived stigma, and attitude toward seeking professional help among doctors.

Methodology

Research Design

Survey research design was used in this study as a cross sectional non-experimental design, trying to explore the relationship between stigmatic beliefs about depression and attitude towards professional help seeking among doctors working in the tertiary care hospitals of Rawalpindi. The quantitative approach allowed for the collection and analysis of numerical data in a systematic way, to explore the relationships between cultural beliefs, attitudes and behaviors, and to test hypotheses and identify patterns.

Participants and Sampling

The doctors involved were selected purposively and the sample size was 200. The sample size was calculated using G*Power with an effect size of 0.5; statistical power of .95; and alpha error probability of .05. The minimum sample size to use after adjusting for a 20% non-response was 110 physicians. Finally, 99 males and 101 females doctors were selected for the final sample. The participants included those from Rawalpindi Teaching Hospital (90), Benazir Bhutto Hospital (60), Rawalpindi Institute of Cardiology (11) and Holy Family Hospital (39). Consultants, post-graduate trainees, house officers and medical officers were included.

Doctors working in Rawalpindi tertiary care hospitals, doctors not psychiatrists and age 25–60 who was willing to participate in the study were included. Doctors on leave, doctors not working in hospitals, doctors with physical disability, doctors who have been diagnosed with a medical or mental illness, and doctors who had experienced a traumatic event recently or major life events were also excluded from the study, as were doctors who did not have complete survey data.

Measures

Depression Stigma Scale (DSS)

Stigmatizing attitudes toward depression were assessed using the Depression Stigma Scale (DSS), which comprises two subscales measuring self-stigma and perceived stigma. The DSS consists of 18 items rated on a five-point response scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Each subscale contains nine items. The Depression Stigma Scale–Self-Stigma subscale showed good internal consistency, with a Cronbach's alpha of .86 (Conceição et al., 2022).

Attitude Toward Seeking Professional Help Scale-short Form

Readiness to seek professional psychological assistance for emotional difficulties was assessed using the 10-item Attitudes Toward Seeking Professional Psychological Help Scale–Short Form (ATSPH-SF). Items 1, 3, 5, 6, and 7 were scored on a 0–3 scale, whereas items 2, 4, 8, 9, and 10 were reverse scored. The ATSPH-SF showed relatively low internal consistency, with a Cronbach's alpha of .63 (Elhai et al., 2008).

Patient Healthcare Questionnaire (PHQ-9)

Depression severity was assessed using the Patient Health Questionnaire-9 (PHQ-9), which consists of nine items measuring depressive symptoms experienced during the previous two weeks. Each item is rated on a 0–3 scale, with higher total scores reflecting greater severity of depressive symptoms. The PHQ-9 demonstrated excellent internal consistency, with a Cronbach's alpha of .90 (Kroenke et al., 2001).

Ethical Considerations

The study methodology followed the ethical norms of the American Psychological Association. Participant confidentiality was emphasized because the research addressed sensitive mental health subjects. The thesis states that institutional review board approval was requested before initiating the study. Participants were informed about the nature and purpose of the research, their information was to be kept confidential and used for educational and research purposes, and they had the right to withdraw without providing a reason. Written consent was obtained.

Procedure

Purposive sampling was used to recruit 200 doctors working in tertiary care hospitals in Rawalpindi. Participants were selected according to characteristics relevant to the study. G*Power was used to calculate the minimum sample size, and the final sample exceeded the calculated requirement. Participants were provided with the consent form and questionnaires and were given sufficient time to complete them. The thesis reports a 75% response rate. Data collected were analyzed using SPSS to test the hypotheses.

Results

Participant Characteristics. The study included 200 doctors with a mean age of 31.43 years (SD = 6.22). There were 99 male participants (49.5%) and 101 female participants (50.5%). Ninety-one participants (45.5%) were single, 95 (47.5%) married, 12 (6.0%) divorced, and 2 (1.0%) widowed. Education included MBBS for 154 participants (77.0%) and FCPS for 46 (23.0%). Paid training was reported by 189 participants (94.5%) and unpaid training by 11 (5.5%). Medicine was the largest departmental group (33.5%), followed by Surgery (15.5%) and Neurosurgery (11.5%). The largest hospital group was Rawalpindi Teaching Hospital (45.0%). Consultants comprised 51.5% of the sample and hostelites 54.0%. A substantial proportion did not respond to questions concerning family members, family system, family relationship, religion, and cultural background.

Psychometric Properties: The PHQ-9 had 9 items, Cronbach's alpha of .90, mean 7.01, SD 5.95, potential range 0–36, actual range 0–23, skewness .56, and kurtosis -.69. The DSS self-stigma subscale had 9 items, alpha .86, mean 18.01, SD 7.59, potential range 0–36, actual range 7–30, skewness -.22, and kurtosis -.02. The DSS perceived-stigma subscale had 9 items, alpha .80, mean 23.32, SD 5.83, potential range 0–36, actual range 0–36, skewness -.40, and kurtosis .35. The ATSPH scale had 10 items, alpha .63, mean 16.15, SD 4.00, potential range 0–40, actual range 4–36, skewness 1.00, and kurtosis 1.19.

Correlations: Pearson product-moment correlation showed a significant positive correlation of .242 between depression and self-stigma. The correlation between depression and perceived stigma was .078. Self-stigma had a significant negative correlation with attitude toward seeking help of -.454. Perceived stigma and attitude toward seeking help had a correlation of -.056. Depression and attitude toward seeking help had a negative correlation of -.232.

Mediation Analysis: Self-stigma significantly predicted depression ($\beta = .2415$, $p < .001$) and attitude toward seeking help ($\beta = -.4229$, $p < .001$). Depression negatively predicted attitude toward seeking help ($\beta = -.1296$, $p < .001$). The model explained 5.83% of the variation in depression ($F = 12.26$, $p < .001$) and 22.21% of the variation in attitude toward seeking help ($F = 28.12$, $p < .001$). For perceived stigma, the analysis reported that perceived stigma did not significantly predict depression ($\beta = .0783$, $p = .2705$). Depression had a negative association with attitude toward seeking help ($\beta = -.2288$, $p < .05$). The reported R^2 values were .006 for depression and .055 for attitude toward seeking help.

The indirect effect of self-stigma through depression was $\beta = -.0313$, bootstrap SE = .0164, 95% bootstrap CI [- .0653, -.0017]. The indirect effect for perceived stigma was $\beta = -.0179$, bootstrap SE = .0169, 95% bootstrap CI [- .0548, .0126]. The thesis describes self-stigma as having a greater indirect effect than perceived stigma.

Gender Differences. Male doctors had a mean depression score of 6.81 (SD = 6.03), while female doctors had a mean of 7.20 (SD = 5.89). Self-stigma means were 18.89 (SD = 6.69) for men and 17.14 (SD = 8.32) for women. Perceived stigma means were 23.71 (SD = 5.33) for men and 22.94 (SD = 6.28) for women. Attitude toward seeking help means were 16.16 (SD = 3.60) for men and 16.14 (SD = 4.37) for women. The reported t-test statistics were -.462, 1.637, .941, and .023, respectively, with reported p values of .813, .011, .192, and .323 and Cohen's d values of .065, .232, .132, and .005.

Hospital Setting Differences. Depression did not differ significantly among hospital settings ($F = .90$, $\eta^2 = .013$). Perceived stigma also did not differ significantly ($F = 1.80$, $\eta^2 = .026$). Self-stigma differed across hospital settings ($F = 3.58$, $\eta^2 = .051$), with the Rawalpindi Institute of Cardiology group showing the highest mean. Attitude toward seeking help did not differ significantly ($F = 1.64$, $\eta^2 = .024$).

Table 1

Demographic Description of the Sample (N = 200).

Characteristics of participants		<i>f</i>	%	<i>M</i>	<i>SD</i>
Age				31.43	6.22
	Gender				
	Male	99	49.5		
	Female	101	50.5		
Marital status					
	Single	91	45.5		
	Married	95	47.5		
	Divorced	12	6.0		
	Widowed	2	1.0		
Family members					
	2	2	1.0		
	3	1	0.5		
	4	4	2.0		
	5	2	1.0		
	6	6	3.0		
	7	11	5.5		
	8	5	2.5		
	9	5	2.5		
	10	4	2.0		
	0	160	80.0		

Characteristics of participants		<i>f</i>	%	<i>M</i>	<i>SD</i>
Family system					
	Joint	25	12.5		
	Nuclear	15	7.5		
	99	160	80.0		
Family relationship					
	No answer	163	81.5		
	Average	11	5.5		
	Bad	1	0.5		
	Good	19	9.5		
	Normal	5	2.5		
	Toxic	1	0.5		
Education					
	MBBS	154	77.0		
	FCPS	46	23.0		
Training					
	Paid	189	94.5		
	Unpaid	11	5.5		
Department					
	Anesthesia				
	Cardiac	7	3.5		
	ENT	14	7.0		
	Gynecology	20	10.0		
	Medicine	18	9.0		
	Nephrology	67	33.5		
	Neurosurgery	3	1.5		
	Ortho	23	11.5		
	Physio	12	6.0		
	Radiology	3	1.5		
	Surgery	2	1.0		
		31	15.5		

Table 2

Psychometric Properties of Scales and Subscales (N = 200).

Variable	k	α	M	SD	Range		Skewness	Kurtosis
					Potential	Actual		
PHQ-9	9	.90	7.01	5.95	0–36	0–23	.56	-.69
DSS(a)	9	.86	18.01	7.59	0–36	7–30	-.22	-.02
DSS(b)	9	.80	23.32	5.83	0–36	0–36	-.40	.35
ATSPH	10	.63	16.15	4.00	0–40	4–36	1.00	1.19

Note: PHQ-9 = Patient Health Questionnaire-9; DSS(a) = depression self-stigma; DSS(b) = depression perceived stigma; ATSPH = attitude toward seeking professional help.

Table 3
Pearson Product-Moment Correlations Among Depression, Self-Stigma, Perceived Stigma, and Attitude Toward Seeking Professional Help (N = 200).

Variable	Depression	Self-Stigma	Perceived-Stigma	Attitude
Depression	—	.24**	.07**	-.23**
Self-Stigma		—	.13**	-.45**
Perceived-Stigma			—	-.05**
Attitude towards seeking Help				—

Note: *p < .05, **p < .01, ***p < .001.

Table 4
Direct Effects of Mediation Analysis Between Self-Stigma, Perceived Stigma, and Attitude Toward Seeking Help Through Depression (N = 200).

Predictor	Depression β	Depression SE	Attitude β	Attitude SE
Self-stigma	.24***	.0022	-.42***	.034
Depression			-.12***	.043
R ²	.05		.22	
F	12.268***		28.126***	
Perceived stigma	.07	.0723	-.03	.047
Depression			-.22	.046
R ²	.006		.055	
F	1.220		5.749*	

Note: *p < .05, **p < .01, ***p < .001.

Table 5
Indirect Effects of Mediation Analysis Between Self-Stigma, Perceived Stigma, and Attitude Toward Seeking Help Through Depression (N = 200).

Mediator	β	Boot SE	95% Boot CI LL	95% Boot CI UL
Self-stigma	-.0313	.0164	-.0653	-.0017
Perceived stigma	-.0179	.0169	-.0548	.0126

Table 6
Gender Differences in Depression, Self-Stigma, Perceived Stigma, and Attitude Toward Seeking Help (N = 200).

Variable	Men (N=99)		Women (n=101)		df	t	p	Cohen's d
	M	SD	M	SD				
Depression	6.81	6.03	7.20	5.89	198	-.462	.813	.065
Self-stigma	18.89	6.69	17.14	8.32		1.637	.011	.232
Perceived stigma	23.71	5.33	22.94	6.28		.941	.192	.132
ATS	16.16	3.60	16.14	4.37		.023	.323	.005

Table 7

Mean, Standard Deviation, and One-Way ANOVA Across Hospital Settings (N = 200).

Variable	RTH(N=90)		BBH(N=60)		HFH(N=39)		RIC(N=11)		F	η^2
	M	SD	M	SD	M	SD	M	SD		
Depression	7.27	6.08	6.78	5.97	6.12	5.27	9.27	7.10	.90	.013
Self-stigma	16.75	6.77	17.75	8.47	19.79	7.77	23.45	4.98	3.58	.051
Perceived-stigma	22.33	5.74	23.98	5.89	24.00	5.42	25.45	6.96	1.80	.026
ATS	16.58	4.22	16.26	4.07	15.56	3.63	14.09	1.97	1.64	.024

Note: RTH = Rawalpindi Teaching Hospital; BBH = Benazir Bhutto Hospital; HFH = Holy Family Hospital; RIC = Rawalpindi Institute of Cardiology; ATS = attitude toward seeking help.

Discussion

The study examined depression, stigmatic beliefs about depression, and attitudes toward obtaining professional mental health assistance among doctors employed in tertiary care hospitals in Rawalpindi. The sample had a mean age of 31.43 ± 6.22 years and included slightly more women than men. Most participants were single or married. A substantial proportion did not disclose family information, and the thesis relates this pattern to previous literature describing barriers to disclosure of personal information among physicians.

The sample included MBBS and FCPS doctors, and approximately 95% reported paid training. Medicine was the largest specialty group, followed by surgery, neurosurgery, and ENT. The largest proportion came from Rawalpindi Teaching Hospital, followed by Benazir Bhutto Hospital, Holy Family Hospital, and Rawalpindi Institute of Cardiology. More than half of the participants were consultants, and hostelites formed a larger group than day scholars. Religious and cultural information also had a high non-response rate.

The reliability analysis showed alpha values of .905 for depression, .860 for depression self-stigma, .803 for perceived stigma, and .630 for attitude toward seeking help. The thesis interprets these results as demonstrating different levels of reliability across the measures.

The correlation analysis demonstrated a positive relationship between depression and self-stigma. Higher depression was associated with higher personal stigma related to depression. Self-stigma showed a negative relationship with attitudes toward seeking help, while depression also showed a negative relationship with attitudes toward seeking help. Perceived stigma had weaker relationships with depression and help-seeking attitudes. These findings are discussed in the thesis in relation to research showing that stigma can discourage mental health help-seeking. Yang et al. (2020) reported stigma toward depression and emphasized culturally appropriate and targeted educational programs. Conceição et al. (2022) reported negative attitudes associated with personal and public stigma. Ibrahim et al. (2019) reported that high self-stigma and depression were associated with negative mental health help-seeking attitudes and that self-stigma could act as a barrier to seeking help. Walker et al. (2025) similarly reported that stigma was associated with reluctance to seek mental health services.

The gender findings showed a slightly higher mean depression score among female physicians, while male physicians had higher mean scores for self-stigma and perceived stigma. Attitude toward seeking help showed nearly identical means for men and women. The thesis relates these findings to research concerning gender, depression, stigma, and barriers to help-seeking (Jin, 2025).

The mediation analysis showed that self-stigma was associated with depression and attitudes toward seeking help. Self-stigma had a negative association with help-seeking attitudes, while depression also negatively predicted help-

seeking attitudes. The thesis interprets depression as an important link between stigmatizing beliefs and attitudes toward seeking assistance. Corrigan and Rao (2012) describe self-stigma as involving internalization of societal stereotypes, with consequences for self-esteem, self-efficacy, and help-seeking. Vogel et al. (2006, 2007) similarly examined self-stigma, public stigma, and willingness to seek counseling.

Perceived stigma had a smaller effect in the reported mediation model. The thesis notes that public stigma may be more situational and less internalized than self-stigma, which may explain its more limited direct effects (Clement et al., 2015). The study therefore emphasizes the role of self-stigma in the relationship between stigmatic beliefs, depression, and attitudes toward help-seeking.

The hospital setting analysis showed that depression, perceived stigma, and attitudes toward seeking help did not differ significantly across the four hospital settings, whereas self-stigma scores differed. The Rawalpindi Institute of Cardiology group had the highest self-stigma mean. The thesis interprets these results as indicating variation in personal stigma while showing relatively consistent levels of depression, perceived stigma, and help-seeking attitudes across hospital settings.

Conclusion

The study looked at depression, stigma-related attitudes toward depression, both personal and public, and attitudes toward seeking mental health help among doctors working in tertiary care hospitals in Rawalpindi. The study revealed positive associations between depression and self-stigma and a negative relationship between depression and attitudes toward help-seeking. Self-stigma was negatively related to attitudes toward help-seeking and positively related to depression. The mediation analysis indicated that depression mediated the association between self-stigma and attitudes toward help seeking, while perceived stigma had a limited effect. Mean depression scores were somewhat higher among female physicians, while mean stigma scores were higher among male physicians. Attitudes toward seeking help were similar across genders.

Limitations

The study had a high rate of non-response from doctors on several personal topics. It relied on self-reported data from doctors who were hesitant to answer questions related to themselves. Because the design was cross-sectional, causal relationships could not be established. Generalizability was limited by the sample size and the possibility of reporting bias. Unequal numbers of participants from departments and hospitals also limited generalizability. Demographic variables such as age, marital status, rank, specialty, religion, and cultural factors remained less explored.

Recommendations and Implications

The thesis recommends targeted interventions to promote education, awareness, and better help-seeking behaviors. Qualitative research can explore the underlying reasons for reluctance to disclose personal and stigma-related information. Longitudinal research may identify and investigate causal relationships among depression, stigmatic beliefs, and help-seeking behaviors of doctors. Stigma-reducing campaigns for male doctors and depression-reducing therapies are also recommended. Institutes can provide more individualized mental health services for doctors.

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