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WHY THE SILENCE? MULTIDIMENSIONAL BARRIERS AND AN INTEGRATED EXPLANATION FOR THE AVOIDANCE OF OFFLINE PROFESSIONAL HELP AMONG INDIVIDUALS WITH DEPRESSION: A NARRATIVE REVIEW

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Abstract: Many individuals with depression who need treatment do not seek professional help. This paper systematically reviews the main barriers to offline help-seeking among people with depression through a literature review and provides an integrated analysis from the perspectives of individual psychology, cognition, structural factors, sociocultural context, and digital environment. The findings show that stigma, fear of seeking help, structural barriers, cognitive biases, personality traits, and the substitution effect of the digital environment interact to create a complex, layered barrier to help-seeking. Although existing interventions can help improve help-seeking intentions, they often fail to convert these intentions into actual help-seeking behavior, revealing an "intention-behavior gap." This paper also proposes an integrated explanatory framework and offers implications for digital mental health services and science communication.
Keywords: Depression; Help- seeking behavior; Treatment gap; Stigma; Digital mental health; Literature review

1 INTRODUCTION

Depression is a common mental health condition. It involves a persistent low mood or loss of enjoyment and interest in activities. Depression is different from typical mood swings and everyday emotions. It can impact all areas of life, including relationships with family, friends, and the community. It may be caused by or lead to problems at school and work.

Depression is one of the mental disorders with the highest disability rates worldwide. A 2017 World Health Organization (WHO) report showed that the global number of people with depression increased by 18% between 2005 and 2015. WHO stated that the illness affects individuals of all ages, backgrounds, and countries, and it is the leading single contributor to global disability. Dr. Dan Chisholm of the WHO Department of Mental Health explained that depression is highly stigmatized, leading to its under-recognition and undertreatment. He pointed out that the treatment gap is especially large in low-income countries, where "more than 90% of those who could benefit from treatment do not receive it." Dr. Chisholm also mentioned that depression accounts for about 7.5% of the global disability burden and is a major cause of death by suicide[1].

However, the WHO overview on depression shows that in low- and middle-income countries, more than 75% of people with mental disorders do not get treatment [2]. This "treatment gap" not only causes personal suffering but also creates a large socioeconomic burden.

The 2025 WHO report states that depression can affect anyone. People who have experienced abuse, severe losses, or other stressful events are at a higher risk of developing depression. It is estimated that about 332 million people worldwide suffer from depression [3].

Strangely, even when mental health services are available, many people with depression still choose not to seek help. They may recognize their emotional issues and even complete online depression self-assessments, yet they hesitate to go into a counseling room or psychiatric outpatient clinic [4]. This "cognition-behavior gap" raises a key question: What exactly blocks help-seeking among people with depression?

Existing research has examined help-seeking barriers from various angles: stigma is seen as the most central factor [5-6]; structural barriers such as cost and accessibility are also significant [7]; and cognitive biases and personality traits are important as well [8]. Recently, the growth of digital mental health services has brought a new perspective: do anonymous self-help tools inadvertently replace professional help-seeking [9-10]?

This paper aims to systematically review the literature, synthesize the multidimensional barriers to offline help-seeking among individuals with depression, propose an integrated explanatory framework, and identify implications for improving help-seeking behavior. This paper does not involve primary data collection and is a theoretical and exploratory analysis.

2 METHODS

2.1 Literature Search Strategy

This study uses a narrative review approach to systematically examine the literature on help-seeking barriers among individuals with depression. The search databases include PubMed, Web of Science, APA PsycINFO, and CNKI, with a search cutoff date of April 2026. Search terms included: “depression” OR “depressive disorder” AND “help-seeking” OR “treatment seeking” OR “barriers” OR “stigma” OR “service utilization.” Classic literature and recent high-quality studies were also included.

2.2 Inclusion Criteria

Inclusion criteria for the literature were as follows: (1) study participants included individuals with depression or depressive symptoms; (2) the research focused on help-seeking behavior, barriers to help-seeking, or the treatment gap; (3) the publication was an original research article, systematic review, or meta-analysis; (4) the publication language was Chinese or English.

Literature quality screening criteria: To ensure the academic quality and reliability of the included literature, this study prioritized the selection of articles published in journals classified as Chinese Academy of Sciences (CAS) Tier 1 or Tier 2 (or the corresponding JCR Q1/Q2 categories). Two authors independently verified the journal classifications of the articles, and any disagreements were resolved through discussion. Only articles that passed the tier-based screening proceeded to the thematic analysis stage; those that did not meet the tier criteria were excluded. This screening strategy was designed to control literature quality at the source and thereby enhance the robustness of the review’s conclusions.

2.3 Analytical Framework

This study used a thematic analysis to categorize the help-seeking barriers into five areas: the Individual-Psychological Level, the Cognitive Level, the Socio-cultural Level, the Structural Level, and the Digital Environment Level. Building on this classification, an integrated framework showing how these barriers interact was proposed (see Section 4.2, Figure 2).

2.4 Specific Process of Thematic Analysis

Both authors (first and second) participated in the entire thematic analysis process. First, prior to formal coding, the two authors independently conducted a pilot coding of 5 representative articles and reached a unified understanding of the initial coding framework through discussion. Second, during the formal coding stage, the two authors independently coded the full texts of all included articles using NVivo 15 software. The coding employed a combined inductive-deductive approach: deductive coding was performed based on 5 pre-established dimensions (individual-psychological, cognitive, socio-cultural, structural, and digital environment), while inductive coding was applied to capture new or recurring concepts emerging from the literature that fell outside the pre-set framework. Any coding disagreements were resolved through discussion and negotiation.

Based on the coding results, the two authors further conducted thematic synthesis and theoretical construction. Specifically, similar concepts from the coding results were grouped into sub-themes. For example, ‘public stigma’ and ‘self-stigma’ were grouped under the subtheme ‘stigma’. Subsequently, based on these sub-themes and guided by theoretical perspectives, an integrative analysis was performed to extract higher-level themes. It should be noted that the extraction of sub-themes was not a mere aggregation of data, but rather an analytical synthesis grounded in the coding results and informed by the research question and theoretical framework of this study. Through iterative comparison and discussion, the final multi-dimensional thematic framework of barriers was established.

2.5 Descriptive Distribution of the Coding Results

Following independent coding by the two authors, a total of 388 reference points were generated across the 34 included literature sources, distributed among the 5 pre-defined dimensions. The number of literature sources covered and the distribution of reference points for each dimension are presented in Table 1.

Table 1 Distribution of Coding Reference Points Across Dimensions

Dimension	Number of literature sources	Number of reference points	Percentage	Mean reference points per source
Individual-psychological level	13	134	34.50%	10.3
Cognitive level	11	82	21.10%	7.5
Structural level	7	68	17.50%	9.7
Digital environment level	11	71	18.30%	6.5
Socio-cultural level	5	33	8.50%	6.6

Dimension	Number of literature sources	Number of reference points	Percentage	Mean reference points per source
Total	47	388	100.0%	—

Note: Some literature sources were coded into multiple dimensions; therefore, the sum of the number of sources across dimensions (47) exceeds the total number of included sources (34).

As can be seen from the distribution, the individual-psychological level (centered on stigma, fear of help-seeking, and personality traits) accounts for the highest proportion of reference points (34.5%), confirming the consensus in the literature that stigma is the most central barrier [5-6]. Thirteen literature sources address this dimension, with an average of 10.3 reference points per source, indicating that stigma and related psychological barriers are discussed with high frequency across the majority of the literature. The cognitive level (problem recognition bias, treatment expectations, and metacognitive beliefs) appears in eleven literature sources, representing 21.1% of the reference points, reflecting that cognitive factors are commonly referenced in help-seeking decisions. The structural level (economic cost, geographic accessibility, waiting time) is covered in only seven literature sources, yet accounts for 17.5% of the reference points, with an average of 9.7 points per source, suggesting that this dimension constitutes a classic and stable type of barrier. The digital environment level is covered in eleven literature sources (comparable to the cognitive level), accounting for 18.3% of the reference points. This indicates that substitution effects and trust issues related to the digital environment are mentioned in a considerable number of literature sources; however, the average number of reference points per source is relatively low (6.5), indicating that the depth of discussion on this dimension is relatively dispersed across individual sources. The socio-cultural level has the lowest proportion (8.5%), with only five literature sources addressing this dimension. This reflects a relative scarcity of systematic research on culturally specific barriers such as family values and cultural taboos, or may also suggest that such barriers are often subsumed under the dimension of stigma in the existing literature.

3 MULTIDIMENSIONAL BARRIERS TO HELP-SEEKING AMONG INDIVIDUALS WITH DEPRESSION

3.1 Individual-Psychological Level: Stigma and Fear of Help-Seeking

Stigma is widely seen as the main obstacle to help-seeking among people with depression. It can be divided into two types: public stigma, which involves negative stereotypes and discrimination from society against those with mental illness; and self-stigma, which is when individuals internalize public attitudes, resulting in shame, self-blame, and self-deprecation [5]. Research indicates that stigma is a key barrier that causes patients to abandon mental health treatment; it greatly decreases help-seeking intent and makes patients more likely to hide symptoms instead of seeking help. The literature clearly states that the link between stigma and help-seeking behavior is moderate ($d = –0.27$), with internalized stigma (believing stigmatizing views about oneself) and treatment stigma (the stigma associated with seeking or receiving mental health treatment) showing the strongest association with decreased help-seeking behavior [6].

Studies on cognitive behavioral therapy indicate that stigma is closely related to coping styles. Patients who tend to use avoidance and fantasy have stronger stigma, whereas those who actively solve problems have weaker stigma [11]. This suggests that stigma is not only a barrier to help-seeking but also interacts with the course and recovery of depression.

Fear of help-seeking is another key psychological barrier. Many patients worry about being labeled as “mentally ill,” facing discrimination, or being perceived as weak. A study of primary care patients found that 36% of individuals with depression did not recognize themselves as depressed; this recognition bias directly hinders help-seeking behavior [12]. Additionally, doubts about treatment effectiveness, distrust of mental health professionals, and fear of self-disclosure all serve as psychological hurdles for seeking help [7,13-14].

Personality traits also influence help-seeking behavior. The Five Factor Model (FFM) is a widely accepted personality theory that describes human personality across five broad, empirically supported trait dimensions: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. The model offers a comprehensive framework for understanding and assessing an individual’s unique personality traits. A 2025 systematic review and meta-analysis found that neuroticism is associated with negative attitudes toward help-seeking; however, individuals high in neuroticism tend to seek help more often. This may be because they experience distress more frequently and, even with negative attitudes, are more likely to seek help. Conversely, individuals with paranoid and schizotypal personality disorders exhibit both negative attitudes toward help-seeking and reduced help-seeking behavior. Extraversion (describing the extent to which a person seeks and enjoys external stimulation, social engagement, and positive expression) is associated with seeking social support, whereas conscientiousness (referring to the tendency to control impulses, be goal-oriented, plan, execute tasks, and fulfill commitments in an organized manner) is linked to seeking professional care.

3.2 Cognitive Level: Problem Recognition Bias and Treatment Expectations

Problem recognition bias is a cognitive necessity for help-seeking behavior. Many people with depression do not see their issue as a “disorder” but simply as “low mood” or “excessive stress.” One study found that over one-third of

individuals meeting the diagnosis criteria for depression did not view themselves as "depressed" [12]. This cognitive bias directly leads to avoidance of help-seeking—meaning that if someone does not see themselves as sick, they will naturally not pursue treatment.

Treatment expectations are equally crucial. Patients who doubt the effectiveness of treatment are less likely to seek help. This doubt may come from misunderstandings about psychiatric medication, prejudice against psychological counseling, or previous negative treatment experiences [15]. Outcome expectations and beliefs about treatment are key factors that influence help-seeking decisions; when patients have negative expectations, their motivation to seek help drops significantly. Research indicates that both outcome expectations and attitudes play a role in help-seeking decisions, with risk expectations affecting help-seeking intention and utility expectations influencing it respectively [15].

Metacognitive beliefs are also important to note. These beliefs refer to individuals' evaluations of their own thoughts [16]. Some patients think that "I should solve my own problems" or "Seeking help is a sign of weakness." This belief is especially common in individualistic cultures but is also present in collectivist cultures [17]. Metacognitive beliefs affect how people interpret and respond to their emotional distress; when patients see help-seeking as a sign of incompetence, they are more likely to delay or avoid seeking help. Research shows that emotional openness is a key factor in help-seeking attitudes; people who avoid emotional experiences tend to be less willing to seek professional help [17].

3.3 Socio-cultural Level: Family Values and Cultural Taboos

Family values are especially strong in collectivist cultures. Patients may worry about "losing face" and affecting their entire family, or fear that family members will not understand or support them. A study of Chinese individuals with depression found that family members' attitudes greatly influence help-seeking behavior; when family members have negative attitudes, patients are more likely to hide their symptoms [18]. Confucian culture values social harmony over individual psychological states, and its strong tendency toward self-restraint causes many Chinese people to internalize psychological issues rather than seek professional help [18].

Cultural taboos also serve as barriers. In some cultures, emotional problems are seen as "overthinking" or "weakness of character" instead of as treatable illnesses. This view is held not only by society but also by patients themselves [19]. Patients might think, "I should be able to solve this on my own," which delays help-seeking.

The dual role of social support networks is also noteworthy. Good social support can encourage help-seeking, but it can also replace the need for professional help—if patients receive enough emotional support from family and friends, they might stop seeking professional assistance [20]. Social presence significantly influences help-seeking behavior; when social support adequately meets needs, the motivation to pursue professional help may decrease [20].

3.4 Structural Level: Cost, Accessibility, and Waiting Time

Structural barriers directly cause many patients' difficulty in accessing treatment. Economic costs are among the most prominent barriers. Even in countries with health insurance, out-of-pocket expenses, transportation costs, and income loss from taking time off work can discourage patients [7]. Data from the WHO World Mental Health Surveys show that among those who perceive a need for treatment but do not receive it, "wanting to solve the problem oneself" is the most common barrier (63.8%), and attitudinal barriers are far more significant than structural ones [7]. In developing countries, mental health service resources are limited, and professional facilities are mostly in urban areas, making it hard for rural patients to access services. It is important to note that different types of barriers often coexist in the same patient. Although economic barriers are structural and stigma is attitudinal, they often intertwine: financial hardship may increase patients' sensitivity to stigma because they depend more on limited social support networks [21].

Geographic accessibility is just as important. Many areas lack psychiatrists or mental health counselors, forcing patients to travel long distances for help, which is a big challenge for people with depression who already have low energy [13]. Long wait times also block help-seeking: it can take weeks or even months from making an appointment to actually seeing a clinician, while the patient's distress is immediate [22].

Long waiting times decrease patients' willingness to seek in-person help, leading some to turn to online self-help tools, thereby creating a "substitution for help-seeking." A qualitative study of a waiting list for child and adolescent mental health services in the United Kingdom revealed that long wait times are directly linked to lower treatment engagement. Without professional support, "using self-help and parental resources" (including mental health websites and applications) becomes one of the most common coping strategies during the wait, forming a forced mechanism of "substitution for help-seeking." However, participants stressed that these self-help methods are not a long-term solution or a replacement for professional support [23].

3.5 The Digital Environment: The Substitution Effect of Anonymous Self-Help and Pathways to Professional Care

In recent years, the rise of digital mental health services has introduced new perspectives into research on help-seeking behavior [24]. Online screening tools, mobile applications, and internet-based counseling platforms provide anonymous, convenient, and low-cost channels for seeking help. The digital environment may serve both as a "bridge" that alleviates traditional barriers to help-seeking and as a "barrier" that impedes access to professional care.

Digital mental health interventions (DMHIs) offer unique advantages in addressing traditional barriers to help-seeking [25]: anonymity can effectively mitigate stigma; accessibility is significantly enhanced, eliminating concerns about transportation and time costs, and some applications are free [26]. However, the digital environment may also generate new problems. First, anonymous self-help may produce a substitution effect, in which patients become satisfied with safe yet limited self-exploration [9] and no longer actively seek professional help. Second, the "assessment-as-satisfaction" phenomenon creates a false sense of resolution among individuals who complete online assessments; patients may believe that "they have already done what they needed to do," thereby reducing their motivation to seek further help [4,27]. Third, low-quality digital interventions may lead users to develop distrust toward the entire mental health service system, and such a lack of trust is particularly detrimental [14,26,28]. Finally, the digital divide may exacerbate service inequities, as older adults and low-income populations face greater difficulties in accessing digital services [29].

What is the pathway for transforming the digital environment from a "substitute" into a "bridge"? The key lies in constructing a stratified, progressive, and user-led pathway for help-seeking translation. Starting with an anonymous assessment, the system automatically matches service levels based on symptom severity scores; subsequently, low-threshold actions are provided, such as email guidance delivered by relevant personnel; this is followed by the provision of anonymous support communities; finally, when symptoms reach moderate to severe levels, users are guided toward face-to-face professional services [30]. This pathway transforms digital tools from "information providers" into "care navigators" [31]. Behavioral change is a systematic process that requires simultaneous attention to the three dimensions of capability, opportunity, and motivation; only a combination of intervention strategies targeting these three dimensions can effectively facilitate behavioral translation [32].

4 THE INTERACTION OF BARRIERS AND THE INTEGRATED FRAMEWORK

4.1 Interaction Mechanisms Among Barriers

The barriers described in Section 3 are interconnected and mutually reinforce each other. This paper proposes a three-level interaction model (Figure 1):

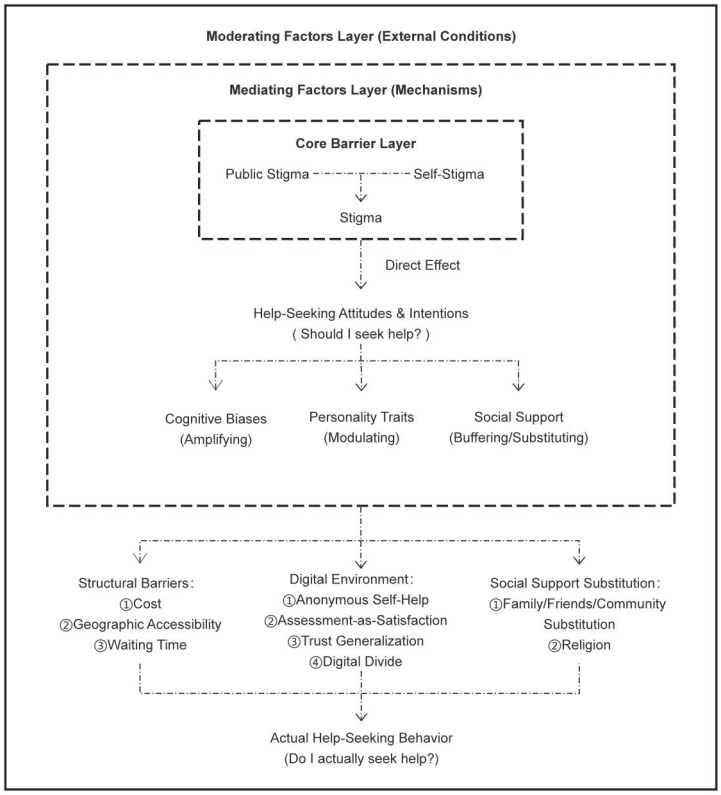

Figure 1 Three-Level Interaction Model of Help-Seeking Barriers

This model shows three categories of factors that influence help-seeking behavior and how they relate to each other. The main barrier (inner layer) is stigma (including public stigma and self-stigma), which directly impacts help-seeking attitudes and intentions. After help-seeking attitudes and intentions are formed, the mediating factors layer (comprising cognitive biases, personality traits, and social support networks) further moderates the subsequent process: cognitive biases amplify the psychological resistance to translating attitudes into behavior, personality traits influence individuals'

coping tendencies, and social support networks may either buffer or substitute for professional help-seeking. The moderating factors (outer layer) include structural barriers, the digital environment, and social support substitution. These function as external conditions that directly act upon actual help-seeking behavior, potentially exacerbating or alleviating help-seeking barriers. For example, high costs may deter individuals who are inclined to seek help; anonymous self-help tools may produce a "substitution effect," reducing users' motivation to seek professional assistance; and excessive support from family, friends, or the community may also substitute for professional help-seeking. These three layers of factors are nested and intertwined, jointly shaping the ultimate trajectory of help-seeking behavior.

4.2 Integrated Explanatory Framework

Based on the above analysis, this paper proposes an explanatory framework for why individuals with depression often do not seek help (Figure 2).

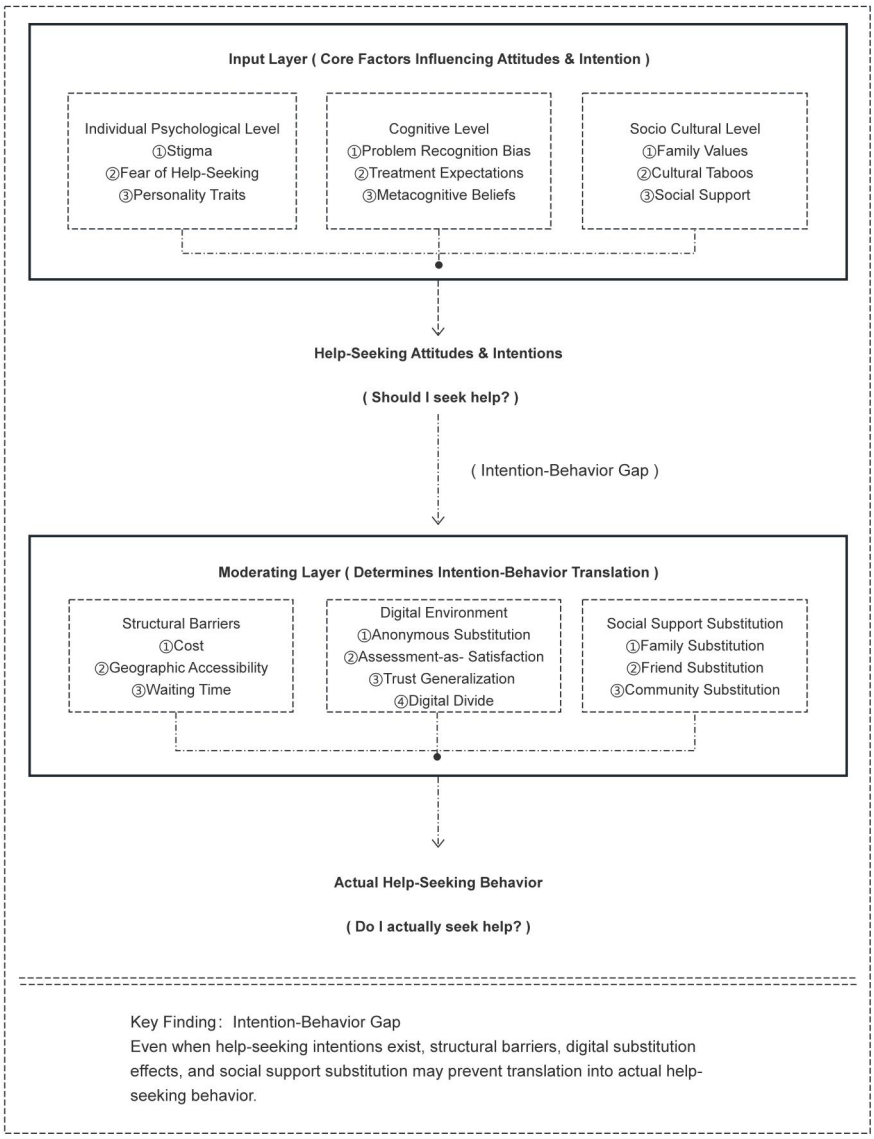

Figure 2 Integrated Framework for Help-Seeking Barriers Among Individuals with Depression (2026)

Figure 1 and Figure 2 are complementary, together providing a complete explanation of barriers to help-seeking. Figure 1 focuses on revealing the interaction mechanisms among barriers, addressing the question of "how different barriers influence one another." Its core lies in the internal dynamics by which stigma, as the central barrier, affects help-seeking behavior through mediating factors (cognitive biases, personality traits, and social support networks) and moderating factors (structural barriers, the digital environment, and social support substitution). Figure 2, in contrast, emphasizes the process of translating cognition into behavior, answering the question of "how barriers step by step affect the final behavior from the attitudinal level." Its function is to demonstrate the complete pathway from the input layer to the output layer. Figure 2 specifically highlights the "intention-behavior gap," namely that even when patients have formed help-seeking attitudes and intentions, the three categories of factors in the moderating layer may still prevent their

translation into actual behavior. In short, Figure 1 explains "why barriers take effect" (mechanism), while Figure 2 explains "the entire process through which barriers operate" (process). The two are mutually reinforcing and irreplaceable.

To clearly elucidate the internal logic of Figure 2, the following section provides a layer-by-layer interpretation of its four levels.

First, the input layer: core factors influencing help-seeking attitudes and intentions. This layer integrates three dimensions – individual psychological, cognitive, and socio-cultural – which together constitute the psychological and social foundation for patients' willingness to seek help. The individual-psychological level (stigma, fear of help-seeking, personality traits) serves as the "driving source" of help-seeking intentions: stigma directly undermines help-seeking motivation, fear of help-seeking increases the perceived risk of self-disclosure, and personality traits influence individuals' coping tendencies. The cognitive level (problem recognition bias, treatment expectations, metacognitive beliefs) functions as the "regulating valve" of help-seeking intentions: patients' underestimation of the severity of their own problems, low expectations of treatment effectiveness, and metacognitive beliefs that regard help-seeking as a sign of weakness all significantly reduce their willingness to seek help. The socio-cultural level (family values, cultural taboos, social support networks) provides the "contextual background" for help-seeking intentions: concerns about "losing face" under collectivist cultures, stigmatizing societal attitudes toward mental health problems, and informal support from family and friends may either facilitate or inhibit the formation of help-seeking intentions.

Second, the attitude and intention layer: the transitional hub between cognition and behavior. This layer represents the psychological state that patients form after integrating the three dimensions of influencing factors described above – namely, "should I seek help?" It is a key node connecting cognition and behavior, and also the logical starting point of the "intention-behavior gap" revealed by the present framework. A large number of patients remain at this layer – they acknowledge that they need help, yet repeatedly fail to take the step of actual help-seeking.

Third, the moderating layer: external conditions determining whether intentions translate into behavior. This is the most practically instructive part of the framework, revealing the critical obstacles between "wanting" and "doing." This layer comprises three categories of moderating factors that do not affect help-seeking intentions; rather, on the basis of already-formed intentions, they directly act upon actual help-seeking behavior, thereby exacerbating or alleviating the "intention-behavior gap." First, structural barriers (economic costs, geographic accessibility, waiting times) directly constrain patients' physical ability to access professional services, constituting a "hard" threshold. Second, the digital environment (anonymous substitution effect, assessment-as-satisfaction, trust generalization, digital divide) has a dual nature: anonymity can mitigate stigma and serve as a "bridge" to help-seeking; however, it may also produce a "substitution effect," allowing patients to settle for superficial self-exploration and thereby substitute for the need for offline professional services, thus becoming a "barrier" to help-seeking. Third, social support substitution (substitution by family, friends, community, and religious leaders) reveals the "double-edged sword" effect of informal support networks: when patients receive sufficient emotional support and problem-solving assistance from family, friends, or religious leaders, even if they know they suffer from depression, they may refrain from seeking professional treatment because their needs are already partially met.

Fourth, the output layer: actual help-seeking behavior. This layer represents the endpoint of the framework, indicating whether a patient ultimately enters a counseling room or a psychiatric outpatient clinic or not. The translation process from the second to this layer is significantly influenced by the third layer's moderating factors. The "intention-behavior gap," as the core finding of the present framework, refers to the rupture in this translation process: patients hold intentions but fail to take action due to structural barriers, the digital environment, or the substitution of social support.

In summary, Figure 2, through the process of "Input Layer - Attitude and Intention Layer - Moderating Layer - Output Layer," systematically explains the core puzzle of "why patients have intentions yet still do not seek help."

Empirical evidence for the intention-behavior gap. The "intention-behavior gap" revealed by the above framework has received empirical support. A 2025 systematic review found that existing interventions can improve help-seeking intentions among individuals with depression, but fail to translate these intentions into actual help-seeking behavior [33]. Another systematic review of internet-based health behavior change interventions found that the thorough application of theoretical foundations, a combination of multiple behavior change techniques, and multi-channel interactive approaches (particularly text message reminders) can enhance intervention efficacy [34]; however, a significant gap still exists in translating intention into behavior. These findings corroborate the central claim of the present framework: future interventions must not only enhance intentions but also help patients overcome moderating factors such as structural barriers, digital substitution, and social support substitution.

To facilitate quick understanding of the framework's key points, Table 2 provides a summary of the four layers.

Table 2 Framework Explanation

Level	Content	Function
Input Layer	Individual psychological, cognitive, and sociocultural dimensions	Influence help-seeking attitudes and intentions

Level	Content	Function
Attitude & Intention Layer	Help- seeking attitudes and intentions	Starting point of the intention-behavior gap
Moderating Layer	Structural barriers, digital environment, social support substitution	Determine whether intention translates into behavior
Output Layer	Actual help- seeking behavior	Final behavioral outcome

5 DISCUSSION

5.1 Integration and Extension of Existing Theories

This study combines multiple barriers and introduces a three-level interaction framework, thus adding to existing theories that have largely ignored how barriers interact. Past research has mainly focused on individual barriers (e.g., stigma) or just listed several barriers without explaining how they connect. Our framework shows that core barriers (stigma) affect help-seeking intention through mediating factors (cognition, personality) and then influence help-seeking behavior through moderating factors (structural barriers, the digital environment).

5.2 Empirical Support of the Integrated Framework from the Coding Distribution

The coding distribution shown in Table 1 provides empirical support for the integrated framework proposed in this paper from a quantitative analytical perspective.

First, the individual-psychological level accounts for the highest proportion of reference points (34.5%), consistent with the framework's position on stigma as the central barrier. Second, the widespread presence of the cognitive level (21.1%) supports the role of "cognitive biases" and "treatment expectations" as mediating factors in the framework, i.e., they link stigma with help-seeking attitudes. Third, the structural level (17.5%) and the digital environment level (18.3%) together account for over 35% of the reference points, validating the importance of "moderating factors" in the framework: even when patients have intentions, actual help-seeking behavior remains difficult to achieve if they lack affordable and accessible services, or if they indulge in a false sense of resolution from anonymous self-help. Fourth, the socio-cultural level has fewer coding references (8.5%), but this does not diminish its theoretical value. On the contrary, it suggests that existing quantitative research has insufficiently measured and reported on cultural mechanisms (such as "face," family decision-making, and religious beliefs), and that more cross-cultural or locally grounded studies are needed to enrich this dimension.

It is worth noting that, for each dimension, the mean reference points per source tend to be balanced: individual (10.3), psychological (9.7), structural (7.5), digital environment (6.5), and socio-cultural (6.6). This indicates that all five dimensions are consistently presented in the literature, with no single dimension standing out disproportionately, thus supporting the overall framework of multi-dimensional barrier interaction. Furthermore, the distribution of reference points aligns with the "intention-behavior gap" in the framework[35]: the core dimensions influencing intentions (individual-psychological and cognitive) account for 55.6%, while the moderating dimensions affecting behavioral translation (structural and digital environment) account for 35.8%. The proximity of these two proportions suggests that the literature pays equal attention to two types of questions: "why individuals do not want to seek help" and "why individuals want to seek help but fail to act." This finding reinforces the central claim of this paper: intervention design must distinguish between intention enhancement and behavior promotion; improving attitudes alone is insufficient to bridge the gap.

5.3 Implications for the Design of Interventions

From an intervention standpoint, this study suggests three main implications: (1) interventions should differentiate between "intention" and "behavior." While strategies that boost intention are effective, they are not enough to turn intention into action. It is also crucial to help patients overcome structural barriers and digital substitutes concurrently; (2) digital tools need to provide clear transition pathways. Anonymous self-help should serve as a starting point, not the final goal. Tools should include "next-step" guidance to assist users in moving from anonymity to seeking professional help; (3) reducing stigma requires a comprehensive approach. Cognitive-behavioral therapy, social contact, and public awareness campaigns can all reduce stigma, but they must be tailored to the specific needs of different populations.

5.4 Limitations and Future Directions

This study is a narrative review that did not follow the rigorous procedures of a systematic review, and therefore may be subject to literature selection bias. Future research could: (1) use meta-analysis to synthesize the effect sizes of different barriers; (2) examine cross-cultural differences in barriers; and (3) perform longitudinal studies to explore the dynamic mechanisms behind barrier interactions.

Existing evidence gaps suggest that help-seeking behavior among certain groups, such as health and social care professionals, may involve unique mechanisms that warrant dedicated investigation. A systematic review of health and social care professionals revealed a substantial help-seeking gap [36]: although the proportion of individuals perceiving a need for psychological support ranged from 54.9% to 97.9%, the actual rate of seeking formal support was only 30.2%. The review further identified core barriers, with stigma and concerns about confidentiality being the most commonly reported obstacles. Across studies, 41%–67% of professionals refrained from seeking help due to fears of stigmatization or breaches of confidentiality, and certain subgroups also expressed deep concerns about potential negative career impacts. This finding provides an important reference for understanding help-seeking behavior in other occupational groups: in highly demanding, identity-sensitive professional environments, professional identity can act as a "double-edged sword." On one hand, it endows individuals with professional competence; on the other hand, it may impede them from seeking necessary psychological support due to the associated risk of stigmatization. This reference framework suggests that when designing and promoting psychological support services for other occupational groups, particular attention should be paid to confidentiality safeguards, stigma reduction, and respect for professional identity to bridge the gap between perceived need and actual help-seeking [37].

6 CONCLUSION

The reluctance of individuals with depression to seek offline professional help stems from multiple, interacting barriers. Stigma is the primary barrier, affecting help-seeking intention through mediators such as cognitive biases, personality traits, and social support. Structural barriers (cost, accessibility) and the digital environment (anonymous self-help) serve as moderating factors that influence whether intention leads to action. There is a notable gap between "wanting to seek help" and "actually seeking help"; while existing interventions can increase intention, they often fail to close this gap.

Digital mental health services present both opportunities and challenges. While they alleviate traditional barriers, they may also give rise to a new problem: "anonymous substitution." Future intervention design should shift from "providing information" to "building bridges," helping patients move from anonymity to professional help- seeking.

Only when we understand why patients remain silent can we better help them speak out.

COMPETING INTERESTS

The authors have no relevant financial or non-financial interests to disclose.

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