

Stigma as a Behavioral Determinant of Healthy Aging: Ageism and Dementia as Illustrative Contexts [†]

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Abstract

Stigma, including ageism and dementia-related stigma, operates as a behavioral determinant shaping beliefs, expectations and actions across the life course. This narrative conceptual synthesis draws on World Health Organization frameworks and selected literature to examine how stigma influences behavior at individual and professional levels. Ageism reinforces assumptions of decline and dependency, which may be internalized, reducing engagement in health-promoting behaviors. Dementia stigma contributes to delayed help-seeking, underdiagnosis, and therapeutic nihilism, influencing clinical decision-making and access to rehabilitation and psychosocial interventions. Addressing stigma is critical to modifying behavior, improving care engagement, and supporting inclusive, person-centered approaches to healthy aging and dementia.

Keywords: ageism; behavioral determinants; dementia stigma; healthy aging; help-seeking behavior; therapeutic nihilism

1. Introduction

Population aging is one of the most significant demographic transformations of the 21st century, with wide-ranging implications for health systems, social structures, and individual well-being. The World Health Organization (WHO) conceptualizes healthy aging as the process of developing and maintaining functional ability in older age [1]. This perspective emphasizes that health outcomes in later life are shaped by social and behavioral determinants in addition to biological processes.

Among these determinants, stigma is a pervasive and under-recognized influence. Stigma operates through socially constructed beliefs and attitudes that affect how individuals perceive themselves and others. In the context of aging, stigma is commonly expressed as ageism, defined by WHO as stereotypes, prejudice, and discrimination based on age. Ageism is often normalized and embedded within institutions, influencing policy, clinical practice and everyday interactions [2].

Dementia-related stigma further compounds these effects. Despite increasing global awareness, dementia continues to be associated with fear, misunderstanding, and low expectations for care and recovery. The Alzheimer's Disease International (ADI) World Alzheimer's Report 2024 highlights persistent misconceptions about dementia and the substantial gap between diagnosis and access to meaningful support [3].



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This narrative conceptual synthesis draws upon WHO frameworks on ageism, ADI reports and global evidence on dementia stigma as a behavioral determinant of healthy aging. It explores how stigma affects beliefs, behaviors, and health outcomes at individual, professional, and system levels. Particular attention is given to ageism and dementia-related stigma as illustrative examples of how stigmatizing beliefs may influence health behaviors, clinical decision-making, and care delivery.

2. Conceptual Framework: Stigma as a Behavioral Determinant

Stigma can be understood as a multidimensional construct operating through interrelated cognitive, affective, and behavioral mechanisms. Stigma refers broadly to processes of stereotyping, prejudice, and discrimination directed toward particular characteristics or groups [4]. Ageism represents stigma based on chronological age [5], whereas dementia-related stigma refers to negative attitudes, stereotypes, and discriminatory behaviors associated with cognitive impairment and dementia [6]. In healthcare settings, these processes may contribute to therapeutic nihilism, a related but distinct phenomenon whereby healthcare professionals underestimate the potential benefits of assessment, treatment, rehabilitation, or supportive interventions.

At the cognitive level, stigma is expressed through stereotypes and socially constructed beliefs, such as the assumption that aging is inevitably associated with decline, dependency, and reduced capacity for change. At the affective level, these beliefs generate emotional responses including fear, pity, discomfort, or avoidance, particularly in relation to conditions such as dementia that are associated with loss of identity and autonomy. These cognitive and emotional processes translate into behavioral consequences, influencing how individuals act toward themselves and others [7].

From a behavioral science perspective, stigma affects a person's beliefs and influences intentions, decisions, and actions [8]. At the individual level, stigma may be internalized, leading to negative self-perceptions of aging, reduced self-efficacy, and diminished expectations for recovery or improvement. These internalized beliefs can alter motivation and engagement in health-promoting behaviors, including physical activity, preventive healthcare, and social participation [9]. At the interpersonal level, stigma shapes interactions between individuals, families, and healthcare providers, affecting communication, trust, and care-seeking behavior. At the institutional level, stigma is embedded within policies, clinical norms, and resource allocation, often in subtle and unrecognized ways that systematically disadvantage older adults [10]. For example, assumptions that functional decline is an inevitable consequence of aging rather than a potentially modifiable condition may lead to lower prioritization of rehabilitation services for older adults. Such institutional practices may unintentionally reinforce disparities in access to care and opportunities for healthy aging.

Stigma is a dynamic process that is reinforced through repeated social interactions and cultural narratives. In the context of aging and dementia, stigma is often normalized and therefore less visible, yet its effects are cumulative [11]. In aging, normalization may occur through commonly accepted assumptions that frailty, dependency, and reduced participation are inevitable aspects of later life. Similarly, dementia stigma may be reinforced through narratives that equate diagnosis with irreversible decline and loss of personhood. Because such beliefs are often socially accepted rather than overtly challenged, their influence on behavior and decision-making may remain largely unrecognized despite their cumulative impact. Understanding stigma through this multilevel behavioral framework allows for clearer identification of intervention points to promote healthier aging trajectories.

3. Evidence Synthesis

3.1. Ageism and Its Behavioral Consequences

The WHO Global Report on Ageism identifies ageism as a widespread and often invisible form of discrimination with significant consequences for health and well-being. Ageist stereotypes commonly portray older adults as frail, dependent and resistant to change. These assumptions can become internalized, influencing how individuals perceive their own aging process [2].

Internalized ageism has been associated with lower physical activity levels, reduced engagement in health-promoting behaviors, poorer self-rated health and increased risk of functional decline. According to stereotype embodiment theory [12], age-related stereotypes may become internalized across the life course, subsequently affecting perceived control, self-efficacy and motivation, which are essential for sustaining healthy behaviors. These effects may influence uptake of preventive screening programs, falls prevention initiatives, rehabilitation services, and community-based healthy ageing programs, thereby contributing to avoidable health inequalities in later life [13].

At the professional level, ageism may impact clinical decision-making. Healthcare providers may hold implicit biases that lead to under-screening, less aggressive treatment, or assumptions that certain interventions are not beneficial for older patients. Similarly, ageist assumptions may contribute to reduced referral to rehabilitation and more conservative treatment approaches, potentially resulting in inequitable care and poorer outcomes [14]. These practices contribute to disparities in care and suboptimal health outcomes.

3.2. Dementia Stigma and the Care Gap

Dementia-related stigma represents a significant barrier to effective care. The ADI World Alzheimer's Report 2024 described how misconceptions about dementia are common, including beliefs that dementia is a normal part of aging and that little can be done after diagnosis [3]. These beliefs have direct behavioral consequences. Individuals may delay seeking help due to fear or denial, leading to late diagnosis when opportunities for intervention are reduced. Families may conceal symptoms due to stigma, limiting access to formal care services [15].

ADI also identified a global post-diagnostic care gap, where individuals receive a diagnosis but lack access to ongoing support, rehabilitation and psychosocial interventions. This gap is partly driven by therapeutic nihilism among healthcare providers, who perceive dementia as a condition where little can be done beyond diagnosis and underestimate the benefits of available interventions. Despite increasing evidence supporting rehabilitation, cognitive stimulation therapy, and post-diagnostic support, low expectations regarding treatment benefits may contribute to underutilization of these interventions [3,16].

4. Behavioral Pathways Linking Stigma to Health Outcomes

Stigma influences health outcomes through multiple, interacting behavioral pathways that operate across the life course. At the individual level, internalized stigma plays a central role. Older adults who adopt negative societal beliefs about aging may experience reduced perceived control, lower motivation, and diminished expectations regarding their ability to benefit from interventions [9]. These psychological shifts translate into behavioral disengagement from health-promoting behaviors. Over time, this contributes to a self-reinforcing cycle in which negative expectations lead to poorer functional outcomes, which in turn reinforce the original beliefs [17].

At the interpersonal level, experiences of stigma, such as dismissive communication or perceived discrimination, can erode trust in healthcare providers and systems. This may

lead to delayed help-seeking, reluctance to disclose symptoms, and reduced adherence to treatment recommendations [18]. For dementia, stigma-related fear and denial are particularly salient, often resulting in delayed diagnosis and missed opportunities for early intervention and support [6].

At the professional level, stigma manifests through implicit biases and low expectations among healthcare providers. Therapeutic nihilism, characterized by the belief that little can be done to improve outcomes, can influence clinical decision-making, resulting in under-referral to rehabilitation, cognitive stimulation, and psychosocial interventions. These behaviors are not necessarily intentional but reflect deeply embedded assumptions about aging, cognitive decline and the perceived futility of treatment [14]. Despite increasing evidence supporting rehabilitation approaches and post-diagnostic support programs, these assumptions may contribute to inequities in access to person-centered care and opportunities to live well with dementia.

At the system level, stigma impacts the broader patterns of care delivery through its influence on policy priorities, funding decisions, and service design. Conditions associated with aging, including dementia, may receive less emphasis in prevention and rehabilitation strategies, reinforcing gaps in service provision [10]. Although multiple factors contribute to differences in service development, societal perceptions and expectations surrounding aging and dementia may partly influence policy priorities and patterns of care. This may be illustrated by comparison with other chronic conditions such as cancer. In many health systems, cancer pathways include structured screening programs, multidisciplinary treatment teams, survivorship services, rehabilitation, and extensive public awareness campaigns [19]. In contrast, dementia services frequently remain fragmented, with substantial variation in access to timely diagnosis, rehabilitation, and post-diagnostic support [20]. These structural factors interact with individual and interpersonal processes, creating cumulative disadvantage over time.

Together, these pathways illustrate how stigma acts as a behavioral determinant that links beliefs and attitudes to tangible differences in health behaviors, service utilization, and outcomes [21]. Addressing these pathways requires interventions that target not only individual beliefs but also professional practices and systemic structures.

5. Synthesis of Mechanisms and Outcomes

Stigma operates across multiple interacting domains, linking underlying mechanisms to observable behavioral responses and clinical outcomes. Table 1 summarizes these relationships across individual, professional, and system levels.

Table 1. Stigma as a Behavioral Determinant: Pathways and Consequences.

Domain	Mechanism	Behavioral Impact	Clinical/System Outcome
Ageism (Individual)	Internalized stereotypes of decline	Reduced physical activity, disengagement from care	Functional decline, poorer mental health
Ageism (Professional)	Implicit bias, low expectations	Under-screening, conservative treatment	Inequitable care, missed interventions
Dementia stigma (Individual)	Fear, denial, shame	Delayed help-seeking, symptom concealment	Late diagnosis, reduced treatment window
Dementia stigma (Family/Society)	Misconceptions, social exclusion	Reduced disclosure, reliance on informal care	Care burden, inadequate support

Table 1. Cont.

Domain	Mechanism	Behavioral Impact	Clinical/System Outcome
Dementia stigma (Healthcare)	Therapeutic nihilism	Under-referral to interventions	Reduced function, poorer outcomes
System-level stigma	Policy neglect, resource bias	Limited service development	Structural inequities

Adapted from WHO Global Report on Ageism [2], ADI World Alzheimer’s Report 2024 [3] and Hatzenbuehler et al. [21].

Similar mechanisms, such as low expectations and internalized beliefs, manifest differently across contexts but converge in limiting engagement with care and access to effective interventions. Thus, it is important to address stigma as a cross-cutting determinant, rather than as isolated phenomena within aging or dementia initiatives.

6. Implications for Policy, Practice and Future Research

Addressing stigma requires coordinated, multilevel strategies that align with both WHO and ADI recommendations [2,3]. At the policy level, anti-discrimination frameworks and age-inclusive health strategies are essential to counter structural ageism. Educational interventions targeting the public and healthcare professionals can help challenge misconceptions about aging and dementia while promoting more accurate and empowering narratives. In clinical practice, efforts should focus on strengthening person-centered care and addressing therapeutic nihilism through evidence-based training. At the community level, dementia-friendly initiatives and social inclusion programs can help reduce stigma and support participation [22]. Together, these approaches emphasize that stigma is not only a social issue but a modifiable determinant of health behavior and outcomes.

As a narrative conceptual synthesis, this paper was not intended to provide a systematic review of the literature, and the relationships described should be interpreted as conceptual pathways supported by selected empirical evidence rather than definitive causal mechanisms.

Although evidence supports associations between stigma and adverse health behaviors, important knowledge gaps remain. Longitudinal studies examining causal pathways between stigma and healthy aging outcomes are limited, particularly in low- and middle-income settings. Further research is needed to determine which anti-stigma interventions produce sustained changes in attitudes and whether reductions in stigma translate into measurable improvements in help-seeking, service utilization, functional outcomes, and quality of life. Greater understanding of professional stigma and therapeutic nihilism may also inform the development of more effective person-centered models of care.

7. Conclusions

Stigma, particularly ageism and dementia-related stigma, is a significant behavioral determinant of healthy aging. It affects beliefs, expectations and actions across individual, professional and system levels. Stigma creates barriers to care, reduces engagement in health-promoting behaviors, and contributes to inequitable outcomes.

Importantly, stigma is modifiable. Addressing it through coordinated policy, education, and practice interventions is essential for achieving inclusive, person-centered approaches to healthy aging and dementia care. Integrating efforts to combat ageism and dementia stigma is essential to realizing the goals of the Decade of Healthy Ageing.

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Abbreviations

The following abbreviations are used in this manuscript:

WHO World Health Organization
ADI Alzheimer's Disease International

References

1. Rudnicka, E.; Napierała, P.; Podfigurna, A.; Męczekalski, B.; Smolarczyk, R.; Grymowicz, M. The World Health Organization (WHO) approach to healthy ageing. *Maturitas* **2020**, *139*, 6–11. [CrossRef] [PubMed]
2. World Health Organization. *Global Report on Ageism*; WHO: Geneva, Switzerland, 2021. Available online: <https://iris.who.int/server/api/core/bitstreams/71ad96a0-d29a-4457-9d54-52029c24c76c/content> (accessed on 22 March 2026).
3. Alzheimer's Disease International. *World Alzheimer Report 2024*; ADI: London, UK, 2024. Available online: <https://www.alzint.org/u/World-Alzheimer-Report-2024.pdf> (accessed on 22 March 2026).
4. Turan, J.M.; Elafros, M.A.; Logie, C.H.; Banik, S.; Turan, B.; Crockett, K.B.; Pescosolido, B.; Murray, S.M. Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med.* **2019**, *17*, 7. [CrossRef] [PubMed]
5. Chang, E.S.; Kanno, S.; Levy, S.; Wang, S.Y.; Lee, J.E.; Levy, B.R. Global reach of ageism on older persons' health: A systematic review. *PLoS ONE* **2020**, *15*, e0220857. [CrossRef] [PubMed]
6. Low, L.F.; Purwaningrum, F. Negative stereotypes, fear and social distance: A systematic review of depictions of dementia in popular culture in the context of stigma. *BMC Geriatr.* **2020**, *20*, 477. [CrossRef] [PubMed]
7. Coelho-Junior, H.J.; Calvani, R.; Picca, A.; Landi, F.; Marzetti, E. The influence of ageism on the hallmarks of aging: Where age stigma and biology collide. *Exp. Gerontol.* **2024**, *196*, 112575. [CrossRef] [PubMed]
8. Tyler, I.; Slater, T. Rethinking the sociology of stigma. *Sociol. Rev.* **2018**, *66*, 721–743. [CrossRef]
9. Alonson, M.; Guillén, A.I.; Muñoz, M. Interventions to reduce internalized stigma in individuals with mental illness: A systematic review. *Span. J. Psychol.* **2019**, *22*, E27. [CrossRef] [PubMed]
10. Allen, J.; Sikora, N. Aging stigma and the health of US adults over 65: What do we know? *Clin. Interv. Aging* **2023**, *18*, 2093–2116. [CrossRef] [PubMed]
11. Kaufman, J.M.; Johnson, C. Stigmatized individuals and the process of identity. *Sociol. Quart.* **2016**, *45*, 807–833. [CrossRef]
12. Levy, B. Stereotype embodiment: A psychosocial approach to aging. *Curr. Dir. Psychol. Sci.* **2009**, *18*, 332–336. [CrossRef] [PubMed]
13. Turpin, R.E. Health care stereotype threat: The danger and damage of stigma and discrimination in health care. *Am. J. Public Health* **2025**, *115*, 265–267. [CrossRef] [PubMed]
14. Nyblade, L.; Stockton, M.A.; Giger, K.; Bond, V.; Ekstrand, M.L.; McLean, R.; Mitchell, E.M.H.; Nelson, L.R.E.; Sapag, J.C.; Siraprapasiri, T.; et al. Stigma in health facilities: Why it matters and how we can change it. *BMC Med.* **2019**, *17*, 25. [CrossRef] [PubMed]
15. Nguyen, T.; Li, X. Understanding public-stigma and self-stigma in the context of dementia: A systematic review of the global literature. *Dementia* **2020**, *19*, 148–181. [CrossRef] [PubMed]
16. Banerjee, S.; Willis, R.; Graham, N.; Gurland, B.J. The Stroud/ADI dementia quality framework: A cross-national population-level framework for assessing the quality of life impacts of services and policies for people with dementia and their family carers. *Int. J. Geriatr. Psychiatry* **2010**, *25*, 249–257. [CrossRef] [PubMed]
17. Corrigan, P.W.; Bink, A.B.; Schmidt, A.; Jones, N.; Rüsch, N. What is the impact of self-stigma? Loss of self-respect and the 'why try' effect. *J. Ment. Health* **2016**, *25*, 10–15. [CrossRef] [PubMed]

18. Darnell, W.H.; Chunduru, J.; Rosenblum, J.L.; South, A.L.; Altman, W. “It makes me feel bad about the world of medicine, makes me not want to go”: Understanding weight stigma, disconfirming messages and health outcomes. *Health Commun.* **2026**, *1*, 1–15. [[CrossRef](#)] [[PubMed](#)]
19. Krishnasamy, M.; Hyatt, A.; Chung, H.; Gough, K.; Fitch, M. Refocusing cancer supportive care: A framework for integrated cancer care. *Support. Care Cancer* **2023**, *31*, 14. [[CrossRef](#)] [[PubMed](#)]
20. Smith, R.; Martin, A.; Wright, T.; Hulbert, S.; Hatzidimitriadou, E. Integrated dementia care: A qualitative evidence synthesis of the experiences of people living with dementia, informal carers and healthcare professionals. *Arch. Gerontol. Geriatr.* **2021**, *97*, 104471. [[CrossRef](#)] [[PubMed](#)]
21. Hatzenbuehler, M.L.; Phelan, J.C.; Link, B.G. Stigma as a fundamental cause of population health inequalities. *Am. J. Public Health* **2013**, *103*, 813–821. [[CrossRef](#)] [[PubMed](#)]
22. Herrmann, L.K.; Welter, E.; Leverenz, J.; Lerner, A.J.; Uderson, N.; Kanetsky, C.; Sajatovic, M. A Systematic Review of Dementia-related stigma Research: Can we move the stigma dial? *Am. J. Geriatr. Psychiatry* **2017**, *26*, 316–331. [[CrossRef](#)] [[PubMed](#)]

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