Polish Annals of Medicine

Journal homepage: https://www.paom.pl

Review Paper

The vicious cycle of depression and stigma: Sociocultural determinants and measurement challenges

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ARTICLE INFO

Article history
Received: December 20, 2025
Accepted: December 23, 2025
Available online: December 31, 2025

Keywords
Depression
Social stigma
Mental health literacy
Help-seeking behavior
Sociocultural determinants

Doi
https://doi.org/10.29089/paom/216045

ABSTRACT

Introduction: Stigma remains a major barrier to the recognition and treatment of depression, operating through sociocultural and structural mechanisms that vary across age groups. Despite widespread awareness of depression and the importance of early intervention, significant gaps persist between clinical need and access to care. Stigma contributes to delayed help-seeking, misinterpretation of symptoms, and underdiagnosis across diverse populations.

Aim: To examine how stigma functions as a dynamic, bidirectional process influencing depression identification and help-seeking among adolescents/young adults and older adults.

Material and methods: An integrative review of literature published between 2015 and 2025 was conducted using PubMed, ERIC, and Google Scholar. Twenty-seven studies meeting inclusion criteria were analyzed thematically, focusing on sociocultural determinants and measurement challenges.

Results and discussion: Stigma manifested differently across age groups: youth experienced fears of invalidation and inauthenticity, while older adults normalized distress and frequently somatized symptoms. Cultural beliefs, family honor, ageism, and structural barriers further shaped disclosure and access to care. Mental health literacy interventions showed limited impact in high-income regions but were more effective in Asian contexts.

Conclusions: Stigma sustains a vicious cycle that hinders depression recognition and treatment across the lifespan. Effective interventions must move beyond education alone and adopt culturally sensitive, trust-based approaches to promote disclosure and timely care.

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1. INTRODUCTION

Depression has become a defining global health challenge, affecting 5.7% of adults in the world. It is a common mental health disorder, which involves a depressed mood or loss of pleasure or interest in activities for long periods of time.[1] It frequently manifests during the vulnerable years of adolescence and early adulthood.[2] Despite widespread recognition of the importance of early intervention, a substantial gap persists between clinical need and available support. There is a global discrepancy across all nations, each with their own challenges and cultural obstacles. However, there is one aspect shared by them all: Stigma.

While there are other factors that may influence in the treatment of depression, the psychological wall produced by stigma remains as the main deterrent to seek help.[3] No matter the country, the age, the culture or the generation.

Stigma is the often-overlooked hindrance that accompanies and affects depression. Moreover, it is a complex sociological process that involves differences linked to negative stereotypes, leading to a possible status loss, discrimination, and a deep emotional reaction for the sufferer. For individuals with depression, this triggers a 'Vicious Cycle.' Factors such as race, gender, social roles or culture shape how symptoms are expressed and perceived by each patient, and the society around them.[4] Such perceptions can fall into the patient being called an 'attention-seeker' label in the youth or having to ignore such symptoms for the sake of family honour.[3–5]

2. AIM

To examine how stigma functions as a dynamic, bidirectional process influencing depression identification and help-seeking among adolescents/young adults and older adults.

3. MATERIAL AND METHODS

This study utilized an integrative review design to synthesize empirical and theoretical literature regarding the intersection of depression, stigma, and sociocultural determinants. A systematic search was conducted across three primary electronic databases: PubMed, ERIC and Google Scholar. The research parameters were restricted to literature published between 2015–2025 to capture a perspective that is more grounded in modern times.

The search strategy was divided into two target populations to address the different developmental stages of the 'Vicious Cycle:'

- Youth Cohort, we searched combined terms for the condition ('Depressive Disorder,' 'Major Depressive Disorder – MDD') with social factors ('Social Stigma,' 'Labelling,' 'Self-Stigma') and demographic identifiers such as ('Adolescent,' 'Generation Z,' 'Students,' 'Social media').
- Elderly Cohort, we searched terms related to late-life factors. ('Late-life depression,' 'Ageism,' 'Double Stigma') and geriatric contexts such as ('Baby Boomer,' 'Retirement,' 'Nursing Home').
- We applied additional filters to isolate clinical trials, comparative studies, observational studies and randomized controlled trials.

3.1. Inclusion and exclusion criteria

Studies were considered if they met the following criteria: If they targeted primarily on depression stigma and help-seeking behaviours. Targeted adolescents/young adults (15–24 years) or older adults (65+ years). Proved empirical data on sociocultural barriers or measurement validity.

Exclusion criteria were applied to papers focusing on general mental health without a depression-specific analysis and those for which the full text was not available after multiple retrieval attempts.

3.2. Data selection and synthesis

Following the PRISMA guidelines, a total of 388 records were identified. After removing 32 duplicates and screening 356 titles/abstracts, 42 reports were sought for the full-text assessment. Nine reports were not retrieved due to institutional access limitations. Of the remaining 33 reports, 6 were vetoed during the final critical appraisal for lacking depth with the themes regarding the 'Vicious Cycle,' resulting in a

Table 1. Database search parameters and boolean logic.

Database	Group	Search Query / MeSH Terms	Results
PubMed	Youth	("Depressive Disorder"[Mesh] OR "Depression" OR "MDD") AND ("Social Stigma"[Mesh] OR "Self Stigma" OR "Social Distance" OR "Labeling" OR "Perceived Discrimination") AND ("Adolescent"[Mesh] OR "Young Adult"[Mesh] OR "Generation Z" OR "Gen Z" OR "Students" OR "Social Media" OR "Youth") AND ("Severity" OR "Outcome*" OR "Relapse" OR "Recurrence" OR "Adherence" OR "Compliance" OR "Drop-out" OR "Discontinuation" OR "Help-seeking" OR "Access" OR "Barrier*")	63
PubMed	Elderly	("Depressive Disorder"[Mesh] OR "Depression" OR "MDD" OR "Late-life depression") AND ("Social Stigma"[Mesh] OR "Self Stigma" OR "Ageism" OR "Stereotyping" OR "Double Stigma" OR "Perceived Discrimination") AND ("Aged"[Mesh] OR "Middle Aged"[Mesh] OR "Baby Boomer" OR "Geriatric" OR "Retirement" OR "Elderly" OR "Older Adults" OR "Nursing Home") AND ("Severity" OR "Outcome*" OR "Relapse" OR "Recurrence" OR "Adherence" OR "Compliance" OR "Drop-out" OR "Discontinuation" OR "Help-seeking" OR "Access" OR "Barrier" OR "Chronicity")	65
ERIC	Youth	(Depression OR "Mental Health") AND (Stigma OR Labeling OR Bullying) AND (Adolescents OR Students OR Schools) AND (Barriers OR "Help Seeking")	160
Google Scholar	Elderly	"Depression" AND "Stigma" AND ("Baby Boomers" OR "Elderly" OR "Older Adults") AND ("progression" OR "severity" OR "relapse")	100

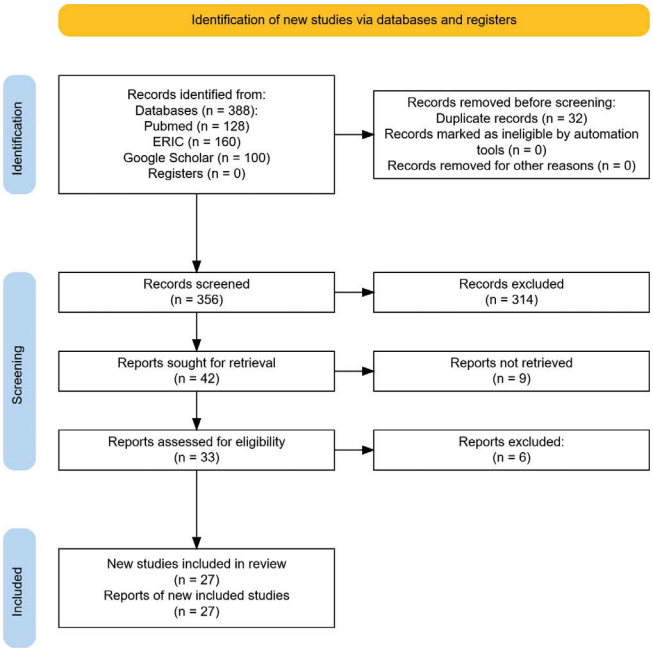

Figure 1. Identification of new studies via databases and registers (PRISMA Flow Diagram).

final data set of 27 primary studies and relevant systematic reviews retained for theoretical context. Data was acquired via a thematic analysis approach, focusing in identity factors and clinical identification.

3.3. Statistical analysis

As this study is an integrative review – which means we consolidated themes from existing literature rather than recruiting patients – statistical power analysis was not applicable. The final sample size ($n = 27$) was not calculated mathematically, but rather reflects the number of studies that met our rigorous inclusion criteria as shown in Figure 1.

4. RESULTS

The final data set consisted of 27 papers in total. The general idea of these findings reveal that stigma isn't a static barrier, bur rather a dynamic 'Vicious Cycle' that operates through different mechanisms across generations.

4.1. The sociological mechanism of stigma

This review identified that stigma is a dynamic sociological process rather than a static barrier. According to Link and Phelan's framework, stigma requires the convergence of labelling, stereotyping, separation, status loss, and discrimination.[5] This process triggers a 'Vicious Cycle" where prejudice is internalized by the sufferer, creating a 'self-stigma".[6,7] This leads to stigma stress, a chronic, psychological burden, a thought, where individuals must constantly calculate the risks of disclosing their invisible dilemma to others.[8] Research leans toward a bidirectional relationship: reducing stigma may facilitate disclosure, but the fear of judgement prevents the very disclose needed to challenge the stigma or to get treatment.[2]

4.2. 'Inauthenticity' in youth population

When it comes to the youth, the cycle of stigmatization starts with their fear of invalidation. This review found that the accusation of being an 'attention-seeker' acts as a weaponized form of stigma, framing the sufferer as deceptive rather than sick.[6]

Therefore, the dilemma of the youth has three focal patterns. Digital invalidation: Through the analysis of communities online, there is a rigid dichotomy between 'legitimate' sufferers and 'fakers.' Adolescents often must go under a 'authentication ritual' to prove their distress is real, for example, proving their BMI in the case of anorexia.[6] On the other hand, university students on Instagram reported 'faking' their behaviours by acting 'normal' to avoid the 'social risk' of vulnerability, fearing their distress would be dismissed as a performance.[9]

This external pressure would lead to an internal self-stigma, which leads to an 'imposter syndrome' regarding mental health, where the youth question themselves if they are 'sick enough' to even deserve care.[9]

Moreover, there are some key differences between gender. Adolescent females demonstrate higher 'mental health literacy,' whereas males are significantly likely to endorse and embrace stigmatizing views, often interpreting depression as a failure of willpower or masculinity.[10]

4.3. Invisibility/Tradition in Elderly Population

As a contrast, while the youth experienced a cycle of unauthenticity, the elderly experience a cycle of normalization and dismissal.

For the elderly, there is a normalization of distress, due to the fact that they see depressive symptoms as part of the 'normal aging process.' Feelings of loneliness or stress are often perceived as normal signs of aging rather than symptoms of a treatable illness, and individuals are therefore more prone to somatize their problems; as a result, emotional distress may be reported less frequently as sadness and more often as physical symptoms such as fatigue or sleep disturbances, contributing to underdiagnosis.[11,12]

At last, stigma in the elderly manifests as a stoic barrier, a rigid self-reliance. One study found that 80% of rural older adults endorsed the belief of 'I should not need help,' viewing psychologists as being only for 'people who can't help themselves.'[13,14] Health care providers realized that older adults often build a 'psychological wall' if the word 'depression' is used, referring it as 'the big D word.'[14]

4.4. Cultural and structural factors

Cultural background directly affects and reshapes the stigma experience for both groups.

Family honour is key, for example, in Asian and Latin American families, particularly in adolescents, where help-seeking is often viewed as a violation of family honour, or losing 'face,' therefore resulting in significant levels of

shame. A consequence that many of their White peers do not experience at all.[3]

Additionally, in India, a significant proportion of older adults' attribute mental illness and its qualities to 'black magic' or 'past sins,' leading them to seek help from traditional faith healers, rather than medical professionals.[15,16]

However, among the student-athlete population, there was a counter-intuitive finding. On one hand, while ethnic minorities athletes reported higher levels of personal and public stigma, this didn't predict their help-seeking behaviour.[17] On the other hand, white athletes who perceived a higher public stigma were more likely to seek help. This suggests that stigma operates differently across racial or cultural lines when it comes to athletes.[17]

4.5. Impact of interventions

By taking the peer-led intervention 'Honest, Open, Proud' (HOP) as an example, it has shown efficacy in reducing 'stigma stress' and improving quality of life, particularly for adolescents.[8] However, other interventions such as the HOPE program have demonstrated that while educational videos could reduce personal stigma immediately, the effects would often fade by an average of two months, suggesting that videos do not suffice for long term change.[18]

5. DISCUSSION

5.1. Interpreting the 'Vicious Cycle'

This review shows that the stigma isn't a barrier, but a dynamic vicious cycle that alters how individuals process their own suffering. By following the literature and its sociological framework, stigma functions by self-classification done by individuals and by the society around them, converting their differences and their problems into a status loss and/or discrimination.[5] For both groups, this prejudice is internalized and ranges from alienation, marginalization, or even a lack of desire to seek treatment by accepting their views regarding self-stigmatization. However, recent predictive modelling helps to visualize the elements of this cycle. Independent motivation is the main drive to seek help, while self-stigma serves as a deterrent.[7] Moreover, the literature indicates stigma operates through a mediation effect, it doesn't always stop behaviour directly, but it drains the patient's mental health literacy, motivation, and eventually their will to seek care before the decision is even made.[7]

5.2. The youth paradox

The biggest problem for youth is the 'Authenticity Paradox' which is found especially in the digital generation. Theoretically, the onset of mental illness averaged by age 25 years, coincides with peak social media usage, offering a window for intervention. However, stigma effectively eliminates this potential, transforming platforms that were created for connection into environments of curated concealment. University students view disclosure as a threat to their social likelihood, forcing them to sanitize their digital reality, and not speak up.[9]

This is shown by the use of euphemisms in their lingo which is observed in the data, where patients were so guarded they refused to use terms such as 'mental health,' and they'd substitute them with softer words, like 'moods' in order to avoid the 'patient' label.[9] This 'tailored silence' contrasts with the hostility found in anonymous communities, where adolescents enforce a 'toxic hierarchy,' requiring their peers to perform 'authenticating rituals' to prove they are not 'fakers' or 'attention-seekers.'[6] Furthermore, long-established gender norms remain a formidable barrier. While girls often use social groups to process their thoughts and symptoms, boys are taught to view depression as a failure of masculinity or of their strength, leading to higher stigma levels and avoidance of the 'patient' label, as they perceive it as a weakness.[10]

5.3. Elderly paradox

In a striking contrast, the elderly face a cycle of invisibility often driven more by ageism than by mental health stigma itself. Perceived age discrimination has been found to predict the degradation of health and the onset of depressive symptoms over time, operating independently of socioeconomic status.[19] Qualitative research further clarifies this, finding that older adults are often more affected by ageism than by the stigma of mental illness itself. While they may overcome public stigma to seek help, they may continue to grapple with the internalized belief that they should be able to self-manage their condition without professional support.[30] This discrimination is often systemic, healthcare professionals frequently do not recognize the signs of depression while the elderly consider depression as 'part of aging,' leading to a 'benign neglect' where symptoms are attributable to loneliness rather than illness.[20]

In non-Western backgrounds, this invisibility is convoluted by supernatural misattribution. A significant proportion of older adults in India attribute depression to a 'curse or past sin,' leading many to seek help from traditional faith healers rather than clinicians.[16] Essentially, the stigma here is 'familial,' families actively hide an elder's mental illness out of fear, because public disclosure may 'delay finalizing marriage proposals of their children,' creating a 'stigma by association.'[16] However, internet use has been shown to significantly reduce depression in older adults by widening social connections and activities.[21] In addition, older adults engage effectively with online therapy when given the training and access.[22]

5.4. Intergenerational bridge

Despite the generational gap, the experiences between the digital youth and the invisible elderly, this review identifies a profound connection in their therapeutic needs.

For the elderly, the fear of treatment is significant, yet it is counterbalanced by a key human need. The literature indicates that their concerns over potential harm from treatment were balanced against the 'desire to be listened to.' Trust and familiarity, as well as past experiences, were important in determining the form of treatment which

older people wanted. Despite the fear of stigma, talking to someone was generally viewed as helpful, and psychological therapies were positively endorsed, especially if the counsellor was perceived to be professional, nonjudgemental and trustworthy.[11]

This eventually shows an echoing result for the youth group. For adolescents, 'self-disclosure' is identified as a key process in recovery, providing a release of emotions and a sense of belonging. Just as the elderly need a 'nonjudgemental' counsellor to help them break their walls, the youth require a 'supportive, empathic, and non-stigmatising' approach to overcome their fear of labelling.[5] This connection suggests that path to break the 'Vicious Cycle' is identical across the generations: a relationship defined by trust rather than judgement.

5.5. Structural nuances

This review challenges the hypothesis that psychological stigma is the only barrier. For 'First in Family' students, the primary obstacle is often a lack of 'system knowledge' rather than a refusal to help. These students frequently navigate a solitary path where their home culture may delegitimize mental health concerns, leaving them without the necessary roadmap to access university support services.[23] This gap in literacy is common, even in healthcare systems where the medical attention is free, adolescents often mention perceived costs and a lack of knowledge, simply not knowing where to go, as their main deterrents.[24]

Correspondingly, structural realities often override psychological attitudes among student-athletes. For racial and ethnic minority athletes, higher levels of stigma did not predict a reluctance to seek help, rather, the strongest predictor of utilization was simply 'possessing insurance.'[17] Additionally, for this group, the source of stigma should be viewed a little differently. There is a critical distinction that must be made between broad public stigma and social network stigma, which, the latter is the judgement perceived specifically from teammates. The literature indicates that within these close-knit micro communities, fear of peer judgement is a unique and potent predictor of self-stigma, carrying far more weight than societal views.[25]

5.6. Efficacy of interventions

Finally, this review highlights that intervention success depends on cultural context. 'Mental health literacy' interventions appear to have limited additional benefit in high-income regions, but they are highly impactful in Asian contexts by addressing and correcting fundamental misconceptions.[26] However, cognitive education has limits, and while the HOPE program reduces personal stigma immediately, the effects tend to fade by the time the two-month follow up takes place.[18] Sustainable change requires the emotional resonance of 'contact-based' approaches to dismantle deep seated narratives such as 'weak-not-sick' belief.[27] Similarly, evaluations of the 'Inquiring Mind' program indicate that while resiliency training successfully improves coping skills, it does not necessarily lead to increased help seeking, as public stigma remains the primary structural deterrent.[29] Evaluations of school-based programs confirm this dilemma: while teacher's stigma scores may improve linearly, students may remain 'indecisive,' reflecting a developmental window where stereotypes are still forming.

6. CONCLUSIONS

(1) By improving mental health literacy through active, systematic education we have the essential tool for better prevention, diagnosis, and treatment of depression.
(2) Culturally sensitive and inclusive strategies are needed to address discrepancies in mental health outcomes in rural populations, older adults, and ethnic minorities, which also includes investing in tailored digital solutions.
(3) The gender differences in recognizing and reporting depression show the importance of targeted mental health education to ensure proper care.

Conflict of interest

The authors report no conflicts of interest.

Funding

The authors declare that no funding was received for the preparation of this manuscript.

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