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A Qualitative Analysis of Consumer Barriers to Mental Health Consumption

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Mental health has a marketing problem. Effective products and services exist to support consumers' mental health, and access has expanded with increasing insurance coverage and technological innovation (National Institute of Mental Health 2024a; Novak et al. 2019). The potential market is enormous: Americans are sleeping less and reporting higher stress than at any point in the past three decades (Gallup 2024). Further, one in four Americans experiences a mental illness; yet only half of those with a mental illness receive treatment (National Institute of Mental Health 2024b). In short, despite available solutions and clear need, consumers often fail to act to improve their mental health.

Despite this environment, marketing researchers have devoted little attention to understanding barriers to mental health consumption. Scholars have repeatedly called for research that addresses problems with broad social impact—including explicit calls to study mental health (Mannarini and Rossi 2019; Mental Health Million Project 2021; Posavac et al. 2022; Rondina et al. 2022; Walsh and Foster 2021). Marketing research has also extensively examined related domains, such as physical health (Huang and Lee 2023). Yet mental health consumption remains underexplored, even though marketing scholars are uniquely positioned to investigate it: it is fundamentally an act of consumption, and it is influenced by the same motivations, social dynamics, frictions, and contexts that marketing routinely examines.

In this research, we ask a simple but fundamental question: What are the major barriers to mental health consumption in America today? We define mental health consumption as the acquisition and use of products or services with the intention of improving one's mental health. Prior work in psychology and public health has emphasized stigma as a dominant barrier to care. Yet few studies assess stigma's importance relative to other obstacles, and even fewer ask consumers directly what prevents them from engaging in mental health consumption. We

address this gap using a grounded theory approach, conducting 24 semi-structured depth interviews that allow us to identify major barriers to mental health consumption while introducing as few a priori assumptions as possible.

Our results reveal that while stigma is widely recognized, it is not the chief obstacle consumers face. Rather than being paralyzed by stigma, participants described adaptive strategies to navigate it. Much as someone can be politically active but choose not to discuss politics with certain family members, participants described that they could engage in mental health consumption but choose not to discuss it with stigmatizing individuals—even when those individuals were as close as a parent or spouse. By contrast, consumers reported being hindered by more immediate barriers: motivational hurdles (struggles initiating care despite willingness), search frictions (difficulty finding appropriate providers), provider skepticism (doubts about efficacy or motives), and structural constraints (cost, time, and availability). We also found that although consumers viewed resilience as one of two pillars of mental health (alongside subjective feeling states), few directed their consumption toward actively building resilience.

This work makes three contributions to the academic literature. First, it highlights a disconnect between academic research and consumers' experiences: while stigma dominates scholarly attention, consumers appear to navigate around it while being blocked by other, more mundane barriers. Second, it provides novel insight into the contemporary mental health consumption journey—we find that consumers view mental health as cyclical and intrinsically intertwined with physical health, that everyday behaviors like socializing or exercising serve as forms of mental health consumption, that negative coping strategies often crowd out positive ones, and that consumers consider resilience a part of mental health but fail to engage with it. Third, it demonstrates that marketing scholars can and should leverage their expertise in

consumer behavior to contribute to the broader conversation on mental health consumption. We hope to highlight novel research questions relevant to marketing, underscore the field's natural strengths for understanding mental health consumption (Farrell et al. 2024; Yeh et al. 2017), and demonstrate that marketing research can enrich the broader literature on mental health consumption. Ultimately, we aim to stimulate marketing research on this important topic.

These findings also offer practical implications for non-academic stakeholders including firms, healthcare providers, universities, and policymakers. Chiefly, our findings suggest trying to reduce search friction, boost motivation, and build trust as pathways to fostering mental health consumption. Practitioners could, for example, design better therapist-matching systems, create lower-stakes entry points for digital tools, or develop interventions that align with the cyclical nature of mental health to reach consumers when they are most receptive. Because stigma has proven difficult to change, addressing these everyday barriers may represent a more effective lever for increasing engagement with mental health products and services.

The remainder of the manuscript proceeds as follows. We first review existing literature on barriers to mental health consumption, emphasizing the field's focus on stigma. We then describe our grounded qualitative methodology, present our results, and conclude with implications for theory and practice, highlighting how marketing scholars and practitioners can complement stigma-reduction efforts by addressing the practical barriers that more directly impede mental health consumption.

(II) THEORETICAL BACKGROUND

While a small number of papers directly categorize or assess the relative importance of barriers to mental health consumption, most research examines single barriers in isolation. This makes it difficult to evaluate which barriers are the most consequential for consumers. The largest body of work has focused on mental health stigma, with smaller literatures addressing mental health literacy and structural or supply-side barriers (because our focus is on consumer perceptions, provider- and system-level factors are largely outside of the scope of this research). Our study contributes by asking consumers directly what they perceive as the primary barriers to their own mental health consumption. This approach provides insight into the relative importance of different barriers while minimizing a priori theoretical assumptions.

Barriers to Mental Health Consumption: Current Understanding

A small literature directly investigates the relative importance of barriers to mental health consumption (Andrade et al. 2014; Mojtabai et al. 2011; Van Beljouw et al. 2010). Across these studies, motivational barriers emerge as the most consequential. For example, in a cross-national study utilizing data from the World Health Organization spanning 24 countries, the most common reason for not seeking treatment was low perceived need, followed by attitudinal barriers such as wanting to handle problems independently (Andrade et al. 2014). U.S. data from 2001–2003 reveal a similar pattern: low perceived need and self-reliance were the leading reasons for avoiding or discontinuing treatment (Mojtabai et al. 2011). A related study from the Netherlands showed that untreated patients with anxiety or depression again cited self-reliance as the chief reason to not using services (Van Beljouw et al. 2010). More recent U.S. data on young adults highlight costs, poor mental health literacy (not knowing where to seek help), and self-

reliance as primary obstacles (Lu et al. 2022). Other studies examine barriers in specific populations—such as low-income African Americans (Hines-Martin et al. 2003), rural older adults (Brenes et al. 2015), refugees (Byrow et al. 2020), and first responders (Haugen et al. 2017). While stigma appears to be more impactful in certain sub-populations, we retain a broad focus, seeking to identify fundamental barriers that cut across demographics and affect the largest number of consumers.

While these studies provide valuable insights, they rely primarily on Likert-type scales, limiting responses to predefined categories. As a result, they may overlook barriers that fall outside their measurement frameworks. For example, some do not include stigma at all (e.g., Lu et al. 2022)—despite stigma constituting the dominant focus of most research on mental health consumption barriers, as we review next.

The Prominence of Stigma in Prior Research

Beyond work that seeks to rank barriers, many papers examine individual obstacles to mental health consumption, such as emotional openness (Komiya et al. 2000), mental health literacy (Jorm 2012), or specific interventions (Sagar-Ouriaghli et al. 2019; Kazdin 2017). By far the largest body of research, however, centers on mental health stigma. A systematic review of youth help-seeking literature concluded that stigma was the most common theme explaining avoidance of mental health services (Gulliver et al. 2010). Decades of research have established that stigma exists (Goffman 1963), identified different forms (e.g., internalized, public, treatment-related; Clement et al. 2015; Corrigan 2004; Fox et al. 2018; Tucker et al. 2013; Vogel et al. 2006), and examined its effects on mental health help-seeking (Bharadwaj et al. 2017;

Clement et al. 2015; Corrigan 2004; Corrigan et al. 2014; Fox et al. 2018; Link and Phelan 2001; Link et al. 1991; Link et al. 2001; Major and O'Brien 2005).

At its core, mental health stigma refers to negative attitudes toward or discrimination against people with mental illness (stigma endorsement; Clement et al. 2015). Scholars distinguish several related forms of mental health stigma: perceived stigma (beliefs about others' attitudes), internalized stigma (applying those beliefs to the self), anticipated or experienced stigma (expecting or encountering unfair treatment), and treatment stigma (negative views of mental health services; Clement et al. 2015). Stigma has measurable consequences. Being labeled with a mental illness reduces self-esteem and deters treatment-seeking (Corrigan 2004; Link et al. 2001). Perceived public stigma often becomes internalized, lowering attitudes toward therapy and willingness to seek care (Vogel et al. 2007; Lannin et al. 2016). Merely anticipating stigma can discourage engagement with services (Quinn et al. 2015). Meta-analytic evidence confirms that both public and self-stigma are reliably associated with lower help-seeking intentions (Clement et al. 2015). Stigma is also disproportionately severe in minority communities (Abdullah et al. 2011; Brewer et al. 2024; De Freitas 2018) and the armed services (Adler et al. 2009).

Despite sustained efforts, stigma appears to be slightly increasing over time (Schomerus et al. 2022; Phelan et al. 2000; cf. Pescosolido et al. 2021), even as mental health literacy improves and biological explanations for mental illness gain wider acceptance (Schomerus et al. 2012). Stigma is difficult to mitigate (Link et al. 1991), though some strategies show promise. Educational initiatives—including social media campaigns and training programs—can reduce stigma (Sampogna et al. 2017; Tomar et al. 2017), as can direct contact with individuals experiencing mental illness (Rusch et al. 2005). Self-affirmation has been shown to reduce

internalized stigma and increase willingness, though not intention, to seek therapy (Lannin et al. 2013). Yet results remain mixed: some campaigns produce little change, while others have unintentionally heightened people's desire for social distance from those with mental illness (Walsh and Foster 2021). Meta-analytic evidence indicates that anti-stigma interventions have moderate effects on attitudes but only small effects on intentions and behavior (Corrigan et al. 2012; Mehta et al. 2015; Yeh et al. 2017).

One aim of our research is to evaluate how prominent stigma actually is as a barrier to mental health consumption. Despite the extensive attention stigma has received, it remains unclear whether it is the central obstacle consumers face today. This question is especially important given evidence that people routinely overestimate stigma—raising the possibility that researchers, like consumers, may also devote more attention to it than warranted (Eisenberg et al. 2009; Pedersen and Paves 2014; Pomerance and Russman 2025).

The Limited but Growing Role of Marketing in Mental Health Consumption

Marketing researchers are fundamentally concerned with understanding and influencing consumption. Yet research on mental health consumption remains sparse within marketing, with much of the existing work published outside the field. For example, Lebow (1982) argued for applying a customer satisfaction framework to mental health treatment in a psychology journal. More recently, Posavac et al. (2022) called for the development of a “clinical consumer psychology; the study of how dysfunctional and maladaptive cognitive and behavioral processes interact with individuals’ consumer experience and behaviors.” Silvan et al. (2024) show that

even basic website design choices, a core marketing domain, influence student engagement with university mental health service sites.

While publishing marketing-oriented research in other disciplines is valuable, evidence suggests that marketing scholars themselves have devoted little direct attention to mental health. Farrell et al. (2024) highlight this gap and argue persuasively that marketing researchers can—and should—play a larger role. Some recent studies illustrate this potential. Lee and Trudel (2025) show that women are more likely than men to use mental health apps because such consumption is stereotyped as feminine, and using these apps heightens feelings of femininity. Yeh et al. (2017) demonstrate how marketing tools can shape the broader conversation on stigma: applying a segmentation approach, they show that tailored campaigns are more effective than one-size-fits-all interventions.

Most directly related to the present research, Kemp et al. (2022) apply a motivation–ability–opportunity framework, commonly used in health decision-making, to mental health consumption. They hypothesize and find that perceived stigma discourages engagement in mental health services (while increasing efforts to manage emotions through other forms of consumption), that trust in providers fosters motivation and ability to engage, and that opportunities hinge on access to professionals. While highly relevant, this research differs from the present research in both method and aim: while this work is quantitative and hypothesis-driven, the present research is qualitative and aims at inductive theory-building.

In sum, marketing journals have published surprisingly little research on mental health consumption (Farrell et al. 2024; Vogel et al. 2007b). A central aim of the present study is therefore to illuminate the contemporary consumer journey while paving the way for future marketing research in this domain. Specifically, we seek to highlight novel research questions

relevant to marketing, underscore the field's natural strengths for studying mental health consumption (e.g., segmentation approaches such as Yeh et al. 2017, and close practitioner ties), and demonstrate how marketing research can enrich the broader interdisciplinary literature on mental health consumption and help-seeking.

(III) METHODOLOGICAL APPROACH

Our goal in this research is to surface underexplored processes in consumers' mental health consumption by identifying prominent but overlooked barriers. Qualitative research offers unique advantages when prior theory is limited and when complex consumer experiences are central. A grounded theory approach enables inductive theorizing without imposing predetermined theoretical frameworks or assumptions (Suddaby 2006; Corbin and Strauss 1990), while semi-structured depth interviews ground emergent concepts in participants' lived experiences (Spiggle 1994). The iterative movement between data collection, coding, and theory-building is particularly well suited to capturing the complexity of mental health consumption.

We conducted 24 semi-structured depth interviews via videochat between May and November 2023 (30–60 minutes each, 279 transcript pages; table 1, following references, for demographic overview), aligning with common guidance for sample sizes in grounded theory research (Zeithaml et al. 2020). Participants were recruited through personal networks, social media, and survey research platforms using purposive sampling to ensure diversity across age, race/ethnicity, geography, gender, and military experience. The only exclusion criterion was age. Respondents received a gift card of their choosing in exchange for participation. One research assistant conducted a subset of interviews after training and observation. Interviews were guided

by a researcher-developed protocol (see online appendix), which remained consistent, though emphasis naturally evolved as insights emerged. We concluded data collection at theoretical saturation.

Analysis proceeded through iterative constant-comparison coding in MaxQDA. We began with inductive open coding to generate bottom-level categories, then advanced to axial coding to identify higher-order relationships. Selective coding produced core categories and an integrative conceptual framework. Three coders (two researchers and one trained assistant) independently coded the data, discussing discrepancies to refine the scheme and enhance rigor.

Critically, in this manuscript we are not considering formal, clinical definitions of mental health—for instance, we are not concerned with whether a consumer meets a specific set of clinical diagnostic criteria from the DSM. We are instead interested in how everyday consumers think about mental health consumption irrespective of their clinical state. Notably, while formal psychological disorders like depression and anxiety came up frequently throughout our interviews (with many respondents volunteering that they had received these diagnoses or dealt with these conditions over the years), we did not seek out respondents on the basis of a mental health diagnosis, and to our knowledge we did not interview people who were currently experiencing serious mental illness (National Institute of Mental Health 2024). We are thus setting out to study lay (rather than clinical) patterns of mental health consumption.

(IV) STUDY: SEMI-STRUCTURED DEPTH INTERVIEWS WITH CONSUMERS

As overviewed in figure 1 and table 2 (following references), this results section synthesizes participants' perspectives on mental health across three central themes: (1) their

definitions of mental health, (2) their mental health consumption, and (3) the barriers they encounter to mental health consumption. First, participants defined mental health as comprising one's feelings state (which is inherently tied to one's physical health, and inherently dynamic), and one's resilience to downturns provided by the inherent dynamism in feelings states. They next detailed various strategies—both formal (e.g., therapy and medication) and informal (e.g., hobbies, physical activity)—that help them maintain or restore their mental well-being. Finally, despite widespread openness to engaging in mental health consumption, participants commonly listed structural and psychological barriers such as financial constraints, limited provider access, and emotional friction in the search for suitable care. In text, we provide illustrative quotes drawn directly from participants to ground these themes; we present extensive tables of quotes for each subsection in the online appendix.

(1) Definitions Of Mental Health

Four themes emerged in participants' responses when we asked them to define mental health. Participants defined mental health as (i) their subjective feeling state, (ii) part and parcel of physical health, (iii) an inherently fluid and/or cyclical construct based on internal and external changes (e.g., work patterns or the changing of the seasons), and (iv) the cultivation of resilience (i.e., one's ability to absorb stressors and bounce back to a place of psychological readiness and efficacy) in the face of fluidity/cyclicity. Collectively, these definitions are suggestive of simple high-level targets for fostering mental health consumption. As discussed in the general discussion, we suggest that marketers could encourage consumers to actively build resilience given the knowledge that the external environment is dynamic and sometimes beyond

their influence. Because consumers define resilience as a part of mental health, but do little to cultivate it, they may benefit from marketing efforts to help them build these skills.

(1a) Mental Health as a Subjective Feelings State

Participants grounded their definitions of mental health in their evaluations of their day-to-day subjective feeling state—that is, their mood, or how they were feeling over a short to medium term period (ID08). Some described mental health in terms of how much stress, anxiety, or numbness they felt in ordinary moments (ID02, ID06). Others focused on how easily they could access joy, motivation, or a sense of balance (ID23). A few participants invoked formal diagnoses like depression or anxiety (ID06), but most emphasized the subjective sense of being either “okay” or “off” (ID06, ID08, ID15). Mental health, in this framing, was largely about personal insight—how a respondent was feeling, and an awareness of when something felt off (ID02, ID11, ID14). Participants also brought up the idea that their feelings states could impede functioning (ID06, ID24)—that is, their mental states can prevent them from functioning effectively at work or in family relationships—and defined mental health by whether or not they were functioning at their desired level.

(1b) Mental Health as Part of Physical Health

Participants frequently described mental health as part and parcel of their physical health (ID02, ID08). Participants felt that feeling mentally well often correlated strongly with sleeping well, eating well or exercising regularly (ID04, ID07). Others described practices like running or yoga as central to their mental health maintenance. Rather than separating mind and body,

participants described a two-way relationship in which physical and mental health influenced one another. Participants' discussion of physical health often made it seem as though the interviewers had introduced a novel or artificial distinction—while we asked about mental health, respondents often quickly brought up physical health, finding it puzzling to try and consider the mental without the physical (ID02, ID08, ID16).

(1c) Mental Health as Inherently Fluid, Episodic, or Cyclical

Many participants described mental health not as a fixed state, but as something that continuously shifts (ID05, ID07, ID10, ID18, ID22). Rather than defining themselves by whether or not they have a mental health issue, they talked about mental health as something is inherently fluid (i.e., shifting over time, ID05, ID07), episodic (i.e., marked by specific episodes such as depressive episodes), or cyclical (i.e., something that shifts in relation to predictable changes like the seasons or busy periods at work; ID16, ID23). Some participants specified that mental health would shift even when there was nothing changing in their external environment (ID07).

This cyclical framing in turn shaped how participants thought about their needs. Some described low motivation toward formal support because they simply expected negative feelings states to pass on their own—perhaps reasonably given their personal experience with their ever-changing nature. Others adjusted their self-care based on where they felt they were in the cycle—leaning more heavily on coping tools when things dipped (although often after a time lag during which they felt unwell), and relaxing those routines when they felt more stable (ID18, ID22). In this view, mental health was not a stable achievement or a clinical threshold—it was a moving target that participants informally tracked and managed over time.

(1d) Mental Health as the Cultivation of Psychological Resilience in the Face of Stressors

Finally, many participants defined mental health as the ability to recover in the face of the life stressors (or the natural internal changes) that cause fluctuations in feelings states described in the previous section (ID01, ID09). This notion of resilience—one’s ability to “bounce back” from negative feelings states to regain a more desirable feelings state and greater psychological functionality—constituted a unique dimension of mental health (ID02, ID09, ID24). Participants described mental health as both the quality of one’s present feelings state, and their ability to restore a positive feelings state when things were not going well. Participants considered their ability to gauge their mental health, endure downturns, and re-emerge, as a core part of what it means to have strong mental health. Coping was a key component of resilience. As we discuss throughout, participants defined coping skills as a part of their mental health (ID05). Participants organically distinguished between problem- and emotion-focused coping (labels we have drawn from the literature), as well as healthier and less healthy forms of coping.

(2) Formal And Informal Mental Health Consumption Behaviors

Participants described a broad spectrum of specific consumption behaviors they used to manage their mental health. Some of these were formal (e.g., therapy), while others were informal (e.g., speaking with friends). Further, these aligned with the distinction drawn in the academic literature between problem- and emotion-focused (Lazarus 1991). That is, participants recognized that support strategies can help them manage emotions (emotion-focused), and/or can help directly address an underlying problem (problem-focused). Mental health consumption

behaviors, in order of most frequently to least frequently mentioned, included social support, therapy, personal hobbies, medication, physical activity/exercise, meditation and mental health apps, and religious practice. These behaviors were not mutually exclusive; many participants described them as if they were a menu. They chose off of the menu based on specific on-ramps (e.g., a friends' recommendation or happening to work near a therapy practice), deliberation (e.g., what they felt they most needed), motivation (e.g., not feeling the need to engage formal therapy), circumstance (e.g., the pandemic limiting opportunities for social support), and simply failing to resist temptation (e.g., drinking, or video games).

In the next three sections, we discuss participants' mental health consumption behaviors in greater detail, beginning with positive coping behaviors (which participants regarded as healthy in the long-term), followed by displacing or ineffective coping tools (which participants regarded as unhealthy/unhelpful in the long term), and concluding with a discussion of the on-ramps and off-ramps to specific behaviors that participants mentioned most often.

(2a) Positive Coping Behaviors

Participants described a wide range of positive consumption behaviors they used to support their mental health. These included both formal tools—like therapy and medication—and informal, self-directed approaches such as physical activity, hobbies, religious practice, and social support.

Social support. Social support emerged as an extremely common behavior across interviews. Participants frequently turned to coworkers, friends, family members, and romantic

partners to vent, reflect, or feel emotionally grounded. These interactions were often framed as substitutes or complements to therapy, especially among those who preferred easy-to-access strategies, or participants who questioned the idea that a therapist could provide something that a friend could not (see Section 3c, Perceived Lack of Need or Value). Participants also noted social support was often the only option that someone had available to them (ID01). Critically, participants needed to feel that they could speak candidly with others in their life for this to be a resource for them—they did not want to have to self-censor or worry about self-presentation (ID05, ID15, ID20). Multiple participants noted that in addition to social support being a valuable coping mechanism, a lack of social engagement could be a trigger that worsens one’s mental health (ID04, ID09, ID13, ID22). Beyond being merely a tool that people sought out upon realizing that their feelings state had deteriorated, multiple participants additionally described the idea that social support acts as a bolster to one’s self-awareness—romantic partners and coworkers could be accountability buddies who helped participants to realize that their feelings states were beginning to deteriorate, thus extending the function of self-monitoring and building resilience to include others (ID07, ID20, ID23).

Therapy. Many participants listed therapy as an important tool in their mental health consumption. However, as we discuss further in Section 3, Barriers to Mental Health Consumption, their experiences varied widely. Some described being in therapy currently (ID16, ID19), some described having done therapy in the past (ID01), and some described a cycle of returning to therapy during periods of high stress or emotional difficulty (ID05). Participants often discussed how effective therapy was in improving both their feelings state, and their resilience (ID01, ID05, ID07, ID12, ID21), making it one of the few behaviors that enhanced

resilience. As with social support, the notion of a non-judgmental listener was important (ID19). Even those who had discontinued therapy often spoke about its benefits in retrospect, and expressed positive sentiment toward the idea of returning to therapy. Yet participants also frequently mentioned how difficult it is to find a therapist, past negative experiences with therapy (ID09), the high price of therapy, and the administrative red tape involved in health insurance (ID09, ID16, ID21, ID22). Some participants mentioned that it did not feel appropriate for them, that they were skeptical that it would be helpful, or that it was not an attractive option to them personally even if they were not sure why (see subsection 3b for further discussion). In brief, while many participants had gone to therapy, and while many had positive experiences, a large number of participants described it as something that was, for one reason or another, not a primary tool for their mental health consumption (ID24). We discuss this further in Section 3b, Psychological and Search Frictions in Therapy.

Personal hobbies. To our surprise, many participants discussed personal hobbies such as reading, writing in journals, listening to or playing music, creating art or dancing, and playing video games, as valuable forms of mental health consumption (ID09, ID10, ID11, ID16). Participants highlighted that personal hobbies were highly accessible when they were in need—critically, participants brought up none of the administrative, financial, or social costs of other forms of mental health consumption such as therapy (see Section 3b, Psychological and Search Frictions in Therapy). Participants additionally noted that these practices were effective—they aided in calming down, shifting attention away from stressors, or numbing unpleasant feelings states (ID09, ID10). This seemed to be a form of emotion-focused coping, but a valuable and healthy one, so long as they did not crowd out problem-focused coping strategies that could

address the root causes of mental health issues (see the following section for a discussion on crowding out). A surprising number of participants mentioned simply getting outside as a valuable tonic (ID10, ID11, ID20, ID23). While not always framed explicitly as mental health consumption in the way that therapy was, these activities clearly served as accessible, effective, and consistently utilized sources of emotional regulation.

Medication. Many participants described either having used medication themselves, or having thoughts about the use of medication that influenced why they were not interested in it (ID09). Participants often framed medication pragmatically—something that made other forms of coping more effective, or helped restore basic functioning during difficult episodes. Some participants described using medication to manage symptoms like anxiety, depression, or mood instability (ID01, ID03, ID18). Participants who felt most comfortable with medication felt either that it was a shorter-term solution, a solution that could simply help them function more effectively day-to-day by reducing negative feelings states, or that it was replacing a biologically generated deficit (ID16). Some participants liked the simplicity that a pill offered (ID02). Yet others did not feel entirely comfortable with long-term use of medication, often because they saw it as more of an emotion-focused coping tool than a problem-focused coping tool (ID09, ID24). The emotion-focused nature of medication was thus both a positive (for individuals who wanted help reducing the severity of their negative feelings states), and a negative (for participants who wanted to address the root cause of their problems). Reflecting the cyclicity of how they defined mental health, participants mentioned the cyclicity of their journeys with medication—how they would go on when times were harder, and come off when they needed it less or when they did not feel it was working effectively (ID11, ID12, ID22). Many participants expressed

frustration that it was difficult to find the right medication or dosage, or that their doctors were not listening to them and turning them toward medication or uncomfortable doses (ID01, ID02, ID03, ID04, ID05, ID16). Overall, participants tended to have some wariness about starting medication, even as they believed in its effectiveness. This wariness stemmed from a sense that medication did not solve the problem but only treated the symptoms, the sense that it is not a viable long-term solution, or a desire to avoid medical professionals in this domain.

Physical health behaviors. Participants often discussed how activities that help them stay physically healthy—e.g., walking, going to the gym, or eating better meals—were also valuable forms of mental health consumption. This was often interrelated with the importance that participants placed on getting outdoors (ID05), as discussed previously. Notably, as with personal hobbies, participants mentioned none of the drawbacks associated with medication when discussing physical health. Multiple participants acknowledged that they had trouble motivating to exercise, or did not enjoy it (ID06, ID10, ID18). Yet even this could be valuable, as overcoming this challenge contributed positively to mental health (ID06). While participants felt that physical health behaviors were primarily emotion-focused (like medication), physical health behaviors lacked the downsides of medication, making them valuable for restoring feelings states and functionality despite their emotion-focused.

Religion. Some participants referenced religion or spirituality as important sources of support or stability over time (ID07). Multiple participants additionally noted that religion offered them easily accessible forms of mental health consumption—for instance, practices like prayer helped participants reframe their experiences as meaningful in the context of a broader plan, and/or stay grounded during periods of distress (ID09, ID17). Some participants noted that

while not religious themselves, they felt religion was a valuable mental health tool to people who are (ID12). However, it is also important to recognize that religion played a negative role in some participants mental health, particularly earlier in life.

Mental health apps and meditation. Finally, a subset of participants reported using mental health apps or guided meditation as self-help tools. These resources were valued for their accessibility, but many people found they had a hard time starting them (ID12), or that they were not right for them (ID13, ID24). Much like with personal hobbies and physical exercise, people had no fears or qualms about potential side effects or downsides of meditation and mental health apps. While some found them to be valuable (ID22), they questioned their effectiveness (ID17), and the profit-seeking motives of firms. Ironically, despite this being an often explicit and commercialized form of mental health consumption, it appealed relatively little to participants, even those who were familiar with the apps and could recall seeing their advertising messages.

Taken together, these accounts reveal that participants actively assembled and experimented with a variety of support strategies. Some were clearly intentional; others evolved through habit or intuition. What unified them was a desire to self-regulate in ways that felt easily accessible and effective—even if only temporarily.

(2b) Harmful, Displacing or Ineffective Coping Behaviors

In addition to these positive coping behaviors, participants also acknowledged engaging in consumption that was ineffective, that was helpful in the very short term but ultimately

harmful, or that “crowded out” more valuable coping strategies. Critically, these activities were not momentary mistakes or lapses in willpower. In many cases, respondents engaged in harmful mental health consumption because it was the most accessible way to relieve one’s aversive feelings state. However, even as they engaged in harmful mental health consumption, participants often recognized that it displaced healthier behaviors. It was thus not a lack of insight that drove these behaviors.

“I guess I'm not holding myself accountable... there's a quote, somebody's like, you know, I'm not fat because I don't know that eating chips are bad. I'm fat because I eat them anyway... Well, why are you sad?” ID20

Displacing, or ineffective coping strategies. Participants sometimes described behaviors that temporarily numbed emotions, but failed to address underlying emotional challenges. These included screen time, overworking, and use of alcohol, tobacco, or marijuana. Participants typically recognized that these strategies were not effective over the long term, that they were more emotion-focused than problem-focused, and that it was best to avoid them (even if they freely recognized that they had fallen into them at some point in their past).

Crowding out. One recurring theme was that unhealthy behaviors crowded out healthy behaviors. This occurred when unhealthy behaviors were more accessible or lower-effort, allowing them to displace mental health consumption that was more helpful in the long term, or that participants said that they knew was better for them (ID03). Participants described defaulting to TV, video games, social media, or drinking not because they believed those strategies would help, but because they required less emotional energy and had an adequate effect (ID03, ID05,

ID12). Notably, participants mentioned that they did not *prefer* these forms of consumption—indeed, they would have preferred to engage in more problem-focused forms of mental health consumption (ID03, ID12, ID14, ID20).

Taken together, these accounts demonstrate that harmful, displacing or ineffective coping behaviors stem from simple accessibility and lack of superior present alternatives. Participants also showed a commendable awareness of the inefficacy of these coping tools, suggesting another potentially promising area for marketing for mental health.

(2c) On-Ramps and Off-Ramps to Mental Health Consumption

Participants often described specific on-ramps and off-ramps to mental health consumption. These were an integral part of a non-linear journey toward mental health consumption. This began with participants considering their need for support (whether informal or formal), was followed by some on-ramp to action, and ultimately by some off-ramp of disengagement.

Unsurprisingly, feeling unwell was a common on-ramp to seeking out mental health consumption (ID05). Several participants described entering therapy, trying an app, or opening up to someone for the first time only after experiencing a specific stressor, or when their feelings state became sufficiently unpleasant. In some cases, participants had been considering support for a long time, but did not feel compelled to act until the emotional negativity spiked. Other on-ramps include simple word of mouth (participants who gave or received recommendations from friends or community members; ID01, ID15), simple environmental cues like happening to work near a therapy practice, or enter family counseling (ID09, ID18, ID19), or recommendations from schools or employer-based insurance (ID05, ID09, ID11, ID20).

Participants also described many clear off-ramps—moments when they stopped engaging in mental health consumption. Some of these exits were intentional (e.g., a participant who stops attending therapy because they felt better), while others reflected very basic frictions or simple disappointment with a product or service (e.g., a participant who stopped going to therapy because they did not feel comfortable driving after dark, or a participant who gave up after not being able to find the right therapist; ID03, ID14, ID17, ID21). Critically, many participants noted that simple structural barriers—e.g., the close of a semester bringing a lapse in healthcare access, or simply moving to a new part of the country—wound up being permanent off ramps from effective coping behaviors (ID05). These in particular represent rich targets for marketing professionals aiming to foster productive mental health consumption, as we discuss later.

In summary, participants described mental health consumption as a dynamic and characterized by on-ramps and off-ramps, rather than a stable or continuous practice. On-ramps included crossing an emotional threshold (e.g., ID19: “I’m not okay... might as well [go]”), serendipitous social recommendations/circumstances (ID15; ID19 “it’s next door”), and institutional nudges (ID01), all of which helped push participants into consideration and/or into actual consumption. Regarding off-ramps, participants ceased mental health consumption when their insurance lapsed (ID05), when fit with a therapist was poor (ID14), or when the experience felt depersonalized or overly clinical (ID21). Across both entry and exit, participants’ decisions were shaped by situational, emotional, and interpersonal cues. The act of starting or stopping mental health consumption thus bore little resemblance to a structured consumer journey or textbook marketing funnel (e.g., awareness, consideration, conversion, loyalty). Instead, participants described a process in which behavior was shaped by exposure to cues about mental health consumption (e.g., ads, offhand comments, or recommendations from one’s social

network) that may or may not hit home, but gained relevance as their feeling state became more and more unpleasant. Rather than the somewhat linear process which takes place when someone is shopping for a more typical consumer good like new jacket (where a consumer might recognize and have knowledge of specific brands, form a consideration set, etc.), most participants described a process that was less intentional, less goal-directed (e.g., participants did not have a goal to find a therapist) and far more fluid—while one’s need for a new pair of jeans will (i) persist until a purchase is made, and (ii) benefit from significant prior knowledge of the relevant brands, alternatives (khakis), and distribution mechanisms (e.g., online vs in store), one’s need for mental health consumption is fluid, and often carries little prior knowledge of alternatives (e.g., therapy versus medication versus journaling versus use of an app) or distribution (e.g., going through insurance, one’s primary care physician; IDxx who walked into a nearby clinic who referred her to more appropriate resources).

(3) Barriers To Mental Health Consumption

Participants identified a wide range of barriers that made it difficult to engage in mental health consumption. Some of these were practical (e.g., cost, time, access); others were internal (e.g., uncertainty, ambivalence, mistrust); and still others were cultural or social in nature. Although the literature often emphasizes stigma as a central obstacle, participants in this study offered a more nuanced picture. While participants were aware of mental health stigma, some clearly holding it themselves, many described it as something they had learned to navigate, or something that they felt affected others more than themselves. By analogy, someone may be politically active but choose not to discuss politics with a specific family members; similarly,

participants described that they could be active in mental health consumption, but choose not to discuss mental health with certain people in their lives—even people as close as a parent or spouse. In many cases, participants thus acknowledged stigma, while simultaneously suggesting that it was not a decisive feature of their decision environment. Participants pointed more commonly to a set of less attention-grabbing frictions that delayed or deterred mental health consumption. Many of these—e.g., the difficulty finding a suitable therapist—seem like rich targets for marketing professionals interested in fostering mental health consumption.

The subsections that follow explore three primary subcodes: stigma, psychological and search frictions related to therapy, and perceived lack of need or value. A final section addresses more straightforward structural and resource-related barriers such as time, cost, and access, though we acknowledge that operating on barriers like lack of insurance coverage or a dearth of local therapists is beyond the scope of this research.

(3a) Stigma (Often Surmountable) and Social Framing

Expression, awareness, and management of stigma. Across interviews, mental health stigma was something that nearly all participants were aware of and something that some participants expressed directly. To the extent that participants did express stigma, they often did so by suggesting that people’s problems are best solved internally, without the use of therapy (ID06, ID08, ID21), questioned the intentions of therapists (as discussed in the next section), or exhibited stigma from the perspective of traditional views of masculinity. More broadly, nearly all participants described being aware of mental health stigma. Several participants reflected on being raised in environments where therapy or mental health care was stigmatized (ID09, ID21),

including religious environments (ID19), or by parents who were not open to mental health discussions (ID01, ID15). In many cases, family members or older generations expressed skepticism, dismissiveness, or discomfort around emotional openness (ID03, ID05, ID07).

However, participants often described stigma as something they were *not* directly constrained by (c.f. ID12, ID22). While participants noted that stigma existed among their family, friends, or in society at large, perceptions of stigma often did not prevent them from engaging in mental health consumption (ID04, ID05, ID07, ID12, ID13, ID15, ID21). Instead, participants seemed to treat stigma as something to be aware of so as to minimize social friction. Much as someone might avoid discussing politics with a specific family member because it will cause unproductive disagreement, participants described simply not discussing mental health with family members who hold stigma (ID01, ID03, ID05, ID07). While many participants knew of people in their lives who held stigma, they typically did not list this as a barrier to mental health consumption. Instead, barriers tended to be far more mundane—as discussed in the following section, things like a lack of therapists, difficulty navigating the various options for mental health consumption, difficulty choosing a therapist, or a simple lack of motivation to do something beyond watching and waiting as one’s mental health cycled back to a more positive place.

Mirroring broader trends in society, many participants spoke of seeing attitudes toward mental health change over time, or vary by geographic region (ID07, ID09, ID10, ID12, ID19, ID23). This sometimes occurred when participants had changed their life circumstances (e.g., someone who had grown up in a stigmatizing religious environment but now had moved out of that environment), and sometimes reflected people simply remembering that society used to be less open to discussing mental health (ID14). Also mirroring broader trends in society, multiple

participants mentioned a sort of backlash to mental health as a virtue signal (ID14, ID20). These participants felt that, while mental health consumption may be legitimate for a subset of people, they resented instances when people in their lives seemed to engage in mental health consumption without needing it, discussed their mental health problems as a way to get attention, or engaged in what could be called performative mental health consumption (i.e., engaging in mental health consumption so as to communicate something to the audience of those around you).

Barriers Related to Identity. A smaller group of participants described encountering stigma in relation to specific aspects of their identity—such as race, gender, sexual orientation, or cultural background. These participants noted that their identity contributed to specific mental health issues (ID02, ID16), or that their identities made it difficult to engage in certain forms of mental health consumption due to having trouble finding suitable therapists (ID05, ID11), or because certain forms of mental health work were not viewed favorably within their communities (ID16, ID22). For example, men, members of religious communities, military members, or immigrant families sometimes felt that emotional expression or help-seeking conflicted with expectations tied to strength, self-reliance, or privacy (ID11, ID22). In some cases, this created discomfort or hesitancy about pursuing care, particularly when providers were perceived as culturally dissimilar or unlikely to understand their experiences (ID05, ID11).

Culturally masculine coping norms. Another pattern emerged among a small but meaningful subset of participants, who endorsed culturally masculine coping norms (ID06, ID10; see also previous section ID 22, ID16). These participants framed help-seeking as a failure of

manliness, suggesting that the solution to mental health issues is to man up and do a better job keeping busy. While not large in number, it is important to recognize that this is likely an attitude that many consumers hold.

Taken together, these patterns suggest that while stigma remains part of the landscape, it may not be the most significant or persistent obstacle to mental health consumption. Critically, participants often found ways to navigate mental health stigma, even when they knew it was present in people close to them such as friends and close family members. As we take up further in the general discussion, this may suggest a novel pathway forward in our efforts to foster mental health consumption. Given past research demonstrating that mental health stigma can be extremely difficult to change, and given our findings that people may have the capacity to “go around” mental health stigma, researchers and practitioners hoping to foster mental health consumption may consider how they can help consumers go around stigma rather than how they can change the attitudes of the general public.

(3b) Psychological and Search Frictions in Therapy

Even when participants expressed openness to mental health consumption, many described frictions that were substantial enough to override people’s willingness to work on themselves. These barriers were often about the psychological and logistical hurdles inherent to the search process, and were most prominent when discussing therapy. For instance, the mere prospect of starting therapy—choosing a therapist and explaining your life’s story to them, when there is a real “risk” that they may not be a good fit (particularly if one has a history of negative experience with therapy)—was repeatedly mentioned as something that could prevent help-

seeking. Relatedly, while many people had heard of meditation apps, people often noted that they had no impetus to try them even if it was something they were open to. Together, these frictions illustrate how the very act of getting started can be a significant barrier.

Motivational Barriers to Initiating Search. A number of participants described struggling to take the first step toward therapy, even when they believed it might be helpful. This included difficulty initiating a search, procrastination over contacting a potential therapist, or feeling resistant to therapy despite understanding that it is a viable option (ID02, ID04, ID05, ID10). Some participants noted that even the idea of reaching out felt draining, especially during periods of distress (ID22). They described wanting help, but finding the initiation process too cognitively taxing, too emotionally heavy, or simply too logistically difficult to undertake. This internal resistance often contributed to long delays or a pattern of stopping and restarting the search multiple times (ID02). In these quotes, participants tell a story not of lacking the knowledge to pursue mental health consumption, but of lacking the motivation (ID20, ID23).

Therapist Search Friction and Past Negative Experience. Beyond motivational barriers, participants also described the process of finding a therapist as confusing, opaque, and even emotionally difficult. Some pointed to structural issues—such as difficulty evaluating providers, limited options in their area, or trouble navigating insurance systems. Others noted psychological barriers: the difficulty of repeating their trauma to multiple therapists (ID11, ID16), the discomfort of opening up to a stranger, or the annoyance of spending extensive time and effort finding an affordable therapist only to be unsure if they will be a good fit (ID13; ID16, ID18, ID20). For some participants, reluctance to seek therapy stemmed from direct

experience—they had worked with therapists who did not feel like a good match for them, or who took approaches that participants did not appreciate (ID04, ID09, ID15, ID17, ID22). These negative experiences felt like social rejections, and shaped expectations going forward, making it harder to justify trying again (ID16, ID17, ID22). A few participants described feeling “burned” by therapy—disclosing vulnerable material without feeling heard or helped. Even when participants acknowledged that not all therapists were the same, the effort involved in restarting felt prohibitive (ID05, ID22). As one participant implied, the idea of repeating the whole process—rebuilding trust, re-explaining their history, and risking disappointment again—felt like too much.

These logistical and emotional frictions often compounded each other. Participants who felt emotionally vulnerable described being especially overwhelmed by the idea of “shopping” for the right therapist—something they saw as time-consuming, uncertain, and deeply personal (ID16, ID18, ID20, ID22). People described simply leading busy lives, and shopping for a therapist being something that they have difficulty adding on top of their already busy schedules. As discussed throughout, this lead people to be more likely to engage in mental health consumption that was easiest to access in terms of fitting into their schedule, or in terms of requiring as little administrative set-up as possible (see section 2a; ID02, ID12)

Taken together, these accounts highlight the importance of distinguishing between willingness to seek therapy and the actual ability to engage it. Many participants did not resist therapy itself—they were simply unwilling or unable to complete the labyrinth of steps that precede therapy. As we take up in the general discussion, we recommend a series of simple steps that providers could take to reduce frictions for consumers, such as creating easily accessible

short videos of a therapist describing their personal history (to the extent they are comfortable doing so), their professional style, and who to contact.

(3c) Perceived Lack of Need or Value

Another significant barrier participants described was the perception that formal mental health support was unnecessary or unlikely to be helpful. In some cases, participants felt that their current strategies, as described in sections 2a/2b, were meeting their needs. Yet for some participants, this was rooted in doubts about the value of therapy. Some participants questioned whether they really needed therapy, or were an appropriate case. Some participants recognized they needed help, yet questioned whether therapy or medication was actually effective. Some participants even questioned whether these formalized options were in some manner a scam—for instance, multiple participants mentioned the idea that a therapist or pharmaceutical company was incentivized to *not* solve people’s problems, so as to keep them paying for sessions or medication. While not a widespread view, this is at a minimum a view that marketers and providers should be aware of when confronting new clients whose skepticism may prevent them from meaningful engagement.

Participants’ Current Demand Level. Many participants conveyed that, at the time of the interview, they were not actively seeking additional support. This did not mean they dismissed therapy outright, and many even acknowledged its value. However, they did not feel they needed therapy, medication, or other forms of additional mental health consumption at the present moment. Some described being in a good place mentally (consistent with their

definitions of mental health as involving one's subjective feelings state; ID05, ID13, ID14), while others noted that past efforts had given them the tools they needed to self-regulate and that they would re-approach mental health consumption when they needed it (ID03). As a result, the idea of re-engaging with formal support felt unnecessary at present (ID16).

Matching our prior discussion, mental health consumption for these participants was dynamic rather than continuous. Several participants noted that they might consider therapy or alternatives again if things worsened, but there was no need while things were relatively stable (ID13, ID14, ID20, ID23). In this way, one's subjective feelings state functioned as a gatekeeper—without the presence of acute symptoms or emotional urgency, there was little motivation for mental health consumption.

Skepticism Toward Therapists' Motives or Abilities. A notable group of participants expressed skepticism toward the value of therapy and medication in particular. Some questioned the motives of providers, wondering whether therapists/pharmaceutical companies were truly invested in their clients, or otherwise doubting the effectiveness of therapy (ID09, ID10, ID14, ID20). Others went further, expressing the potentially conspiratorial viewpoint that providers are mainly incentivized to keep clients coming back to pay for additional sessions or medications (ID06, ID10). These participants, mental health products/services were not only viewed as not helpful, but a negative thing for society at large, and as such, something they would not consider for themselves (ID06).

(3d) Structural Barriers (e.g., Time, Cost, Access)

Among participants who were open to therapy and saw value in formal mental health care, structural barriers frequently posed significant challenges to mental health consumption. These non-psychological barriers—financial barriers, lack of time, and lack of therapists—seem to represent supply-side problems that often prevented mental health consumption. In several cases, participants described wanting support, being emotionally ready to engage, and still not being able to follow through due to these external constraints. We discuss these in brief, not because they are unimportant, but because they largely fall outside of the scope of marketing professionals, being more within the domain of those working in areas that can more directly influence the supply of care (e.g., public health or health policy).

Financial Barriers. Cost was one of the most frequently cited barriers to the use of therapy or medication. Participants noted that therapy—especially without insurance—was prohibitively expensive, driving them toward alternative forms of mental health consumption (ID02, ID05, ID07, ID14, ID16, ID19). Some referenced specific price points (\$100–\$200 per session) as untenable given their income, and multiple participants described having a therapist they liked who stopped taking insurance (ID11, ID20, ID21). Several participants reported that once they learned how much therapy would cost, the idea of pursuing it became moot—regardless of motivation or perceived need (ID01, ID09).

Lack of Time. A second common constraint was time. Participants juggling work, family caregiving, school, or other obligations often said they simply did not have the time to pursue mental health consumption, even if they wanted to do more for themselves (ID02, ID04, ID07, ID12, ID24). Interestingly, participants sometimes listed the very busyness that prevented mental

health consumption as a stressor, making it something that both causes negative feelings states and prevents the mental health consumption necessary to reduce them.

Lack of Supply of Therapists. Finally, several participants described struggling to find a therapist at all, or knowing friends who had this experience. Waitlists, geographic limitations, and the inability to find someone who is a good fit while also covered by insurance made the process feel discouraging or impossible (ID15, ID18, ID21).

While we do not discuss them at length, these structural limitations had a significant impact on mental health consumption. The overall picture is that even if participants are not concerned about stigma, are highly motivated, and recognize the value of a particular form of mental health consumption, structural barriers like a lack of money, time, or providers, may prevent them from engaging with it.

(V) GENERAL DISCUSSION

In this research, we address a fundamental question in consumer behavior: What are the major barriers to mental health consumption in America today? Despite the enormous potential market—with one in four Americans experiencing mental illness yet only half receiving treatment (National Institute of Health 2024)—marketing scholars have devoted surprisingly little attention to understanding why consumers underinvest in their mental health (Farrell et al. 2024). The existing literature has largely focused on stigma as the primary obstacle, with smaller bodies of work examining mental health literacy and structural barriers. Yet few studies have assessed stigma's importance relative to other obstacles or asked consumers directly what prevents them from engaging in mental health consumption.

We conducted a grounded theory analysis of 24 in-depth interviews. While participants widely recognized mental health stigma, they described it as something they had learned to navigate rather than an insurmountable barrier. Instead, consumers reported being hindered by more immediate obstacles: motivational hurdles in initiating care, search frictions in finding appropriate providers, skepticism about provider motives and efficacy, and structural constraints around cost, time, and availability. We also found that consumers view mental health as cyclical and intrinsically tied to physical health, rely heavily on informal coping strategies, and consider resilience central to mental health yet rarely engage in consumption designed to build it.

Research Implications and Contributions

This work makes three primary contributions to the academic literature. First, it highlights a meaningful disconnect between research priorities and consumers' lived experiences. While stigma has dominated scholarly attention for decades, our participants described adapting around stigma rather than being paralyzed by it. Much as someone might choose not to discuss politics with certain family members while remaining politically active, participants described selectively sharing their mental health consumption. This suggests that the literatures' emphasis on stigma reduction may overshadowed other critical barriers. This insight also opens new avenues for research on how consumers choose when to disclose and conceal consumption behaviors in stigmatized domains—and in better understanding when stigma *does* play a larger role.

Second, our findings provide novel insights into the contemporary mental health consumption journey. Participants described mental health as fundamentally cyclical rather than

linear, shaped by predictable patterns like seasonal changes and work stress as well as unpredictable life events. This cyclical framing influenced their consumption patterns—many expected negative feeling states to pass naturally and adjusted their coping strategies accordingly. They also viewed mental and physical health as inseparable, finding it puzzling that researchers would distinguish between them.

We identified a gap between how consumers define and pursue mental health. While participants consistently identified resilience—the ability to bounce back from negative feeling states—as central to mental health, nearly all their consumption behaviors focused on managing current emotions rather than building resilience. This stands in contrast to other health domains where preventive consumption is well-established. The gap between valuing resilience and investing in it represents a significant opportunity for both researchers and practitioners.

We also documented how “bad” coping strategies often crowd out “good” ones, not due to lack of awareness but due to differences in accessibility. Participants readily acknowledged that behaviors like excessive screen time or drinking were less effective than exercise or social connection, but defaulted to them because they required less emotional energy and provided adequate short-term relief. This crowding-out suggests that interventions focused purely on education may be insufficient—consumers need practical support in making healthier options more accessible.

Third, this research demonstrates that marketing scholars are uniquely positioned to contribute to mental health consumption research (Farrell et al. 2024). Our discipline’s expertise in understanding consumer journeys, reducing friction, and influencing behavior offers valuable perspectives that complement the primarily clinical and public health approaches that have dominated this field. Marketing’s practitioner connections also provide pathways for translating

research insights into real-world interventions. We hope this work encourages other marketing scholars to engage with mental health consumption as both a substantively important domain and a theoretically rich context for advancing consumer behavior theory.

Implications for Practitioners and Society

These findings offer actionable insights for the diverse stakeholders working to foster mental health consumption, including firms, healthcare providers, universities, policymakers, and consumers themselves. Rather than prescribing universal solutions, our research provides a diagnostic framework—a menu of barriers and opportunities that different stakeholders can evaluate within their specific contexts.

For firms developing mental health products and services, our findings suggest several strategic priorities. First, increasing accessibility should take precedence over changing attitudes. Consumers consistently gravitated toward the most accessible options, even when they recognized that other alternatives might be more effective long-term. This suggests that reducing friction—whether logistical, financial, or psychological—may yield greater returns than traditional awareness campaigns.

Second, the gap between valuing resilience and building it represents an underexplored market opportunity. Participants described their mental health consumption as primarily reactive, seeking to improve current feeling states rather than proactively building future resilience capacity. Firms that can help consumers shift from reactive to preventive mental health consumption may tap into this demand. This might involve reframing existing products around

resilience-building rather than symptom management, or developing new offerings explicitly designed to enhance psychological preparedness for future challenges.

Third, firms should recognize and capitalize on the reality that much mental health consumption happens informally. Participants frequently mentioned hobbies, exercise, social activities, and even simple acts like going outside as central to their mental health maintenance. Companies in adjacent categories—fitness, entertainment, social media, travel—might consider how their offerings could be positioned or enhanced to better support mental health. This represents an opportunity to expand the mental health market beyond traditional clinical boundaries.

The implications extend beyond individual firms to broader societal approaches to mental health promotion. Our findings suggest that the conventional wisdom about stigma reduction—while important—may be incomplete. The persistent focus on changing attitudes has produced mixed results, with some interventions inadvertently increasing social distance from people with mental illness. Our participants' ability to navigate around stigma suggests an alternative pathway: rather than waiting for societal attitudes to change, we might focus on helping consumers successfully pursue mental health consumption despite the persistence of stigma.

This insight points toward a potentially powerful feedback loop. If we can increase mental health consumption through friction reduction and accessibility improvements, the resulting behavior change may naturally erode stigma over time. When celebrities, colleagues, and community members openly engage in mental health consumption, it normalizes these behaviors and creates permission for others to follow suit. This behavioral route to stigma reduction may prove more effective than direct attitude change campaigns.

Our findings also suggest reframing societal conversations about mental health from a linear recovery model to a cyclical resilience model. Rather than conceptualizing mental health as a journey from illness to wellness, we might emphasize building capacity to navigate the inevitable ups and downs of psychological life. This reframing could reduce the stigma associated with ongoing mental health needs while encouraging more proactive consumption.

Finally, our research reinforces an encouraging reality: people generally know what behaviors support their mental health. Participants demonstrated sophisticated understanding of different coping strategies and their relative effectiveness. The primary challenge is not knowledge but execution—helping consumers access and maintain the behaviors they already recognize as beneficial. This suggests that interventions focused on reducing barriers and increasing accessibility may be more effective than those focused purely on education or persuasion.

Conclusion

Mental health consumption represents a critical domain where marketing expertise can meaningfully impact both individual wellbeing and societal outcomes. Our findings suggest that the path forward may be more straightforward than previously assumed. Rather than waiting to eliminate stigma or dramatically restructure healthcare systems, we can focus on reducing everyday frictions that prevent consumers from accessing the mental health support they already recognize as valuable. By understanding mental health as cyclical rather than linear, emphasizing accessibility, and helping consumers build resilience proactively rather than reactively, we can better serve the millions of Americans seeking to improve their mental health. For marketing

scholars, this offers rich opportunities to apply our understanding of consumer behavior to one of the most consequential challenges of our time.

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Table 1. Demographic overview of participants.

ID	Date	Age	Race	Gender	State	Income
1	5/24/23	71	White	Female	KY	\$40,000 - \$49,999
2	5/25/23	34	White	Female	MN	\$70,000 - \$79,999
3	6/8/23	46	White	Female	TN	\$40,000 - \$49,999
4	6/10/23	39	White	Male	CO	\$50,000 - \$59,999
5	6/14/23	23	White	Non-binary	TX	\$10,000 - \$19,999
6	6/14/23	27	Asian	Male	MA	\$30,000 - \$39,999
7	6/16/23	30	Asian	Male	TX	\$140,000 - \$149,999
8	6/16/23	61	White	Female	CO	Prefer not to share
9	6/19/23	37	African American	Female	TN	\$90,000 - \$99,999
10	6/20/23	40	White	Male	CA	\$20,000 - \$29,999
11	9/6/23	31	Asian	Male	IN	\$110,000 - \$119,999
12	9/6/23	29	White	Male	IN	\$120,000 - \$129,999
13	9/11/23	66	White	Female	OH	\$150,000 and up
14	9/8/23	26	White	Female	NC	\$30,000 - \$39,999
15	9/11/23	61	Other	Female	IN	Prefer not to share
16	9/29/23	28	Asian	Male	TX	\$150,000 and up
17	9/29/23	32	White	Female	OH	\$150,000 and up
18	10/2/23	48	White	Female	CA	\$150,000 and up
19	10/2/23	32	White	Female	IN	\$60,000 - \$69,999
20	10/20/23	31	White, Asian	Male	OH	\$150,000 and up
21	10/20/23	31	White	Female	MA	\$40,000 - \$49,999
22	10/30/23	28	White	Male	IN	\$30,000 - \$39,999
23	10/30/23	28	White	Female	OH	Prefer not to share
24	10/30/23	32	White	Male	OH	\$150,000 and up

Table 2. Summary of key results:

<p>Consumer Definitions of Mental Health: Consumers defined mental health as their feelings states, which are intrinsically dynamic and tied to physical health. Consumer also defined one’s ability to cultivate resilience in the face of mental health’s dynamism to be part of mental health.</p>
<p>The Mental Health Consumption Journey is Cyclical, not Linear: Participants described that mental health itself is highly dynamic—it changes in response to the seasons, patterns at work, events in one’s personal life, and even unexplainable internal changes. Thus, the mental health consumption journey is also cyclical, resembling a flow chart rather than a traditional marketing funnel that they drip down.</p>
<p>Resilience Building Takes a Back Seat: While many participants defined resilience as a key component of mental health, few described engaging in mental health consumption to proactively build resilience. This represents an opportunity for marketers that aligns their incentives with consumers’ incentives.</p>
<p>Stigma Exists But Appears Surmountable: Changing people’s attitudes in a durable way is extremely difficult. Yet many respondents reported that their peers, friends or family held stigma, but that this did not prevent them from engaging in mental health consumption. Much as someone might be politically active but opt not to discuss politics with a family member, respondents indicated that they were able to engage in mental health consumption, but not discuss it with stigmatizing others.</p>
<p>Much Mental Health Consumption is Informal: Consumer often engaged in personal hobbies or simple social support in order to improve their mental health, suggesting new areas to explore and new positioning for marketing practitioners.</p>
<p>Crowding Out: “Bad” coping mechanisms—those that are either ineffective, or simply distracting, or overtly harmful, often crowd out “good” coping mechanisms (i.e., those that consumers themselves recognize to be more helpful). Many respondents expressed a desire to do more for their mental health, suggesting that marketers attempting to bolster demand for mental health consumption may be pushing on an open door.</p>
<p>Therapy Comes with Frictions: While a number of participants had positive experiences with therapists, and/or still utilized them today, many also described intense search frictions in finding a therapist, mistrust of therapists (and psychiatric professionals/pharmaceutical companies), and past negative experiences with therapists.</p>
<p>Structural Barriers: Solving structural barriers to mental health consumption—such as a lack of available providers, a lack of insurance coverage, or a lack of time—is in many ways beyond the scope of the present research. Nevertheless, because these structural barriers frequently came up during our depth interviews, suggesting the need for marketers to factor them in when aiming to foster mental health consumption.</p>

Figure 1. Conceptual map of coding scheme, reflecting major areas of reporting.

