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The impact of social stigmatization on health seeking behavior among susceptible groups and public health policy responses

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Abstract. The global gap in the treatment of mental disorders is huge, and the inhibitory effect of social stigma on patients' seeking help behavior is one of the key causes of this gap. However, the pathways of stigma and the effectiveness of existing interventions still lack systematic integration. This article summarizes the psychological, social, and structural triple mechanisms through which stigma affects the health seeking behavior of susceptible groups, and evaluates the main intervention strategies such as community promotion, medical service adjustment, legislative protection, and individual empowerment. Research has found that expected stigma and internalized stigma weaken the motivation to seek help, social network fragmentation cuts off support channels, institutional exclusion within the healthcare system perpetuates the stigma of seeking medical treatment, and the triple mechanism of delayed medical treatment becomes a reasonable response for individuals to the risk of exclusion. In terms of intervention, contact intervention has a good effect on improving attitudes, but most strategies are difficult to promote the transformation from attitude to actual behavior, and structural stigma adjustment is beyond the capacity of the health department. In the future, it is necessary to develop standardized measurement tools, promote the integration of interventions from a scientific perspective, and strengthen the causal assessment of health outcomes through anti stigma laws. Balancing individual empowerment with structural reform is the key to achieving measurable health improvement.

Keywords: Social stigmatization, health seeking behavior, intervention policies.

1. Introduction

In the field of mental health services, the burden of mental disorders continues to increase, and effective treatment methods already exist. However, a large number of patients still delay or even avoid seeking professional help. According to data from the World Health Organization, there is a huge treatment gap for mental disorders worldwide, with this proportion exceeding 80% in low-income countries. The reason for this gap, in addition to insufficient medical resources, is an increasingly important factor that is receiving attention, which is the inhibitory effect of social stigma on patients' seeking help behavior. That is to say, the obstacles that hinder patients from receiving appropriate care include not only the capacity limitations of service providers, but also the avoidance psychology of demanders due to fear of social exclusion [1].

Previous studies have conducted much research on the association between stigma and health behaviour. Goffman's first work defined stigma as a way in which people are socially excluded, not a flaw in character; Link and Phelan later developed a multi-factorial model to explain stigma through five interconnected links: labelling, stereotypes, discrimination, reduced social status and other forms of social exclusion. Based on this, contemporary scholars have divided the three levels of public stigma, self-stigma and structural stigma, and conducted research along the respective paths of social attitude, individualisation and institutional arrangement. There are no specific instructions on how to apply the theory of stigma effectively in public health policy at present [2] [3].

This paper will systematically integrate the psychological, social and structural mechanisms through which stigma affects health-seeking behaviour, and based on this, assess the effectiveness and applicability of existing policy interventions. This study has constructed an all-encompassing analytical chain for the generation of stigma, behavioral consequences and policy responses; thus, it

can help to bridge the gap between mechanism characterisation and intervention evaluation in previous studies and offer an integrated conceptual system for subsequent empirical research.

2. The mechanism and pathway of social stigmatization affecting health seeking behavior

2.1. Psychological mechanism

The psychological impact of stigma on health seeking behavior often begins with individuals' concerns about others' evaluations. This concern manifests as' expected stigma ', where individuals anticipate being rejected, degraded, or discriminated against when considering seeking help. This type of expectation can stimulate strong avoidance motivation. A systematic review covering multiple European countries suggests that personal level stigma significantly reduces the likelihood of individuals seeking psychological help, even if they are aware of their health issues. In the Korean male population, researchers have also found that concerns about "shame" indirectly affect attitudes towards seeking help, with self stigma playing a complete mediating role. In other words, what really makes people retreat is often not the disease itself, but the social consequences that may arise after being discovered to be sick [4].

Compared to expected stigma, the impact of 'internalized stigma' is more profound. When individuals internalize societal biases towards their group as their own cognition, they are prone to forming negative beliefs such as ‘I am not worth being treated 'or' it is useless to treat people like me '. Clement et al.'s meta-analysis showed a significant negative correlation between stigma and seeking help behavior, and this relationship persisted throughout an individual's entire life cycle. Self stigma not only weakens people's willingness to seek help, but also directly reduces their self-efficacy, causing individuals to no longer believe in their ability to change their current situation.

Shame and emotional avoidance are another key influencing pathway. For many susceptible groups, seeking medical attention proactively often means openly acknowledging their "deficiency". In the elderly population with dementia, stigmatization can lead to social and psychological problems such as loneliness and depression, and some people may even actively avoid socializing or deliberately concealing their condition. This avoidance behavior not only delays the timing of treatment intervention but may also form a vicious cycle: worsening symptoms increase shame, and stronger shame further exacerbates avoidance behavior [5].

2.2. Social mechanism: Relationship breakdown and information isolation

The impact of stigma is not limited to the individual's inner self; it can also reshape their social network. Among them, the lack of "quasi social support" caused by social network rupture is an important mediating path for stigma to affect health seeking behavior. When individuals are excluded due to their stigmatized characteristics or have a premonition of being excluded, the emotional and informational support they receive from family members, friends, and neighbors will significantly decrease. A study on grassroots healthcare workers in China found that social support partially mediates the relationship between mental health literacy and attitudes towards seeking help, while mental illness stigma weakens the positive effects of social support.

Another noteworthy phenomenon is concealment behavior at the family level. In the context of East Asian culture, there is often a situation in the care of dementia where family members, out of embarrassment, actively assist patients in concealing their condition, delaying medical treatment, or seeking help through informal channels. This' collusive concealment 'not only causes patients to miss the best opportunity for early intervention but also creates communication taboos within the family. Research shows that one in four people believe that dementia is preventable, and this misconception is also quite common among healthcare providers [5].

2.3. Structural Mechanisms: Institutional Exclusion and Resource Barriers

Structural stigma is the most concealed and difficult aspect to change among all types of stigma. Within the healthcare system, discriminatory behavior can manifest in various forms, such as doctors treating stigmatized groups differently, lacking necessary privacy protection in the medical environment, or leaving stigmatized records through "special tags" in electronic medical records. A study found that structural barriers, including insufficient social support and geographic differences in service accessibility, are important factors affecting the seeking behavior of European populations. When the healthcare system itself becomes a source of threat, susceptible groups choosing to avoid seeking medical attention is actually a rational response strategy [6].

3. Response strategies and effectiveness evaluation of public health policies

3.1. Community and Social Dimensions

Among various decontamination strategies, contact intervention is currently the most supported by evidence. The core mechanism is to reduce prejudice and stereotypes in the public's minds by allowing members of stigmatized groups to share their experiences or personal statements. The results of the meta-analysis indicate that exposure intervention is more effective in changing people's attitudes than simple knowledge education. A study on online anti stigma intervention targeting adolescents also found that online forms of intervention have a significant effect on reducing public stigma. Although their effect on improving self stigma is relatively limited, overall, they still help to increase willingness to seek help and positive attitudes [7].

In contrast, there is still much controversy over the actual effectiveness of anti stigma movements in the field of mass communication. A prominent issue is that there is often a clear "asynchrony" between knowledge improvement and attitude change: the public may have acquired the correct disease knowledge, but their emotional biases remain strong. A systematic review targeting the age group of 14 to 25 suggests that although online interventions can be considered a "routine success" in reducing public stigma, there are significant differences in quality among studies, which to some extent limits the generalizability of the conclusions.

Legislative protection is an important institutional tool for promoting stigmatization. The establishment of anti discrimination laws and privacy protection laws (such as the HIPAA Act in the United States) aims to reduce structural stigma at the legal level. However, there is often a gap between the "paper effect" of the law and its "actual protective effect". The existence of legal provisions does not automatically translate into a sense of security that stigmatized groups truly feel, especially in situations where law enforcement is insufficient or where social norms conflict with legal provisions.

3.2. Medical System Level: Stigma Safe Medical Environment

Reduce structural stigma by altering the working mode of the service. Drug-addicted individuals are a typical case; under the "low-threshold service" model, the prerequisites for traditional treatment have been reduced (e.g., no longer requiring complete abstinence), and instead, non-judgmental counseling and support are offered. This service design considers the actual circumstances of addicts and promotes a change in service philosophy from a "punitive logic" to a "caring logic".

Task transfer and task sharing can be used to increase the convenience of the service. Train non-specialist medical staff, such as community health workers, to offer basic mental health services and thus reduce the sense of shame patients feel about seeking specialist care. Given the constraints of low- and middle-income countries, this way will help expand service coverage more easily.

The Foundation of Trust Between Doctors and Patients is Increased Protection of Privacy and Informed Consent. Specifically, measures have been taken to set up a hierarchy of permissions for electronic medical records, open an anonymous diagnosis and treatment window, and promote the

de-tagging of medical treatment processes. Anonymity is also a reason why some young people are hesitant to ask for help. When people believe that their "stigmatised identity" in the healthcare system will not be disclosed, they are more willing to seek medical help [8].

3.3. Individual and Behavioral Dimensions: Empowerment and Coping

The main goal of self-help training and resilience training is to enhance individuals' psychological skills in coping with stigma. The basic logic behind such interventions is that even if external stigma cannot be eliminated in the short term, individuals can still reduce the internalized harm caused by stigma through strategies such as cognitive restructuring and emotional regulation. However, this path also faces the risk of blaming the victim, which may shift the responsibility for the problem from the social structure level to the individual psychological level.

Online health services and anonymous mobile applications have shown certain advantages in reducing perceived stigma. Due to its de materialization feature, telemedicine allows individuals to avoid exposing their identities in public waiting areas. However, this model also has obvious limitations, including uneven service quality, the absence of regulatory mechanisms, and the inequality of services caused by the digital divide. For the elderly population with dementia, the barrier to technological use may actually exacerbate their isolation.

3.4. Effect evaluation

The comprehensive evaluation of existing intervention measures reveals two prominent issues. The first issue is that most interventions still remain at the cognitive level, and the evidence for behavior change is relatively weak. A systematic review pointed out that although there are a large number of measurement tools currently in use (over 750 stigma measurement tools), most of them mainly focus on attitude measurement and are clearly insufficient in tracking actual help seeking behavior. The "intention behavior gap" between attitude and behavior is the core challenge faced by de stigmatization interventions.

The second issue is that changes in structural stigma often exceed the capacity of a single health department. The root of stigma is deeply embedded in broader social structures such as poverty, housing discrimination, employment discrimination, and the criminal justice system. If the sanitation department's decontamination project does not simultaneously address these structural factors, its effectiveness will inevitably be limited. As pointed out by a systematic review, current research still lacks sufficient attention to the driving factors of structural stigma [9][10].

4. Challenges and Future Research Directions

4.1. Limitations

There is a fundamental strategic controversy surrounding the intervention of decontamination naming, which is whether to focus on "repairing individuals" or "transforming the environment", and these two approaches each have obvious limitations. Individual level empowerment interventions may strengthen the "self responsibility" of stigmatized victims, shifting the root of the problem from the social structure to the individual psychological level. In contrast, structural reforms at the environmental level often progress slowly and involve complex political and economic games, making it difficult to achieve significant results in the short term. In addition, there is a cautionary "rebound effect" during the intervention process. During the promotion process of the de stigmatization project, it may actually reinforce the "special" label of minority groups. When the public is repeatedly told that 'a certain group should not be discriminated against', this statement itself may solidify the implicit assumption that 'this group is indeed different'. This paradox suggests that intervention design needs to be wary of the risks brought by "over labeling".

There are still three prominent gaps in current research, which limit the depth and breadth of knowledge accumulation in this field. Firstly, there is a severe lack of empirical data in low - and

middle-income countries. The existing research on stigma is highly concentrated in high-income countries, with only 15.2% of the tools focused on tool development in a systematic review of 2267 studies, and most of them were completed in high-income contexts. The operational logic of stigma in different cultural contexts may have fundamental differences, but the current understanding of this is still insufficient. Secondly, long-term tracking studies from "stigma perception" to "actual medical behavior" are relatively scarce. Most studies use cross-sectional designs, making it difficult to establish clear causal relationships. There is a complex mediating and moderating mechanism between attitude questionnaire responses and actual actions, and existing research still lacks in-depth characterization of this. Thirdly, there is a relative lack of mixed design studies on multi-level interventions. Stigma itself is a phenomenon that operates across levels, but most interventions only target a single level within individuals, communities, or policies. Future research requires more complex designs to test the synergistic effects between multi-level interventions.

4.2. Future research directions

Based on the above analysis, the following three directions are proposed for future research. The first is to develop standardised instruments for measuring stigma behaviour that can be applied to all diseases and groups of people. Construct a reasonable system of measurements for the results of all relevant studies to provide a stable basis for meta-analysis. The second direction is to adopt a scientific approach and determine how to integrate the proven effective de-stigmatisation intervention into the existing health service system.

Thirdly, study policy diffusion and, given the different political system backgrounds, examine the causal effects of anti-stigma laws on health outcomes. The above studies provide certain references for the development of evidence-based anti-discrimination measures.

5. Conclusion

This paper systematically examined the multi-level pathways of social stigmatisation for health-seeking behaviour among vulnerable groups and evaluated the effectiveness and limitations of existing public health intervention strategies based on this. According to the three levels of psychology, society and structure, it can be concluded that stigma is not only a problem of individual psychology but also a systemic issue affecting people's daily lives, social networks and institutional design. Anticipation of stigma and internalised stigma have both reduced people's willingness to seek help and cut off sources of emotional and informational support through the loss of social networks. Institutional exclusion in the healthcare system makes medical behaviour itself an extension of the stigma experience. The overlapping effect of the triple mechanism shows that the delay or avoidance of health-seeking behaviour is, to some extent, a rational response to the risk of exclusion, rather than an irrational choice.

At the intervention level, existing evidence shows that contact intervention has a relative advantage in improving public attitudes, while legal protection and service model innovation have institutional potential, but their actual effects are deeply influenced by situational factors such as law enforcement strength, social norms, and service execution quality. However, most interventions still remain at the level of cognitive change, and the transition from attitude change to behavior improvement is not smooth, and the adjustment of structural stigma has clearly exceeded the scope that a single health department can reach. Based on the above judgment, future research needs to focus on developing standardized measurement tools across diseases and populations, promoting the integration of interventions from a scientific perspective, and strengthening the causal assessment of the impact of anti stigma laws on health outcomes. Only by placing equal importance on individual empowerment and structural reform can de stigmatization strategies truly translate into perceptible health improvements for susceptible populations.

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