MEDWAVE
PEER REVIEWED MEDICAL JOURNAL

RESEARCH

Depression stigma in Chile: A qualitative study of beliefs, emotions, and behaviors toward people with depression

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ABSTRACT

INTRODUCTION Depression is one of the leading causes of disability in Chile and significantly affects adults' well-being and social participation. Despite its high prevalence, depression stigma has been scarcely studied in the country. Because its manifestations vary across sociocultural contexts, understanding how it is configured in Chile is essential for developing contextually relevant interventions. Within this framework, depression stigma is examined through its core components -stereotypes, prejudice, and discrimination- by analyzing the beliefs, emotions, and behaviors directed toward people living with depression. The aim of this study is to explore, from the perspective of Chilean adults, the socially shared beliefs about people living with depression, as well as the emotions and behaviors directed toward them, and to examine the extent to which these contents are understood as expressions of depression stigma.

METHODS A qualitative study was conducted using purposive sampling and minimum group representativeness criteria based on gender, socioeconomic status, and history of depression. Sixty-six adults from three regions of Chile took part in individual semi-structured interviews. Interviews were transcribed, reviewed, returned to participants for checking, and coded by two independent coders. Data were then analyzed using a deductive-inductive content analysis approach supported by Atlas.ti, and findings were triangulated.

RESULTS Findings were organized into three analytical macro-categories - beliefs, emotions, and behaviors directed toward people with depression - consistent with the cognitive, affective, and behavioral components of stigma described in the literature. Within beliefs, contents related to affective characteristics, behavioral characteristics, and dispositional attributions associated with people with depression emerged. Within emotions, compassionate emotions, defensive and discomfort-related responses, and affective disconnection were identified. Within behaviors, overprotection, social distancing, invalidation and judgment emerged, along with interaction scripts based on avoidance or support.

CONCLUSIONS Depression stigma in Chile is configured through contents that, to varying degrees, are understood as stereotypes, prejudice, and discrimination. Beliefs combine elements linked both to mental health literacy and to stereotypes; emotions are primarily interpreted as expressions of prejudice; and behaviors reflect both subtle and overt forms of discrimination. Additionally, some themes showed divergent interpretations among participants, particularly between those with and without a history of depression. Taken together, these findings contribute to a better understanding of how this phenomenon is structured in the Chilean context and provide input for the development of culturally relevant assessment instruments and intervention strategies.

KEYWORDS Depressive Disorder, Social Stigma, Social Discrimination, Chile, Mental Health

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Citation Salinas-Oñate N, Segú-Flores MJ, Salazar-Fernández C, Alarcón-Jouanet T, Alvarado Muñoz R. Depression stigma in Chile: A qualitative study of beliefs, emotions, and behaviors toward people with depression. Medwave 2026;26(06):e3227
DOI 10.5867/medwave.2026.06.3227
Submitted Apr 7, 2026, **Accepted** Jun 24, 2026,
Published Jul 29, 2026
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INTRODUCTION

The stigma surrounding depression has been documented internationally, showing negative effects on social inclusion, access to and adherence to treatment, and the quality of life of those affected [1–3]. However, much of this evidence comes from English-speaking countries, which limits our

MAIN MESSAGES

- Depression is a significant public health issue, and the stigma surrounding it can affect daily life, social relationships, and the pursuit of help. To date, the stigma of depression has not been characterized in Chile.
- This study provides evidence on how the stigma of depression manifests among Chilean adults, identifying beliefs, emotions, and behaviors that help explain its manifestations within the local sociocultural context.
- The stigma surrounding depression in Chile is structured around stereotypes, prejudices, and discrimination, linking stigmatizing views with mental health literacy and behaviors that promote support and inclusion.
- Among the study's limitations, it is worth noting that the sample's proximity to people with depression may have influenced the reported levels of stigma.

understanding of how stigma manifests in other sociocultural contexts, such as Latin America and, particularly, Chile [4,5]. Given that stigma is a culturally situated phenomenon, this study seeks to characterize it based on the beliefs, emotions, and behaviors of Chilean adults.

Depression as a public health problem

The World Health Organization (WHO) [6] estimates that more than 300 million people worldwide live with depression, making it one of the leading causes of the global disease burden [7]. In Chile, it is recognized as a priority public health issue, constituting one of the main causes of disability and loss of healthy life years [8]. Among the adult population, the 2016–2017 National Health Survey estimated a prevalence of 6.2% [9], while recent studies have reported a prevalence of 13.7% for moderate to severe depressive symptoms in adults [10]. In addition, depressive symptoms have been associated with an increased risk of mortality [11] and high comorbidity with chronic diseases, which increases the burden of disease and complicates its clinical management [12].

Furthermore, depression has a multidimensional impact on people's lives, affecting their daily functioning and their participation in personal, family, and community settings [13–15]. These consequences also translate into high economic costs throughout the life course [16,17]. From the perspective of this study, depression is understood as a mental health problem whose onset, manifestation, and course are influenced by the interaction of biological, psychological, and sociocultural factors [6]. Its impact stems not only from the symptoms and limitations associated with the condition but also from the social responses it elicits. In this sense, the stigma faced by people with depression constitutes a particularly significant manifestation of its social impact. Although effective treatments for this condition exist, stigma remains one of the main barriers to accessing mental health care, even surpassing structural or economic obstacles [3,18,19].

Stigma of depression

Social stigma is defined as a process by which a person is attributed to a socially devalued characteristic—such as suffering from depression—which labels them as deviant or undesirable, leading to a loss of status and discrimination [19–21]. This stigma is expressed through various interrelated components [22]. First, stereotypes are shared and oversimplified social beliefs about a social group that function as cognitive frameworks for organizing information about its members [23]. Second, prejudice refers to the emotional (generally negative) responses directed toward that group [24]. Finally, discrimination manifests itself in specific behaviors or practices that treat these individuals or groups differently and disadvantageously [25].

Taken together, these components allow us to understand stigma as a dynamic process that links beliefs, emotions, and behaviors directed toward a socially devalued group [26,27]. This interpretive framework has been developed in influential theoretical models of mental health stigma, such as Corrigan's cognitive-social model of stigma [28], and subsequently operationalized in integrative approaches such as the Mental Illness Stigma Framework [22]. From this perspective, social stigmatization goes beyond the mere occurrence of discriminatory behaviors. Furthermore, it allows for a comprehensive understanding of the phenomenon, considering cognitive (stereotypes) and affective (prejudice) dimensions directed toward the socially devalued group.

The stigma surrounding depression makes it difficult to recognize it as a health problem, discourages people from seeking professional help, and is associated with lower treatment adherence and higher rates of treatment dropout [29–31]. In fact, people living with depression identify shame and the fear of being perceived as "weak" or "unstable" as among the main barriers to seeking mental health care [29,32]. Additionally, a lack of support from their social environment contributes to their isolation and helps perpetuate barriers to access [33]. The lack of timely access to mental health care is associated with an unfavorable clinical course, a lower probability of spontaneous recovery [34], and various psychosocial repercussions. Among the latter are family conflicts, financial difficulties, suicidal ideation, withdrawal from daily activities, and decreased academic performance [35].

Although research on the stigma of depression has grown steadily worldwide, bibliometric analyses show that scientific output remains concentrated in high-income English-speaking countries, while regions such as Latin America continue to be underrepresented [36]. This gap takes on particular significance

when considering that social stigma is a context-specific phenomenon [37,38]. Therefore, it is expected that stereotypes, prejudices, and forms of discrimination toward people with depression will vary according to cultural context.

Local context and objectives of the present study

In Chile, the stigma surrounding depression has not been specifically described. Although available evidence suggests that the threat of stigmatization is part of the experience of people living with depression [39], to date, the stereotypes, prejudices, and discriminatory behaviors that shape this phenomenon have not been characterized. In this regard, this research constitutes one of the first efforts to describe the stigma of depression in Chile. Having this evidence would allow us to understand how this phenomenon manifests in the Chilean cultural context, as well as provide input for the development of culturally relevant assessment tools and stigma-reduction interventions.

Given this knowledge gap, the present study takes as its starting point an analysis of public stigma, understood as the majority of society's view of people living with depression. Given the exploratory nature of the study, the analysis does not presuppose the prior existence of stigmatization but rather begins by identifying socially shared beliefs, emotions, and behaviors directed toward these individuals, as well as the meanings that the participants themselves attribute to these elements. Based on this exploration, the study examines the extent to which these patterns can be interpreted as stigmatization of depression and identifies their main characteristics.

Consequently, the overall objective of this study was to explore, from the perspective of Chilean adults, the socially shared beliefs about people living with depression, as well as the emotions and behaviors directed toward them. It also seeks to examine the extent to which these elements are interpreted as expressions of stigma toward depression.

METHODS

Participants

A qualitative, descriptive study was conducted with 66 Chilean adults. Data collection lasted five months (between August and December 2024 and January 2025). The inclusion criteria were: being 18 years of age or older, holding Chilean citizenship, and residing in one of the three participating regions. The exclusion criterion was experiencing a depressive episode at the time of the interview, given that the conversation could trigger distress or be perceived as a re-stigmatizing experience.

Purposive sampling with theoretical stratification and maximum variation criteria was used. Recruitment was conducted through self-selection and snowball sampling, aimed at capturing the diversity of perspectives on the topic. The definition of the strata was based on three variables identified as relevant in the literature: sex, socioeconomic status, and history of depression. In particular, it has been reported that men tend to express higher levels of stigma toward mental health problems [37,40–42], that socioeconomic status is associated with variations in the level of stigma [43], and that a history of depression may be linked to lower levels of stigma toward this condition [44]. To incorporate geographic diversity, three regions of Chile were selected that were accessible to the research team and representative of the country's northern, central, and southern macrozones: Coquimbo, Metropolitan, and La Araucanía. These regions exhibit distinct structural profiles in terms of poverty, urbanization, and the prevalence of mental disorders [45,46], which allows for the capture of contextual variations relevant to the phenomenon under study. These regions did not serve as a criterion for combinatorial stratification but rather as a complementary axis for diversifying the study population. Efforts were made to achieve a balanced distribution by region and stratification variables, resulting in a minimum number of participants in each of the 12 cells formed by combining the variables of sex (male/female), socioeconomic status (high, medium, and low), and history of depression (yes/no). Sample closure was based on meeting these quotas rather than on the criterion of theoretical saturation.

The sample showed a relatively balanced distribution in terms of sex, personal history of depression, and region of residence. With regard to socioeconomic status, a higher concentration was observed in the middle socioeconomic groups. Furthermore, among those who reported a history of depression, nearly half received mental health treatment, primarily psychotherapy, which was rated as very helpful. Finally, most participants reported a history of depression among people in their immediate social circle (for more details, see Table 1).

Data collection method

A single-session, semi-structured interview method was used, featuring open-ended questions designed to explore beliefs, emotions, and behaviors toward people living with depression. The interview guide was validated by a committee composed of experts by experience from outside the research team, researchers with expertise in mental health and intergroup rejection processes, and psychologists with clinical expertise in caring for people with depression and their families. The questions followed a progressive sequence that began with general topics on mental health and moved toward depression and people living with it, focusing on exploring beliefs, emotions, and behaviors toward them. For example: What is the first thing that comes to mind when you think of people with depression?

The interviews were conducted remotely via Google Meet, lasted approximately 60 to 90 minutes, and were led by four psychologists from the research team (three of whom held master's degrees); two of them were affiliated with the university where the study is being conducted as doctoral and master's students, and the other two were external professionals. All had between 2 and 13 years of professional experience in clinical and professional settings. None had any prior

Table 1. Characteristics of the study sample (n = 66).

Variable		% (*N*)
Genre	Female	53.0 (35)
	Male	47.0 (31)
Region of residence	Coquimbo	31.8 (21)
	Metropolitan	33.3 (22)
	La Araucanía	34.8 (23)
NSE	High	6.1 (4)
	Medium-high	27.3 (18)
	Medium	31.8 (21)
	Medium-low	30.3 (20)
	Low	4.5 (3)
Personal history of depression	Yes	51.5 (34)
	No	48.5 (32)
If you have a history of this condition. did you receive treatment?	Yes	45.4 (30)
	No	54.5 (36)
Type of treatment received previously	No treatment	54.5 (36)
	Pharmacologic	3.0 (2)
	Pharmacologic, psycotheraphy	21.2 (14)
	Psycotheraphy	16.6 (11)
	psycotheraphy, other	1.5 (1)
	Other	3.0 (2)
Level of satisfaction with the treatment received	Does not recieve treatment	54.5 (36)
	Much	28.7 (19)
	Bastante	12.1 (8)
	Slightly	3.0 (2)
	Nothing	1.5 (1)
Has anyone in your inner circle suffered from depression?	Yes	87.9 (58)
	No	12.1 (8)

Source: Prepared by the auhors of this study.

relationship with the participants. Prior to data collection, they participated in a five-session theoretical and practical training program aimed at standardizing the application of the protocol. This training included conceptual instruction on stigma in mental health and depression, as well as role-playing exercises focused on managing emotionally complex situations. Finally, it included conducting a simulated interview via Google Meet to replicate the conditions of the virtual data collection setting. The interview script was not pilot-tested with participants. During fieldwork, the research team supervised the process to ensure consistency. In addition, sociodemographic and clinical background information was collected from the participants.

Procedure

The protocol was approved by the Ethics committee of the university where the research is being conducted. Recruitment was carried out through a call for participants posted on social media, which included an online form for preliminary verification of inclusion and exclusion criteria. Subsequently, eligible individuals were contacted by phone and administered the Patient Health Questionnaire-9 (PHQ-9) [47] as a screening tool to rule out significant ongoing depressive symptoms, for ethical safeguards. A cutoff score of 10 or higher was used, corresponding to moderate-to-severe symptoms [48], which may indicate either an active depressive episode or incomplete remission. Since this was an exclusion criterion intended for safety rather than diagnosis, this conservative threshold was chosen to protect the well-being of the participants. Consequently, participants who scored 10 or higher were excluded from participating in the study.

Informed consent was obtained during the telephone contact, covering the study objectives, the training and role of the interview team, conditions of participation, ethical safeguards, use of information, and financial compensation for the time and resources invested in participating (CLP 10 000). No additional information was provided regarding the team's personal motivations or specific interests in the topic. The consent form was sent via email and signed prior to the interview. Although the interviews were conducted remotely, each participant was asked to be in a private space with no other people present to safeguard confidentiality. All interviews were audio-recorded with the participants' consent. No systematic field note protocol was implemented. At the conclusion of the study, an informational wrap-up was provided by sending an infographic on depression stigma that included general information and contact details for free mental health support services. Compensation was provided via bank transfer.

The interviews were transcribed using Sonix.ai and reviewed manually. During this process, the transcripts were anonymized by assigning a code to each participant. As a credibility strategy, they were sent to the participants for review, without requesting any modifications. The transcripts were stored on a password-protected, encrypted hard drive, which was accessed only by the team responsible for data analysis. In total, two participants did not complete the study: one was excluded during screening due to clinically relevant depressive symptoms and received mental health counseling; the other voluntarily withdrew after signing the consent form.

Data analysis

A content analysis with a mixed deductive-inductive approach was conducted using Atlas.ti version 25 software, aimed at identifying and classifying units of meaning present in the participants' narratives [49]. The analysis was grounded in stigma theory [27,31], which conceptualizes stigma as a phenomenon composed of stereotypes, prejudices, and discrimination. These components were used as predefined analytical categories to guide the coding process.

Coding was performed by a team of seven people organized into two groups, with each interview assigned to two independent coders. This process unfolded in two stages [50]. In the first stage, a preliminary codebook was developed and used as a common reference. In the second stage, emerging codes and subcategories were incorporated to more accurately describe the content expressed in the interviews. Finally, the constant comparative method [51] was employed, which allowed us to verify the relevance of the quotes to the codes grouping them, as well as to refine the analytical categories [52]. The code

trees resulting from the analysis are presented as supplementary material (see Supplementary Material 1, 2, 3).

Reflexivity

The research team consisted of professionals with training in psychiatry and/or social psychology with diverse backgrounds, including experience in research on mental health stigma or other lines of research, as well as personal or family experience with depression. We acknowledge that this diversity may have influenced the research process in varying ways, serving as both an analytical resource and a potential source of bias. Both aspects were addressed through reflective discussion among team members. Findings were not verified with the study participants.

RESULTS

The content analysis was organized into three analytical macro-categories: beliefs, emotions, and behaviors directed toward people living with depression.

Beliefs about people with depression

Within this macrocategory, three main categories were identified:

1. Affective characteristics.
2. Behavioral characteristics.
3. Dispositional attribution.

Illustrative quotes can be found in Table 2.

1. **Affective characteristics**. This category encompasses a set of beliefs that describe people living with depression, based on the emotional characteristics attributed to them. It also corresponds to the theme that emerged most spontaneously when participants were asked to describe a person with depression. In these accounts, people with depression are characterized by a predominant state of emotional flatness, lack of motivation, and sadness. Additionally, they are characterized as emotionally overwhelmed, vulnerable, and at constant risk of suicide. It is suggested that these manifestations are not always evident to those around them, especially when the person maintains functional behavior.

2. **Behavioral characteristics**. This category groups together beliefs regarding the behaviors attributed to people living with depression. Social isolation emerges as the most common behavior, portraying the person with depression as someone who keeps to themselves, stays at home or in bed, and significantly reduces their social interactions. Likewise, accounts characterize them as inefficient at work, unable to function adequately in daily activities (for example, regarding personal hygiene or work), lazy, and a burden on those around them. They are also described as people who tend to hide their diagnosis. This reinforces the perception that it is difficult to interact appropriately with those suffering from depression.

3. **Dispositional attribution**. This category encompasses beliefs that describe people with depression based on personal traits considered stable. Among the most frequently reported are the ideas that they are incapable of recovering, that they need constant care, and that they are weak. In some accounts, these attributions are linked to explanations about the origin of depression, focusing on the individual characteristics of the person suffering from it. Likewise, they are described as strange, crazy, negative, and dramatic. These latter attributions showed greater variability among participants, since they are not endorsed by everyone but are frequently recognized as ideas held by their social circle.

Emotions toward people with depression

Emotions were organized into three categories:

1. Compassionate emotions.
2. Defensive emotions and discomfort.
3. Emotional detachment.

Examples can be found in Table 3.

Compassionate emotions. This category encompasses emotions focused on recognizing the suffering of those living with depression. The most commonly reported emotions were sadness and concern, which tend to be experienced more intensely when there is a close bond, as well as empathy and understanding. Some accounts also mentioned pity and hopelessness in the face of the perception that the person is unlikely to recover. These last two emotions were interpreted differently by the interviewees: those without a history of depression viewed them positively, while those who have suffered from depression consider them stigmatizing.

Defensive emotions and discomfort. This category encompasses negative emotions that arise when interacting with people living with depression and that express interpersonal discomfort and defensive reactions. The most frequently reported emotion was the fear that the person might get worse or commit suicide, which can lead to patronizing treatment. A sense of helplessness was also reported, stemming from the perception of being unable to help in a meaningful way. Additionally, anger toward the person with depression was reported, linked to the belief that their recovery depends on their willpower. This emotion is reported primarily as a reaction from people in the person's social circle rather than from the participants themselves. Along with this, fatigue is noted in interactions with people with depression—especially among those in their immediate social circle—linked to the aforementioned belief that the person is a burden to them. Finally, the accounts reveal feelings of discomfort and anxiety in social interactions with people with depression, which lead to greater caution in these interactions due to the fear of making mistakes that could have negative effects, such as triggering suicidal thoughts. Interpretations of this caution differed among participants. While some understood it as an expression of concern and care, those with a history of depression more frequently interpreted it as a form of social exclusion.

Table 2. Examples of illustrative citations from the "beliefs" macrocategory.

Category	Cite
Emotional characteristics	"Well, of course, nothing very positive. Things like discouragement, despondency, hopelessness, and, of course, not being able to see the bright side of things or situations." (Woman, no history of depression, lower-middle socioeconomic status). "It's just that they want to… they have an instinct to kill themselves. I mean, because… They feel like they can't get ahead. It's because they don't ask for help." (Woman, no history of depression, low socioeconomic status).
Behavioral characteristics	"Depression, for me..., has to do with a person who is already isolated, that's true. In this image I see (...) of the person who is in bed, who doesn't go out, who finds it hard to go out, who doesn't socialize, who doesn't talk about it, who says they're fine. All of this points to a person who is closed off, isolated, withdrawn into themselves, and who doesn't step outside their comfort zone—not out of fear, or anything like that... (...) But also, because they take refuge in that." (Male, with a history of depression, middle socioeconomic status). "'Oh, so-and-so is in a bad way.' So it carries a connotation of being lazy, of wanting to shirk responsibilities, or of being crazy, or maybe not being fit for the job you're doing." (Woman, no history of depression, middle socioeconomic status). "I think it's super hard to tell. I mean, to know whether someone does or doesn't have depression (...), like with people who seem totally fine, who you spend time with every day, who make you laugh a lot, or with whom you share really nice moments—and you look at them and say, 'How could they possibly have depression?' You know what I mean? If you didn't know. No, no… And then there are also people who are affected in a different way and just shut down." (Woman, with a history of depression, lower-middle socioeconomic status). "I remember it perfectly as a burden. I already felt like a burden, even to my closest friends—the ones I thought were my closest friends. And I felt like a burden, like, you know, something uncomfortable to have around at those times." (Man, with a history of depression, lower-middle socioeconomic status).
Dispositional attribution	"I think that, well, this (…) used to happen more often. But I think there must still be some of that—the idea that people used to associate it a lot with a person's weakness. Yeah, like this person (...) isn't as strong as usual, let's say. And that's why—that's why they get depressed in circumstances where another person would just be sad, or it would be something more fleeting, let's say. I think you still see that today." (Male, no history of depression, lower-middle socioeconomic status). "Well, there's this other group that thinks these people are too… that they lack inner strength. They're mentally weak. Therefore, they shouldn't even be allowed to hold positions of importance because of their emotional or mental weakness. So they see them as people who are depressed because, basically, they want to be depressed." (Male, no history of depression, very high socioeconomic status).

SES, socioeconomic status.
The quotes represent subcategories of "beliefs" about people with depression.
Source: Prepared by the authors of this study.

Emotional Disconnection. This category groups accounts that express emotional distance from the suffering of people living with depression. The most reported emotion was indifference, which some participants interpreted as a characteristic of Chilean society, perceived as increasingly individualistic. Likewise, this response was linked to beliefs that dismiss depression as an illness. According to the accounts, the workplace is the setting where this response appears most frequently, especially among people without close ties.

Behaviors toward people with depression

The findings suggest that the way people interact with those suffering from depression depends on their prior relationship with them, such that emotional closeness appears to modulate the type of behavior exhibited. Furthermore, although it is noted that awareness of depression has increased, this has not necessarily led to a decrease in discriminatory behaviors toward those who suffer from it. Based on the analysis of the narratives, these behaviors were organized into four main categories:

1. Overprotection.
2. Social distancing.
3. Dismissal and judgment.
4. Interaction scripts.

Table 4 presents illustrative quotes.

Overprotection. This category encompassed actions aimed at supervising and directing the behavior of the person with depression. The practices described take three main forms:

1. Monitoring, which refers to remaining alert and vigilant regarding the actions of the person with depression, along with acts of care accompanied by suggestions—especially regarding seeking professional help.
2. Pressure and insistence, referring to direct and sometimes repeated requests for the person to change their behavior or emotional state. From the perspective of those who have experienced them, these practices can be stigmatizing, as they are interpreted as questioning the person's behavior or as expectations that they should feel better.
3. Infantilization refers to forms of treatment characterized by attributing fragility, overprotection, and the use of infantilizing language toward the person with depression (for example, using diminutives).

Table 3. Examples of illustrative citations from the "emotions" macrocategory.

Category	Cite
Compassionate emotions	"Yes, they were sad for me, for… everyone who was affected by this news. So… I think it was sadness; that was the feeling that stood out the most, both for me and because of what had happened." (Male, with a history of depression, middle socioeconomic status). "Concern because you know that when someone has depression, it's like being in a hole, and to get out of there, you can't do it alone—(and…) I mean, you have to do things for yourself, but others also have to help you get out of that hole. It's not easy." (Woman, with a history of depression, lower-middle socioeconomic status). "Honestly, what happens to me—speaking in general terms—is that I see a person and, well, I don't know, I can tell they have depression. What that makes me feel… I think it's a feeling of compassion, I'd say, because I understand that it's a complex thing to live with, isn't it?" (Man, no history of depression, lower-middle socioeconomic status). "I think that when people know you have it, they treat you well—not like you're weird, but more like… a little pitiful." (Man, no history of depression, middle socioeconomic status). "Yes, I also felt something like compassion, but a somewhat uncomfortable kind of compassion… like pity, maybe. Those people made me feel like they pitied me." (Male, with a history of depression, low socioeconomic status).
Defensive emotions and discomfort	"Mainly, I think one thing is the fear that the person won't recover and that, as a result, they'll either live their whole life in depression or commit suicide. That's the greatest fear, I think." (Woman, no history of depression, lower-middle socioeconomic status). "They were very careful about the words they used and the topics of conversation. It was mostly that—they were very cautious with me. It's like I felt a little—how can I put it?—excluded. Maybe it's because sometimes I didn't… I didn't feel included because of that very situation—because they were so cautious, and sometimes they just didn't want to, or couldn't, be 100% open with me." (Man, with a history of depression, low socioeconomic status). "The first thing I feel, I think, is a sense of helplessness. Because it's like, 'I want to help you,' but I… I don't know how to do it right, because I'm not always going to know what your situation is, and I'm not going to have all the tools to do it either. I mean, I don't have all the tools to help you psychologically. And no, I don't have all the tools to help you in your particular situation." (Man, no history of depression, medium-high socioeconomic status). "Oh, I've seen it all. Even anger… I don't know… How can you be depressed? You're young, you're… I don't know, pretty, you're so… so much, and I must have fallen into that trap myself at some point." (Woman, no history of depression, medium socioeconomic status).
Emotional detachment	"I think most people don't care. I mean, I think most people either don't ask themselves that question, or they don't care, or they're living in their own world—because people are so selfish." (Woman, no history of depression, lower-middle socioeconomic status). "It's just that they don't take it seriously. Like, there are people who actually think that depression is, more than anything else, a game. (...) So they don't take it seriously and try to make you feel bad with certain comments or things like that." (Woman, no history of depression, middle socioeconomic status). "I feel like (...) they don't take them seriously. It's like they say, 'She has depression,' 'She's sad,' 'She's been crying.' I've also heard a lot of comments like, 'She's cutting herself to get attention' or 'She wants to kill herself just because this or that happened to her.' So those comments really do affect you." (Woman, with a history of depression, middle socioeconomic status). "I think coworkers literally don't care, unless they're a good friend of yours. I don't know, but I think coworkers, classmates, and… no. They live their normal lives and worry about their own problems." (Woman, no history of depression, lower-middle socioeconomic status).

SES: socioeconomic status.

Source: Prepared by the authors of this study.

Social distancing. This category encompasses behaviors of rejection or exclusion toward people with depression. Avoidance was mentioned as one of the most frequent. These practices appear to be linked to the need to protect oneself from the emotional drain that interacting with people living with depression can cause.

Invalidation and judgment. This category grouped behaviors directed toward people with depression that involve dismissing the legitimacy of their distress. These behaviors manifested as questioning the diagnosis or the authenticity of their suffering, based on the idea that there are not sufficient reasons to have depression.

Interaction scripts. This category brought together accounts of what participants consider appropriate behavior when interacting with a person with depression. These behaviors were organized into two subcategories:

1. Evasion, which includes avoiding discussions about topics related to depression and death, treating the person condescendingly, addressing sad topics delicately, and attempting to distract the person with recreational activities. While some of these behaviors were described as protective measures aimed at preventing further distress, participants with a history of depression noted that they could lead to experiences of

Table 4. Examples of illustrative citations from the "behaviors" macrocategory.

Category	Cite
Overprotection	Monitoring "Caution—being mindful of how they're doing, calling them in the morning, asking how they're doing, if they're going to get up, what they're going to do. Trying to always stay up to date on their daily activities. Because with this depression, you can't… it's not that you want to kill yourself, but you do things without thinking, and any accident could kill you. But it's because you don't feel like taking care of yourself. It's not like you go there on purpose to do something." (Man, with a history of depression, high socioeconomic status). "It would be a state of alertness, trying to figure out how to help, but in the sense of making them realize they have to do something, seek professional help… It would be more like guidance, so to speak." (Man, with a history of depression, medium socioeconomic status). Pressure and persistence "It was like others were demanding that—well, at that time, my family was already demanding that I feel better—and there was also that belief we talked about at the beginning, like, 'Oh, come on, there are people who are having a really hard time and who have illnesses, and you don't have any illness,' and that I just had to snap out of it." (Woman, with a history of depression, low socioeconomic status). Infantilization "I think there's a lot of paternalism and a lot of… Or an attitude like, 'It'll pass,' treating you more like a child." (Woman, no history of depression, middle socioeconomic status). "They'd say to me, 'How's your little head?'… like in the way they treated me, in asking, 'How have you been?'" (Man, with a history of depression, high socioeconomic status).
Social distancing	"Actually, I think depression is scary. Plus, nobody wants to hang out with someone who has depression. Nobody talks to you when you're depressed. I mean, that creates a kind of isolation—it's like people don't know how to talk to someone who's depressed, and they don't want to get depressed themselves by being around someone who is. And it's brutal." (Woman, with a history of depression, high socioeconomic status). "And of course, what happens? Suddenly, people don't feel as close or as connected to others, and they just pull away because of that. Because it's there—they're also trying to protect themselves. Because it's complex. It's complex, and interacting with and being around someone who's going through a depressive episode is super complex." (Man, with a history of depression, upper-middle socioeconomic status). "When it comes to friendships—which I've also experienced—you tend to put a little more distance between you. At first, you're more—more involved—calling, asking how they're doing, trying to get together, going to visit. But over time, you still end up drifting away because you don't want to be involved in situations like that; because, as I was saying, it drains your energy." (Woman, with a history of depression, high socioeconomic status).
Invalidation and judgment	"'Oh, but how can you drown in a glass of water?' 'What's happening to you is nonsense.' I mean, you have to get up, move forward, and just keep going as you have to—as if it were a race, like it's something that… has a beginning and an end, and we're all moving forward. So if you just stand still, you're failing, right? You can't just stand still." (Woman, with a history of depression, high socioeconomic status). "When I try to recall what's happened to me, it's mainly that they downplay it, downplay it by saying… 'Oh, poor thing.' Mainly that—I'm looking at it very, very much from a work perspective, because that's what I remember most and how they approached it with me." (Man, with a history of depression, middle socioeconomic status). "So I told him, 'Dad, I know I need to see a psychiatrist; I need help.' And at that moment, his response was something like, 'But you're finishing your degree, they're going to give you your house, you have a son—everything's fine, so why can't you see that?'" (Woman, with a history of depression, low socioeconomic status).
Interaction scripts	Avoiding the issue "I think that, in general, people tend to be more careful when they're interacting with someone who has depression—or when they know they're interacting with someone who has depression. Like, I don't know, not talking about certain topics or not asking them certain things. Maybe to (...) prevent any kind of crisis in the person with depression or something like that." (Woman, no history of depression, middle socioeconomic status). "You try to be gentler with that person, treat them as if they were fragile, like a vase that can't be broken anymore. How do you approach it? How do you find the right words so the person doesn't feel bad? Sometimes it's not even that you're using the wrong words, but you think you are—trying to be as gentle as possible with that person." (Woman, with a history of depression, lower-middle socioeconomic status). Support and inclusion "Supporting them, not leaving them alone—that's what's difficult. Depression goes through different stages, so the level of support you provide depends on the stage. For example, with milder cases of depression… you support them, hugging the person when it helps. But, for example, I haven't personally experienced severe depression, but in much more severe cases, you can't really leave the person alone because they might be at risk of—I don't know—suicide, wanting to kill themselves, or things like that." (Man, no history of depression, middle socioeconomic status).

(Continued)

(Continued)

Category	Cite
	"Ultimately, what you have to try to do is listen, and try to make that person feel like doors are opening for them, so they can be understood and cared for." (Woman, no history of depression, high socioeconomic status). "They felt bad for me, as I mentioned. I think they didn't know… they didn't know how to handle the situation I was going through at that moment. They didn't put a name to it either—like saying, 'She has this,' for example, 'depression' or something—but rather, they didn't know what it was, because it also came with stomach pain. (...) But they always kind of supported me—they were more affectionate during that time, saying things like, 'It doesn't matter anymore; don't go to school; you don't want to go.'" (Woman, with a history of depression, low socioeconomic status).

SES: socioeconomic status.
Quotes broken down by the "behavior" category regarding people with depression.
Source: Prepared by the authors of this study.

exclusion, particularly when they involved being left out of relevant conversations or receiving only positive information about shared events.

2. Support and inclusion, which encompasses behaviors such as active listening, companionship, emotional support, motivating the person, and validating their distress.

DISCUSSION

This research explored the beliefs, emotions, and behaviors of Chilean adults toward those living with depression. The findings show that these behaviors differ in their stigmatizing nature, as some do not constitute expressions of stigma, while others are controversial, in that their classification as such depends on how they are interpreted by the study participants. Thus, the stigma surrounding depression does not emerge as a uniform phenomenon, but rather as a set of heterogeneous expressions that, to varying degrees, can be understood as stereotypes, prejudices, and discrimination.

Regarding beliefs about people with depression—both in terms of affective and behavioral characteristics—the findings include content that partially aligns with recognized manifestations of depression in mental health diagnostic systems, alongside other content of a more stereotypical nature. On the one hand, the link between depression and sadness, hopelessness, thoughts of death or suicide, social withdrawal, and difficulties in daily functioning is consistent, at least in part, with the diagnostic criteria described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) [53] and the International Classification of Diseases, 11th Revision (ICD-11) [54], which may reflect a certain degree of mental health literacy [55]. However, biased and stigmatizing content also emerges, such as the idea of constant emotional overwhelm, the generalized association between depression and suicide, or the characterization of these individuals as lazy or a burden to others. This logic is most clearly expressed in dispositional attributions, where depression is interpreted as a reflection of stable personal traits. Thus, characteristics such as weakness, exaggeration, poor work performance, an inability to recover, a need for constant attention, oddness, or overreaction do not describe the depressive condition but rather reframe it as an individual failing.

Regarding emotions, the findings suggest that not all of them can be understood as prejudice toward people with depression. Emotions such as concern, care, empathy, and understanding are instead linked to prosocial responses, especially when they arise in contexts of relational closeness [56]. Others, however, may be ambiguous in their interpretation. Unease—expressed as fear that the person might harm themselves or as anxiety and discomfort during interaction—seems to be linked to overprotective or paternalistic responses. However, in the interviewees' experience, these emotions are interpreted as a form of exclusion. Indifference, although described as a characteristic of the Chilean social context, is experienced by those with depression as a form of personal invalidation. Similarly, pity, although it may appear as a compassionate reaction, is also interpreted as a form of devaluation. This aligns with the literature on paternalistic prejudice, according to which certain groups may elicit pity, sympathy, and protection, yet at the same time be positioned as less competent and less autonomous, giving rise to subtle forms of exclusion [57,58]. Finally, anger emerges as the most clearly prejudicial emotion and is linked to the idea that recovery depends on individual willpower, reinforcing attributions of personal responsibility for depression. This aligns with the international literature on the stigma of depression, in which recovery is often associated with volitional factors [2,59].

In the behavioral dimension, the findings reveal a wide range of behaviors toward people with depression. Among these are acts of social support, as well as both overt and subtle forms of discrimination. Social distance emerges, in line with the literature, as one of the main mechanisms of social exclusion [60,61]. The accounts link this to the emotional strain and discomfort involved in interacting with people with depression. Similarly, invalidating the diagnosis and questioning the legitimacy of depression are explicit forms of discrimination [2,61]. Alongside these, ambivalent forms emerge, in which care is mixed with compassion, paternalism, and control. Within this framework, findings related to monitoring and pressure require careful interpretation. In specific clinical contexts—particularly in cases of severe depression or when there is a risk of

suicide—monitoring constitutes a recommended practice and an expression of social support consistent with therapeutic guidelines. From this perspective, such behaviors cannot be considered stigmatizing. However, our results suggest that when these responses occur in a generalized manner in the mere presence of depression—regardless of the severity of the condition or the needs expressed by the individual—they may take on a different meaning. Several participants described these behaviors as experiences of surveillance, overprotection, or loss of autonomy. This interpretation is consistent with the stereotype content model [58], which describes paternalistic forms of prejudice characterized by a combination of concern and a perception of incompetence, whose behavioral correlates include over-assistance, excessive protection, and supervision. Similarly, Link and Phelan [21] argue that stigma is not limited to overt rejection but can also manifest through practices that reduce people's autonomy and reinforce asymmetrical power relationships. Likewise, Corrigan and Watson [27] point out that seemingly benevolent responses, such as pity and over-help, can constitute forms of stigmatization by implying a perception of incapacity. Consequently, the social meaning of monitoring appears to depend on the context and on how it is experienced by those living with depression.

This complexity is also evident in interaction scripts. Although avoiding certain topics can be understood as a form of protection, it becomes problematic when it involves silencing distress, particularly because it contradicts international recommendations on suicide prevention, which emphasize the need to reduce stigma, encourage open conversations about suicide, and promote responsive listening [62]. In contrast, supportive and inclusive behaviors are prosocial responses, aligned with mental health first aid recommendations. Consistent with international evidence, these findings reflect the coexistence of supportive experiences and ambivalent forms of interaction in everyday life [63].

Across all the components previously reviewed, a key finding is that various responses associated with concern or protection take on different meanings depending on how they are experienced by those living with depression. While some participants describe them as expressions of support, others interpret them as forms of exclusion, invalidation, loss of autonomy, or stigmatization. These differences were particularly evident in relation to emotions such as pity and hopelessness, as well as in practices involving monitoring, avoidance, caution, and insistence. In this regard, the potentially problematic nature of certain responses depends not only on the intention behind them but also on the meanings attributed to them by those who receive them.

Beyond the components of stigma, the findings also point to the workplace as one of the settings where the stigma surrounding depression is most strongly expressed, making it a particularly relevant context for intervention. In this vein, the literature suggests that strategies based on contact with members of the stigmatized group are among the most effective for reducing stigma [63]. Since workplaces bring together diverse individuals in sustained interactions centered on common goals, they could offer favorable conditions for this type of intervention. In the Chilean context, this reinforces the importance of developing stigma-reduction strategies in the workplace. However, their effectiveness depends not only on contact but also on institutional conditions that promote respectful and non-discriminatory interactions [63].

Among the study's strengths is the inclusion of participants with diverse sociodemographic characteristics, which enhances the generalizability of the findings within the studied context. Furthermore, the methodology made it possible to identify patterns of depression stigma that might go unnoticed when using instruments developed in other cultural contexts. In this regard, these findings provide valuable input for the development of instruments to measure depression stigma in Chile. These instruments will make it possible to characterize this phenomenon and examine its relationship with mental health indicators and help-seeking behaviors. Future studies using quantitative designs could confirm whether the items whose inclusion in the construct was ambiguous are, in fact, valid components of it.

However, these results must be interpreted with certain limitations in mind. First, the close social ties that a significant portion of the sample had with people who have experienced depression may have influenced the results by fostering higher levels of mental health literacy and a more context-specific understanding of the phenomenon. This could be associated with both a lower expression of explicit stigmatization and a greater ability to recognize it in everyday contexts. In this regard, direct or indirect experience with depression can influence both the willingness to express stigmatizing attitudes and the way such attitudes are interpreted, especially in the case of ambiguous behaviors.

Second, the sample was closed based on the fulfillment of quotas defined as a priori rather than on the criterion of theoretical saturation, which implies that saturation was not monitored during fieldwork. However, the strategy of maximum variation, together with stratification by relevant variables and geographic diversification, sought to ensure data adequacy by covering heterogeneous perspectives.

Additionally, two interviewers participated in validating the interview guide and conducting the interviews, and subsequently joined the coding process, which could have influenced the interpretation of the data. To mitigate this risk, the analysis was conducted by a team of seven coders—five of whom did not participate in the fieldwork—using independent coding, triangulation of results, prior training, and continuous supervision.

Finally, although the sampling design incorporated relevant variables to promote a diversity of perspectives, the study did not aim to systematically compare manifestations of stigma among the different groups included. Future research could delve deeper into possible variations in stigma across

different social groups. In particular, it is important to explore potential gender differences, given the higher prevalence of depression among women, both nationally and internationally. Furthermore, various studies have documented higher levels of stigmatization toward mental health issues among men, as well as less favorable attitudes toward acknowledging psychological distress and seeking help [37,40–42]. Similarly, the workplace emerged in participants' accounts as a particularly significant setting for the perpetuation of stigmatizing practices toward people with depression; therefore, future research could examine the characteristics and consequences of these experiences in greater detail.

CONCLUSION

This study shows that stigma toward depression in Chile is not expressed solely through open rejection, but also through subtle and ambivalent forms that can be equally harmful. This has direct implications for public health: anti-stigma strategies that focus solely on overtly negative expressions may overlook forms of treatment that, although not perceived as hostile, nonetheless contribute to exclusion and suffering.

The contextual evidence that this study provides on the phenomenon in Chile can thus guide the design of culturally relevant mental health interventions and policies.

Contributor roles NSO: conceptualization, methodology, securing funding, supervision, formal analysis, drafting the original manuscript, and reviewing and editing the manuscript. MJSF: research, formal analysis, reference management, review and editing of the manuscript. CSF: conceptualization, supervision, review and editing of the manuscript. TAJ: project management, research, formal analysis, reference management, review and editing of the manuscript. RAM: conceptualization, supervision, review and editing of the manuscript.

Acknowledgments We would like to thank María José Segú, Catalina Vera, Yusting San Martín, and Catalina Becerra for their work as interviewers. We would also like to thank the lived experience experts for their contributions and for their participation in the study.

Competing interests The authors declare that they have no conflicts of interest.

Funding This study was funded by FONDECYT Regular Project No. 1240745. The funding agency played no role in the study design, data collection, analysis, interpretation of the results, or drafting of the manuscript.

Statement on the use of artificial intelligence models Artificial intelligence tools were used solely to translate the abstract into English. These tools were not used for data analysis, interpretation of results, or drawing conclusions.

Protocol registry It does not have a registered protocol.

Ethics This study has been approved by the Scientific Ethics Committee of the University of La Frontera (Minutes No. 040/24, dated April 8, 2023). All participants provided their informed consent prior to participation.

Data sharing statement The data supporting the findings of this study are available upon request from the corresponding author.

Supplementary files Supplementary material related to this paper is available athttps://doi.org/10.17605/OSF.IO/NUKHW

Language of submission Spanish.

Peer review and provenance Unsolicited. Peer-reviewed by four reviewers, all on a double-blind basis.

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Estigma de depresión en Chile: estudio cualitativo sobre creencias, emociones y conductas relativas a personas con depresión

RESUMEN

INTRODUCCIÓN La depresión constituye una de las principales causas de discapacidad en Chile, afectando de manera significativa el bienestar y la participación social de las personas adultas. A pesar de su alta prevalencia, el estigma de depresión ha sido escasamente estudiado en el país. Considerando que sus manifestaciones varían según el contexto sociocultural, comprender cómo se configura en Chile resulta fundamental para desarrollar intervenciones pertinentes. En este marco, el estigma de depresión se examina a partir de sus componentes clásicos -estereotipos, prejuicios y discriminación a través de las creencias, emociones y conductas dirigidas hacia las personas que viven con depresión. El objetivo de este estudio es explorar, desde la perspectiva de personas adultas chilenas, las creencias socialmente compartidas sobre las personas que viven con depresión, así como las emociones y conductas dirigidas hacia ellas, y examinar en qué medida estos contenidos son significados como expresiones de estigma de depresión.

MÉTODOS Se realizó un estudio cualitativo con muestreo intencional, aplicando criterios de representatividad mínima grupal según género, nivel socioeconómico y antecedentes de depresión. Participaron 66 personas adultas de tres regiones del país, en entrevistas individuales semiestructuradas. Las entrevistas fueron transcritas, revisadas, contrastadas con quienes participaron y codificadas por dos codificadores independientes. Posteriormente, se realizó un análisis de contenido con aproximación deductiva-inductiva, con apoyo del software Atlas.ti, cuyos resultados fueron triangulados.

RESULTADOS Los hallazgos se organizaron en tres macrocategorías analíticas (creencias, emociones y conductas dirigidas hacia personas con depresión), coherentes con los componentes cognitivo, afectivo y conductual del estigma descritos en la literatura. Respecto de las creencias emergieron contenidos referidos a características afectivas, características comportamentales y atribuciones disposicionales asociadas a las personas con depresión. En emociones emergieron del tipo compasivas, defensivas y de malestar, además de desconexión afectiva. En conductas emergieron comportamientos de sobreprotección, distanciamiento social, invalidación y juicio, junto a guiones de interacción basados en la evasión y el apoyo.

CONCLUSIONES Los hallazgos muestran que el estigma de depresión en Chile se configura mediante contenidos que, en distintos grados, son significados como estereotipos, prejuicios y discriminación. Las creencias articulan elementos vinculados tanto a la alfabetización en salud mental como a estereotipos; las emociones son principalmente significadas como expresiones de prejuicio; y las conductas dan cuenta de formas de discriminación sutil y manifiesta. Asimismo, algunos contenidos mostraron interpretaciones divergentes entre los participantes, particularmente entre quienes tenían y no tenían antecedentes de depresión. En conjunto, estos resultados permiten comprender cómo se estructura este fenómeno en el contexto chileno y ofrecen insumos para el desarrollo de instrumentos de evaluación y estrategias de intervención culturalmente pertinentes.