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Gender Differences in Depression and Suicide Stigma: Implications for Help-Seeking and Mental Health Care

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ABSTRACT

Depression and suicide are major global public health concerns that contribute to disability, mortality, and reduced quality of life (Ferrari et al., 2014). Despite the availability of effective psychological and pharmacological treatments, many individuals experiencing depression or suicidal thoughts do not seek professional help. Stigma represents one of the most significant barriers to treatment. This literature review examines gender differences in stigma surrounding depression and suicide and explores how these differences influence help-seeking behaviors. Studies conducted across university, medical, and community populations in several cultural contexts find that men consistently report higher levels of public stigma toward depression and suicide, greater embarrassment about seeking professional help, and lower intentions to seek professional mental health services than women. Evidence further suggests that traditional masculine norms, gender socialization, and lower mental health literacy contribute to these differences. However, although women generally demonstrate lower public stigma, they may experience greater perceived stigma in relation to their own mental health. The reviewed literature also indicates that increased mental health literacy and personal experience with depression are associated with more positive attitudes toward treatment and reduced stigmatizing beliefs. Together, these findings highlight the importance of developing gender-sensitive anti-stigma interventions, improving mental health education, and implementing policies that encourage earlier engagement with mental health services. Future research should employ longitudinal and more diverse study designs to better understand the mechanisms underlying gender differences in mental health stigma.

INTRODUCTION

Depression and suicide are severe global health challenges associated with high mortality. Depressive disorders are a leading cause of global disability, while suicidal behaviors claim hundreds of thousands of lives annually (*World Health Organization*, n.d.). Although effective psychological and pharmacological treatments exist, a substantial proportion of individuals experiencing depressive symptoms or suicidal thoughts do not seek professional treatment. One major barrier to seeking mental health care is social and internalized stigma. Stigma creates psychological, social, and structural limitations to care. Furthermore, stigmatizing attitudes do not develop equally across populations; gender shapes both the prevalence of stigma and the experience of public judgment.

This paper reviews research examining gender differences in stigma surrounding depression and suicide and discusses how these differences influence help-seeking behaviors, highlighting implications for healthcare, anti-stigma interventions, and clinicians. The paper first reviews depression and suicide, including their prevalence and common methods of measurement, before examining gender differences in stigma across diverse populations. It then examines the sociocultural and structural factors that contribute to these differences and concludes by discussing implications for clinical practice, public health policy, and future research.

LITERATURE SEARCH AND STUDY SELECTION

A narrative literature review was conducted between July and August of 2026 to examine gender differences in depression and suicide stigma, with attention to public and self-stigma, help-seeking attitudes, mental health literacy, and sociocultural factors. Relevant literature was identified through PubMed, Google Scholar, JAMA, and ScienceDirect using combinations of terms including *gender, sex, men, women, depression, suicide, stigma, help-seeking,* and *mental health literacy*. Studies were included when they examined depression or suicide in relation to gender and reported findings relevant to stigma, help-seeking, or related sociocultural factors. Studies were excluded when they (a) did not address depression, suicide, or help-seeking; (b) did not provide findings relevant to gender differences; (c) consisted primarily of opinion, commentary, or nonempirical material, unless included to provide contextual background; or (d) were unavailable in English. Additional studies were identified through reference-list searches and citation tracking. Findings were synthesized thematically across study designs and populations, including university students, medical students, psychiatric patients, online respondents, and community samples from multiple countries. During synthesis, attention was given to differences in cultural setting, participant age, educational background, clinical status, and the way each study defined and measured sex or gender. However, race and ethnicity, socioeconomic status, sexual orientation, and gender diversity were inconsistently reported across the included studies, limiting the review's ability to compare findings across these characteristics.

DEPRESSION, SUICIDE, AND MENTAL HEALTH STIGMA

Depression is classified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as a depressive disorder characterized by persistent low mood, anhedonia, cognitive impairment, and feelings of worthlessness. Researchers and clinicians use self-report tools such as the Patient Health Questionnaire (PHQ-9), the Beck Depression Inventory (BDI/BDI-II), and the Center for Epidemiologic Studies Depression Scale (CES-D) to assess symptom severity. Depression is identified as a primary contributor to global suffering, but a large portion of affected individuals remain untreated because of stigma and fear of judgment. Suicidality encompasses several distinct events, including passive thoughts of death, active suicidal ideation, suicide planning, nonfatal suicide attempts, and death by suicide. Researchers use scales like the Literacy of Suicide Scale (LOSS / LOSS-SF), the Stigma of Suicide Scale (SOSS / SOSS-SF),

and the Self-Stigma of Depression Scale (SSDS) to evaluate knowledge, attitudes, and stigma surrounding suicide.

A well-documented phenomenon is the gender paradox of depression and suicide (Qu et al., 2024). Women report higher rates of depressive symptoms and are diagnosed with major depressive disorder at about twice the rate of men (Albert, 2015). Women also show higher rates of non-fatal suicide ideation and attempts (Carretta et al., 2023). Men, however, die by suicide at much higher rates than women (Carretta et al., 2023). This disparity is driven in part by gender biases, differing coping behaviors, and social expectations that discourage men from revealing emotional vulnerability or seeking professional support. Much of the existing literature relies on cross-sectional surveys administered to university students, medical students, and community samples, allowing researchers to compare attitudes across demographic groups. For example, studies involving Chinese medical students found that male students consistently reported higher personal stigma toward depression than their female counterparts despite both groups of participants receiving advanced healthcare training (Qiu et al., 2022). Likewise, surveys of a Canadian general population found that male participants expressed more negative attitudes toward depression and were less willing to interact with individuals experiencing depressive symptoms (Wang et al., 2007). Community-based studies produced similar patterns, suggesting that gender differences in depression stigma are not confined to educational settings but persist in broader populations (Al-Shannaq & Aldalaykeh, 2023; Barney et al., 2006; Kulesza et al., 2014; Ludwig et al., 2020; O'Donnell et al., 2025; Oliffe et al., 2016). Although these studies differ in their cultural contexts and participant populations, they consistently demonstrate that men exhibit greater public stigma toward depression and are less likely to endorse professional treatment than women.

Several sociocultural and structural explanations have been proposed to explain these differences. From an early age, boys and girls are socialized to express emotions differently. Girls are generally encouraged to communicate emotional distress and seek support, whereas boys are more often rewarded for independence, restraint, and toughness. These expectations continue into adulthood, where traditional masculine norms discourage vulnerability and reinforce the belief that emotional suffering should be managed privately (Seidler et al., 2016). Structural factors further reinforce these attitudes through limited male-focused mental health campaigns, workplace cultures that discourage emotional disclosure, and stereotypes portraying help-seeking as incompatible with masculinity. Together, these sociocultural influences help explain why men report lower rates of professional help-seeking despite psychological distress.

GENDER DIFFERENCES IN DEPRESSION STIGMA

Stigma occurs when personal qualities are linked to negative stereotypes, resulting in social rejection and discrimination. Stigma is categorized into three dimensions: public stigma, self-stigma, and structural stigma. When unchecked, stigma delays treatment seeking, increases social isolation, and worsens clinical risks. Across multiple empirical studies, patterns emerge regarding gender, public perceptions,

internalized stigma, and help-seeking behaviors. Although researchers use different stigma measures, including the DSS, the SOSS, and warmth ratings, the findings converge across studies. Regardless of differences in country, age, or educational background, men consistently report more stigmatizing attitudes towards depression and suicide than women, suggesting that these patterns are consistent across diverse populations.

Public attitudes toward individuals with depression depend on whether the target individual is male or female. Felder et al. surveyed adult participants using standardized attitude and warmth-rating measures to examine whether perceptions differed based on the gender of a hypothetical individual experiencing depression. Felder et al. demonstrated that the general public holds significantly more negative attitudes and feels substantially less warm toward depressed men compared to depressed women (Felder et al., 2017). This effect aligns with gender stereotype literature, such as the "women are wonderful" effect, in which female targets generally cause warmer public feelings than male targets (Krys et al., 2018). When men experience depression, public judgment is especially harsh because depressive symptoms like crying, expressing emotional weakness, and loss of functioning conflict with traditional expectations of masculinity. Furthermore, Felder et al. showed that gender differences persist across specific life stages such as the perinatal period. While perinatal depression affects about 20% of mothers and 10% of fathers, fathers experiencing depression often face stigma due to perceived violations of the provider role of a father (Felder et al., 2017). Canadian surveys using the DSS revealed that a greater proportion of male respondents endorsed stigmatizing statements, such as viewing depressed men as "unpredictable" or possessing a "personal weakness," compared to female respondents (Oliffe et al., 2016). Importantly, these findings were observed among respondents without direct personal experience with depression, suggesting that stigmatizing beliefs are often rooted in broader stereotypes rather than lived experience. Among Chinese medical students, researchers used the DSS to compare personal stigma across genders. Male students again reported significantly higher stigma scores than female students and were more likely to endorse statements indicating reluctance to support or befriend individuals experiencing depression (Qiu et al., 2022). Because these participants were future healthcare professionals, these findings suggest that stigmatizing attitudes may persist even among individuals receiving medical education. The consistency of these findings across different populations strengthens the conclusion that gender differences in depression stigma are widespread rather than population-specific. While the magnitude of stigma varies across cultural settings, the overall pattern of men expressing greater public stigma toward depression remains consistent.

SOCIOCULTURAL AND STRUCTURAL CONTRIBUTORS TO GENDER DIFFERENCES

Traditional masculinity norms also play a central role in driving mental health stigma. Societal ideals promote self-reliance, emotional resilience, physical toughness, dominance, and invulnerability, all traits that can be jeopardized by depression or suicidal thoughts. In a study examining university men, O'Donnell et al. explored how specific parts of conformity to masculine norms (assessed via the

Conformity to Masculine Norms Inventory [CMNI]) correlate with suicide literacy, suicide stigma, and help-seeking. Their regression models showed greater conformity to masculine norms such as power over women, dominance, and heterosexual self-presentation predicted higher stigma (O'Donnell et al., 2025). Stronger adherence to self-reliance and emotional control served as barriers to seeking professional treatment. When men experience severe depressive symptoms, adhering to masculine norms creates psychological conflict. Acknowledging a need for help is interpreted as a personal failure or loss of control, reinforcing self-stigma. Oliffe et al. showed that men endorse significantly higher embarrassment about seeking professional help for depression (56.6% in men vs. 39.4% in women) and greater shame if others were to find out (Oliffe et al., 2016).

Gender socialization, the process beginning in early childhood by which individuals internalize the social norms, behaviors, and attitudes associated with their assigned gender, likewise contributes to the gap between male and female stigma and help-seeking. Parents, schools, peers, and media often reinforce different expectations for emotional expression among boys and girls. Over time, these social expectations become internalized and influence how individuals interpret depression, whether they perceive professional treatment as acceptable, and how they judge others experiencing mental illness. Therefore, gender differences in stigma reflect lifelong processes of socialization that shape emotional behavior.

Mental health literacy, which covers knowledge of psychiatric symptoms, causes, risk factors, and available treatments, acts as a counterweight to stigma. Lower suicide literacy measured via the LOSS scale correlates with higher suicide stigma and more negative help-seeking attitudes (Al-Shannaq & Aldalaykeh, 2023; O'Donnell et al., 2025). Studies among young adults and university students show that improving literacy reduces public prejudice and fosters help-seeking. Personal history with depression often decreases public stigma and increases empathy towards others, but can also increase self-stigma as individuals absorb societal prejudices and experience shame regarding their own mental health state (Oliffe et al., 2016). Access to healthcare, workplace norms, and public health messaging all shape attitudes toward treatment. Many existing awareness campaigns emphasize general mental health education but do not specifically address barriers faced by men, such as fears of appearing weak or losing social status. Consequently, these structural barriers interact with cultural expectations to perpetuate lower rates of help-seeking among men despite mental health needs.

Cultural context may also shape how gender influences depression and suicide stigma. Although studies conducted in China, Canada, Ireland, and Arabic-speaking populations have generally identified gender differences in stigmatizing attitudes, the size and form of these differences vary across settings. Cultural expectations surrounding masculinity, emotional expression, family reputation, religion, and professional treatment may affect whether depression is viewed as an illness and whether seeking help is considered socially acceptable. Research conducted among specific populations in Latin America, South Asia, and Africa similarly suggests that mental-health stigma is influenced by community beliefs, access to mental-health education, and the availability of professional services (Peluso and Bay, 2009; Vaishnav et

al., 2023; Faleti and Akinlotan, 2025). These findings indicate that gender does not operate independently of culture. Expectations placed on men and women may strengthen, weaken, or alter gender differences in stigma. However, research remains unevenly distributed across regions, making broad cross-cultural conclusions difficult.

SYNTHESIS AND LIMITATIONS OF EXISTING RESEARCH

While the current literature provides important insights, several limitations must be considered. The survey instruments used in the current studies are susceptible to social desirability bias, where respondents underreport stigmatizing beliefs. These studies use varying stigma scales, making direct comparisons challenging. A significant portion of studies rely on undergraduate samples or online panels, limiting generalizability across broader populations. Additionally, the predominance of cross-sectional, self-reported survey designs prevents researchers from determining whether stigma leads to poorer mental health outcomes over time or whether experiencing depression instead increases self-stigma. More longitudinal and observational research is needed to clarify the causal relationship between gender, stigma, mental health literacy, and help-seeking.

The reviewed literature also gives limited attention to socioeconomic differences. Income, insurance coverage, transportation, provider availability, and prior access to mental health education may influence both attitudes towards treatment and the ability to receive care. Consequently, apparent reluctance to seek treatment should not always be attributed to stigma alone, as structural barriers may prevent individuals from acting on otherwise favorable attitudes.

Another important limitation is that the majority of studies conceptualize gender as a binary variable, comparing only male-identifying and female-identifying participants. Consequently, nonbinary and gender-diverse individuals are largely absent from the literature. This omission limits the generalizability of current findings, particularly given evidence that LGBTQ+ populations experience high rates of depression, suicidality, and barriers to accessing mental health care (Cai et al., 2024). Future research should adopt more inclusive measures of gender identity to better understand how stigma operates across diverse gender identities and sexual orientations.

CLINICAL AND POLICY IMPLICATIONS

Stigma delays treatment, causing men to rely on potentially harmful coping strategies or ignore symptoms instead of seeking clinical services (McKenzie et al., 2022). To mitigate this, clinicians must reframe mental health support in ways that align with healthy masculine values. Positioning treatment as a tool for strength, emotional regulation, and protection reduces the shame associated with perceived weakness. Health professionals must recognize that male patients frequently experience depression through irritability or substance use rather than just sadness (Mayo Clinic Staff, 2024). Creating non-judgmental clinical environments builds trust and encourages honest self-reporting. Routine depression screenings

during annual physical examinations and visits for unrelated medical concerns can help identify individuals who may otherwise remain untreated.

At the policy level, public health agencies should design anti-stigma programs tailored to male audiences. Because standard, gender-neutral mental health campaigns often fail to reach men effectively, educational campaigns should feature male peers, role models, and community leaders discussing emotional struggles to normalize help-seeking behavior (Camacho-Ruiz et al., 2026). Implementing suicide literacy and mental health awareness programs in high schools, universities, and community centers can help to address gender stereotypes early in life. The finding that medical students also expressed stigmatizing attitudes toward depression and suicide suggests that medical education should incorporate training on mental illness stigma, gender-sensitive communication, and suicide prevention.

Education may provide another avenue for reducing depression and suicide stigma. Age-appropriate school programs could improve mental health literacy, normalize help-seeking, and challenge gendered beliefs that associate emotional disclosure with weakness. Involving parents and caregivers may help extend these conversations into families. Similar principles could be incorporated into workplace training and well-being initiatives, provided that these programs offer practical routes to confidential professional support rather than relying only on general wellness campaigns.

CONCLUSION

Ultimately, the evidence reviewed suggests that reducing stigma requires interventions at multiple levels. Individual education can improve mental health literacy, clinicians can create more supportive treatment environments, and policymakers can develop campaigns that challenge harmful gender stereotypes surrounding emotional vulnerability. Addressing both the cultural expectations placed on men and the structural barriers within healthcare systems is likely to improve treatment engagement and reduce the burden of depression and suicide across populations.

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