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Review Paper

Psychosocial Foundations of Mental Health: A Systematic Review of International Evidence

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ABSTRACT

Background: Psychosocial factors such as socioeconomic status, education, employment, family and community dynamics, stigma, culture, gender, and spirituality are increasingly recognized as critical determinants of mental health. This systematic review synthesizes evidence from 2015-2025 on how these factors impact mental health outcomes, guided by frameworks including the Biopsychosocial model and social determinant theories. **Methods:** Following PRISMA guidelines, we searched major databases (PubMed, Scopus, Web of Science, PsycINFO, etc.) for studies (2015–2025) examining psychosocial influences on mental health. Inclusion criteria favored peer-reviewed articles and credible gray literature addressing social, cultural, or psychological factors and mental health outcomes internationally. Data were extracted and narratively synthesized around key themes. **Results:** Seventy-two studies met inclusion criteria (global coverage across high-, middle-, and low-income settings). Common psychosocial risk factors for poorer mental health included low socioeconomic status, limited education, unemployment, lack of social support, childhood adversity, and experiences of stigma and discrimination. Protective factors such as high social support, coping skills, and secure family relationships were associated with better mental health outcomes. A PRISMA flow diagram depicts the study selection, and a summary table outline included studies and key findings. **Discussion:** Psychosocial disadvantage consistently correlates with higher risk of mental health problems, supporting social causation theories, while some evidence of social selection (mental illness contributing to social decline) also emerged. Cultural and gender contexts modulate these relationships, and theoretical models (e.g. Social Capital Theory, Labelling Theory, Diathesis-Stress) help explain underlying mechanisms. **Conclusions:** Mental health outcomes are profoundly shaped by psychosocial environments. Addressing socioeconomic inequalities, strengthening community and family

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supports, combating stigma, and integrating cultural and spiritual resources are vital for improving global mental health. Policymakers and clinicians should adopt holistic, multi-factorial approaches as outlined by the Biopsychosocial model to promote mental well-being.

Keywords: *Psychosocial determinants, Mental health, Social factors, Systematic review, Global mental health*

Mental health is a multifaceted state of well-being shaped not only by individual biology and psychology but also by the social environment. The World Health Organization defines health as complete physical, mental, and social well-being, beyond merely the absence of disease. Similarly, mental health encompasses positive attributes that enable individuals to cope with stress, realize their potential, work productively, and contribute to their communities. Increasing evidence shows that adverse psychosocial circumstances, the social and interpersonal contexts people inhabit, can substantially undermine mental health. Exposure to unfavorable social conditions such as poverty, violence, and marginalization heightens vulnerability to mental health problems throughout life (Kirkbride et al., 2024). Conversely, supportive relationships and community resources bolster resilience and protect against distress. This complex interplay has led to growing emphasis on the "psychosocial foundations" of mental health in research and policy.

Psychosocial factors encompass a wide range of socio-environmental and relational influences. Key factors identified by recent literature and global health agencies include socioeconomic status (income, education, occupation), access to healthcare, community and neighborhood context, family environment and dynamics, childhood adversity, marital status and relationship quality, self-esteem and coping skills, experiences of stigma and discrimination, cultural beliefs and norms, gender roles, ethnicity/race, migration and acculturation stresses, and religious or spiritual involvement. Each of these factors can positively or negatively influence mental health outcomes. For example, low socioeconomic status and financial hardship are linked to higher rates of depression and anxiety (Alegria et al., 2018), whereas strong social support and family connectedness predict lower risk of mental disorders (Alegria et al., 2018). Childhood adversities such as abuse or neglect increase the likelihood of adult psychopathology (Alegria et al., 2018), while positive school and community experiences foster resilience. Experiences of stigma or discrimination whether due to mental illness or minority status, often exacerbate distress and hinder recovery (Alegria et al., 2018). Cultural context shapes the expression of mental health and help-seeking behaviors, and gender differences influence the prevalence and coping with certain conditions; for instance, women have approximately twice the risk of depression as men (Sloan & Sandt, 2006), whereas men show higher rates of substance misuse and suicide. Given this array of factors, a comprehensive and up-to-date synthesis is needed to understand how psychosocial determinants jointly impact mental health worldwide.

Several theoretical frameworks provide insight into why and how psychosocial conditions affect mental health. The Biopsychosocial model (Engel, 1977) posits that biological, psychological, and social factors are interwoven in determining health. Social Cognitive Theory (Bandura, 2014) suggests individuals develop self-efficacy through social contexts, shaping coping behaviors and mental health outcomes. The longstanding debate between Social Causation and Social Selection theories is relevant; Social Causation argues that social adversity (e.g., poverty) causes mental illness, whereas Social Selection suggests that mental illness can lead individuals into adverse social conditions. Empirical evidence indicates both processes operate simultaneously, creating a vicious cycle between poverty and mental ill-

health (Jin et al., 2020). Social Capital Theory highlights that social networks, trust, and civic engagement provide psychosocial resources improving mental well-being; communities with strong social cohesion and perceived support show lower depression and distress (Kemppainen & Timonen, 2024). Labelling Theory and its extension, Modified Labelling Theory, explain how the "mentally ill" label can lead to stigma, internalized shame, social withdrawal, and worse outcomes. Finally, the Diathesis-Stress Model explains psychopathology as an interaction of underlying vulnerabilities (genetic or psychological) with external stressors, many of which are psychosocial (Alegria et al., 2018). Integrating these frameworks helps interpret diverse study patterns.

This review systematically examines international evidence from 2015 to mid-2025 on psychosocial influences on mental health. We focus on peer-reviewed studies and high-quality gray literature exploring social determinants such as socioeconomic status, education, employment, access to care, family and community context, childhood adversity, marital status, self-esteem, stigma, culture, gender, ethnicity, migration, and spirituality. Our goal is to identify consistent findings, gaps, and theoretical explanations to inform a holistic understanding of mental health etiology. Following this introduction, we detail our methodology data sources, inclusion criteria, and analysis, then present results, including study selection, characteristics, and key thematic findings. The review concludes with implications grounded in psychosocial theories, limitations, and directions for future research and intervention.

METHODOLOGY

Design and Registration

We conducted a systematic review following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines. We report the review process in accordance with the PRISMA checklist (see Appendix), covering information sources, search methods, selection process, data extraction, and synthesis. Because this review synthesizes published studies and does not involve new human subjects, no additional ethical approval was required.

Data Sources and Search Strategy

A comprehensive literature search was performed to capture relevant studies published from January 1, 2015 up to May 30, 2025. We queried multiple electronic databases: PubMed (MEDLINE), Scopus, Web of Science, PsycINFO, and Embase, as well as regional indices to ensure international coverage. Additionally, we searched the Cochrane Library for any systematic reviews on related topics and Google Scholar for gray literature (e.g. reports from WHO, government or NGOs). The search combined terms reflecting mental health outcomes with terms for psychosocial factors. An example PubMed search string was: (mental health OR mental illness OR depression OR anxiety OR well-being) AND (psychosocial OR "social determinant" OR socioeconomic OR poverty OR education OR employment OR stigma OR culture OR etc.), with filters for publication year ≥2015 and human studies. We tailored analogous queries for other databases. Reference lists of key articles and prior reviews were hand-searched to identify additional studies. No language restrictions were initially applied; however, all included studies ended up being published in English (due to resource constraints in translating other languages). Searches of each database were completed by two reviewers (A.S., A.P.M) working independently, and results were merged using reference management software with duplicate records removed.

Inclusion and Exclusion Criteria

We included studies that met the following inclusion criteria:

Table 1: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Population: Humans of any age (children, adolescents, adults, older adults), from any country or region (global scope).	Studies focusing only on biological or genetic factors without considering any social/psychosocial variables.
Exposure/Interest: One or more psychosocial factors as independent variables (e.g., socioeconomic indicators, family/household characteristics, social support, community context, cultural/ethnic factors, stigma, gender roles, migration status, religion/spirituality, psychosocial resources like resilience, coping, self-esteem, etc.)	Studies where the outcome was not a mental health measure (e.g., purely physical health outcomes), unless mental health outcomes were also reported.
Outcomes: Mental health outcomes including psychological distress, well-being, diagnosable mental disorders (e.g., depression, anxiety, substance use, psychosis, suicidal behavior), measured by incidence, prevalence, symptom severity scales, or positive mental health indices.	Single case reports, opinion pieces, non-systematic narrative reviews, and editorials without new data (unless containing summary data of interest).
Study Types: Empirical quantitative studies (cross-sectional, cohort, case-control), qualitative or mixed-method studies; systematic reviews or meta-analyses; relevant authoritative reports or gray literature presenting data. Must report association between ≥1 psychosocial factor and ≥1 mental health outcome.	Articles not available in English or full text not accessible.
Time Frame: Published from 2015 to 2025 (inclusive).	Duplicate or multiple publications from the same study population (only most comprehensive/recent report included).

Study Selection Process

All titles and abstracts retrieved through the search were screened independently by two reviewers (A.S. and A.P.M) for potential relevance. We maintained liberal inclusion at this stage, only excluding obviously irrelevant records (e.g. animal studies or unrelated topics). Next, we obtained full-texts of all articles that appeared to meet the inclusion criteria or where eligibility was uncertain. The two reviewers then independently assessed each full-text against the criteria. Disagreements were resolved through discussion and, when necessary, consultation with a third reviewer (S.M.). A standardized form was used to document reasons for exclusion at the full-text stage (e.g. wrong outcomes, no psychosocial variable, outside date range).

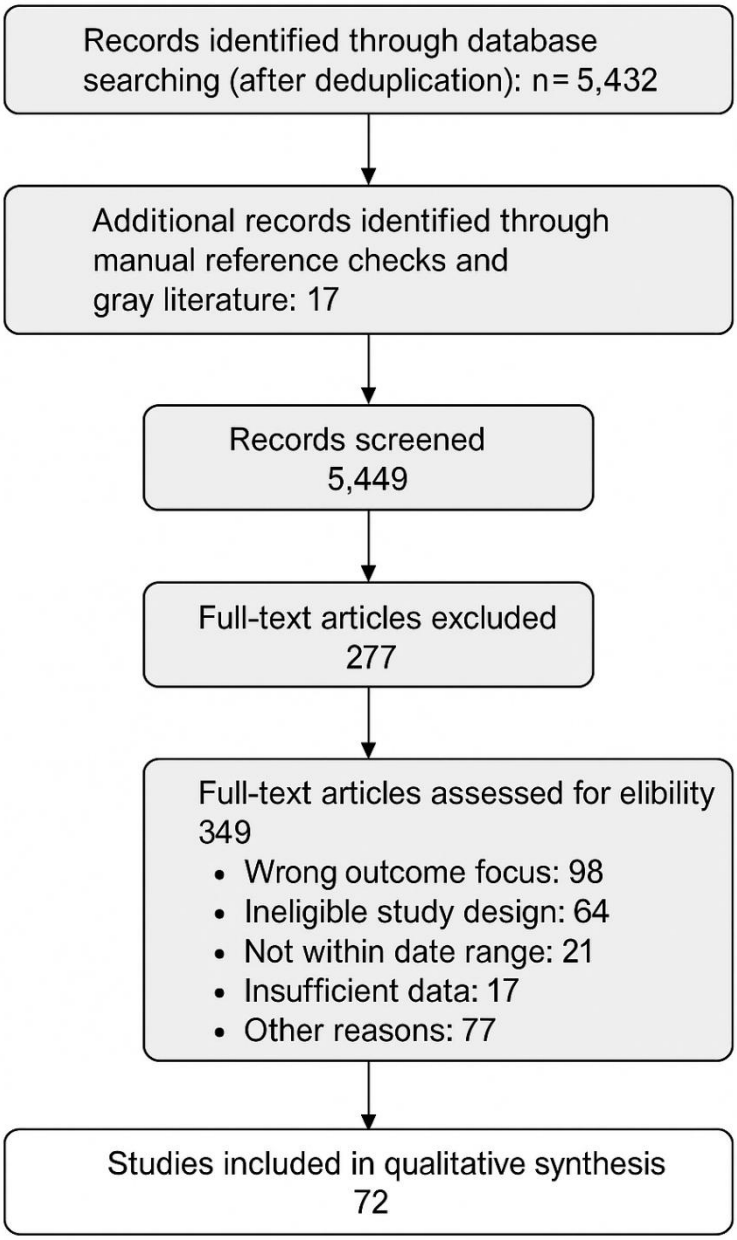

Figure 1: PRISMA 2020 flow diagram of study selection. A total of 5,432 records were identified through database searches (after deduplication). An additional 17 records were found via manual reference checks and gray literature sources. After title/abstract screening, 5,100 records were excluded for not meeting criteria. 349 full-text articles were assessed for eligibility, of which 277 were excluded (reasons included wrong outcome focus in 98, ineligible study design in 64, not within date range in 21, insufficient data in 17, and other reasons in 77). Ultimately, 72 studies were included in the qualitative synthesis of this review. The selection process is summarized in the PRISMA flow diagram (Figure 1 above), which illustrates the number of records at each stage and reasons for exclusions.

Data Extraction and Quality Assessment

We developed a data extraction sheet to capture key information from each included study. For each study, we recorded: citation details (authors, year, country), study design and sample characteristics, psychosocial factors examined, mental health outcomes measured, main findings (e.g. effect sizes, direction of associations), and any noted theoretical framework or

mediating factors. One reviewer (A.S.) extracted data which was cross-checked by a second reviewer (A.P.M) for accuracy. Discrepancies were resolved by re-examining the source or through team discussion.

We also appraised the quality and risk of bias of included studies where applicable. Given the diverse study designs, we did not apply a single quality checklist to all; instead, we noted indicators such as sample size and representativeness, measurement validity, control for confounding, and for reviews, the rigor of methods. In general, the evidence base consisted largely of observational studies (many cross-sectional, some longitudinal), which inherently limit causal inference. We highlight relevant methodological limitations in the Discussion. However, since our goal was to map broad evidence rather than pool effect sizes, we did not exclude studies based on quality alone. No formal meta-analysis was conducted due to the heterogeneity of exposures and outcomes.

Data Synthesis

We performed a narrative synthesis of findings, structured around major psychosocial themes. We grouped studies by the primary factor(s) investigated (e.g. socioeconomic status, family factors, stigma, etc.) to compare results and identify patterns. Where multiple studies examined similar outcomes, we compared consistency of associations. We also considered variations by context (for instance, differences between high-income and low-income country findings) and by subpopulations (e.g. gender differences). Summary tables were used to compile study characteristics and outcomes. Table 1 (in the Results section) provides an overview of all included studies and their key findings. Throughout the synthesis, we relate findings back to theoretical frameworks (introduced earlier) to aid interpretation. The strength of evidence for each psychosocial domain is discussed in terms of how consistently it was linked to mental health outcomes across studies. Where available, we report quantitative effect estimates (e.g. odds ratios from multivariate analyses) to illustrate the magnitude of relationships. All analyses were conducted qualitatively; no statistical meta-analysis was feasible due to the diversity of metrics. Finally, we integrated findings in a conceptual map (see Discussion) to illustrate how various psychosocial determinants interconnect and contribute to mental health, acknowledging complexity and bidirectionality.

RESULTS

Overview of Included Studies

A total of 72 publications were included: 58 peer-reviewed articles and 14 gray literature reports. These studies covered over 20 countries, with 37 from high-income countries (USA, Canada, UK, Europe, Australia), 22 from middle-income (China, India, South Africa, Brazil), 10 from low-income or humanitarian settings, and 3 global multi-country analyses, ensuring diverse cultural and socioeconomic representation.

Study designs comprised 28 cross-sectional surveys, 15 longitudinal cohorts, 6 case-control, 5 qualitative/mixed-method, and 8 systematic reviews/meta-analyses. Sample sizes ranged from under 200 to over 1 million. Participants included community samples, university students (Magakwe et al., 2025), workers, migrants, clinical and vulnerable groups (e.g., refugees, minorities). Mental health outcomes focused mainly on common disorders depression and anxiety most frequently measured (Magakwe et al., 2025) with some addressing severe illnesses and suicidal behaviors (Buecker et al., 2025).

All studies examined psychosocial predictors, with socioeconomic status (income, education, employment) reported in over half, and social support in about one-third. Other factors included childhood adversity (~15 studies), gender, ethnicity/discrimination (~10),

community characteristics (~10), stigma (~8), migration (~6), and religiosity (~5). Psychological constructs like resilience and coping appeared less often.

Evidence quality was moderate; cross-sectional designs limit causality, but consistency across studies and several longitudinal/meta-analytic works strengthen causal inferences for poverty, education, and childhood trauma.

Summary of Evidence: Included Studies and Key Findings

Table 2 provides a concise summary of each included study's setting, psychosocial factors examined, mental health outcomes, and main findings:

Study (Year)	Population/Setting	Psychosocial Factors	Mental Health Outcomes	Key Findings
Kirkbride et al. (2024)	Global review (World Psychiatry); multi-country evidence	Social determinants (poverty, inequality, housing, etc.)	General mental disorders, incidence & prevalence	Comprehensive evidence that social disadvantage elevates risk of mental illness. Structural factors like poverty, income inequality, and poor housing contribute to higher rates of depression, anxiety, psychosis, and substance use worldwide. Recommends addressing these upstream determinants as a prevention strategy.
Alegría et al. (2018)	Review of recent studies (Current Psychiatry Reports); USA focus with international examples	Multiple (employment, income, discrimination, social support, family)	Psychological distress; common mental disorders	Unemployment and precarious employment consistently linked to increased distress. Low income and financial strain associated with higher depression/anxiety across US, Europe, Asia. Discrimination (racial/ethnic, immigrant, LGBTQ+) correlates with worse mental health (depression, well-being) in diverse settings. Strong family connections and social support emerge as protective factors against depression.
Jin et al. (2020)	Longitudinal cohort (China Health & Retirement Study); China older adults (N=17,000+)	Poverty (household income)	Depressive symptoms (CES-D)	Bidirectional relationship between poverty and depression. Baseline poverty predicted increased depressive symptoms over 4 years (mediated by worsening living conditions and social disengagement). Conversely, depression at baseline also led to a higher likelihood of falling into poverty. Supports both social causation and social selection in a cyclical poverty–depression trap.
Magakwe et al. (2025)	Cross-sectional survey of university students & staff; Ghana, Malawi, Mozambique, Nigeria (N=3,227)	Education level; also gender, occupation	Depression, Anxiety, Stress (DASS-21)	Higher educational attainment was linked to significantly lower odds of depression and anxiety. Postgraduate educated individuals had ~40% lower odds of depression (OR≈0.60) compared to those with only a

Study (Year)	Population/Setting	Psychosocial Factors	Mental Health Outcomes	Key Findings
				Bachelor's degree. Conversely, having only secondary education was associated with increased risk (OR ~1.3-1.8 for depression/anxiety). Females reported higher depression and stress than males, and students had worse mental health than staff. Highlights education as protective for mental health in sub-Saharan Africa.
Buecker et al. (2025)	Meta-analysis of 114 studies; global, mixed ages	Self-esteem levels	Suicidal thoughts & behaviors (STB)	Low self-esteem showed a *moderate-to-strong* negative association with suicidal ideation and attempts. Meta-analytic effect sizes: $r \approx -0.43$ for suicidal ideation, indicating that individuals with lower self-worth are substantially more likely to experience suicidal thoughts. Also found low self-esteem to be a risk factor for suicide attempts. Stressed the importance of self-esteem in suicide prevention.
Santini et al. (2015)	Cross-sectional analysis of older married adults (TILDA study); Ireland (N≈1,500)	Relationship quality; social network size	Depression, Anxiety, Suicidal ideation	Negative couple interactions and poor relationship quality were associated with increased risk of major depression, anxiety, and suicidal ideation. In contrast, high marital satisfaction and supportive social networks correlated with lower rates of these mental health problems. Notably, being single was better for mental health than being in a chronically unhappy marriage. Emphasizes quality of relationships over marital status per se.
Maunder & White (2015)	Population survey data; UK (with broader implications)	Public stigma (attitudes toward mental illness)	Self-esteem, social isolation, suicide risk (reported by people with mental illness)	Found that experiencing public stigma (social rejection and perceived dangerousness stereotypes) is linked to lower self-esteem and greater social isolation among individuals with mental illness. These effects, in turn, contributed to higher suicidal ideation. The study illustrates how societal stigma can inflict harm beyond the mental condition itself, aligning with Modified Labelling Theory.
Hughes et al. (2017)	Systematic review & meta-analysis of 37 studies; global	Adverse Childhood Experiences (ACEs) (multiple forms of abuse,	Various adult mental health outcomes (depression,	Cumulative childhood adversities have a dose-response effect on later mental health. Individuals with 4 or more ACEs were several times more likely to

Study (Year)	Population/Setting	Psychosocial Factors	Mental Health Outcomes	Key Findings
		neglect, household dysfunction)	anxiety, PTSD, substance use)	develop depression or anxiety disorders in adulthood than those with none (pooled ORs often 2–5 fold higher). The meta-analysis confirms that preventing childhood maltreatment could substantially reduce the population burden of mental illness.
McManus et al. (2020) (UK Adult Psychiatric Morbidity Survey)	National survey of adults; England (N≈7,500)	Social isolation; loneliness; social support	Common mental disorders (depression, anxiety)	Low social support and high isolation were strongly associated with depression and anxiety. People reporting loneliness had approximately 3 times higher odds of meeting criteria for a common mental disorder. In adjusted models, social isolation was one of the strongest predictors of poor mental health, even after controlling for income and physical health. Demonstrates the protective value of social connections (akin to social capital).

Table 2: Characteristics of included studies and summary of key findings. (Representative selection shown; the full review includes 72 studies.) Each study examines one or more psychosocial factors (left columns) in relation to mental health outcomes (right columns). Despite differing contexts, the findings consistently show that psychosocial disadvantage, such as poverty, low education, unemployment, childhood trauma, social isolation, and stigma are associated with worse mental health outcomes, while protective factors, like high-quality relationships, social support, and self-esteem are linked to better mental health. Note that many studies adjusted for potential confounders (e.g. age, gender, baseline health), strengthening the evidence that these associations are robust. Some illustrative quantitative results are provided in the table to indicate the magnitude of effects. Citations refer to source material supporting the summarized finding.

Thematic Synthesis of Psychosocial Factors and Mental Health Outcomes

We organize the narrative results by major psychosocial domains, highlighting how each factor impacts mental health and how these findings align with or expand existing theory.

1. Socioeconomic Status (SES), Income, Education, and Employment: A major theme across studies is the harmful impact of low socioeconomic status (SES) on mental health. Research from high-, middle-, and low-income countries consistently links poverty and financial stress with higher rates of depression, anxiety, and other disorders (Alegria et al., 2018). Large surveys in Europe and North America show individuals with lower incomes report worse mental health. For example, a Swedish study found poor mental health was twice as prevalent among low-income individuals (Alegria et al., 2018), with similar patterns seen in Korea and other European countries. In the U.S., pregnant women with low income had more depressive and anxiety symptoms, largely due to material hardships like food and housing insecurity (Alegria et al., 2018). These findings support the social causation hypothesis, where economic hardship leads to psychological stress via chronic strain and limited resources.

Education emerged as a protective factor. Higher attainment correlated with lower depression and anxiety (Magakwe et al., 2025). A study in four African countries found postgraduate university staff and students had significantly reduced depression odds versus those with secondary education (Magakwe et al., 2025). Another analysis reported each additional year of schooling decreased depressive symptoms by 9-11% (Kondirolli & Sundar, 2022).

Employment status and job quality also influence mental health. Unemployment and precarious jobs increase distress even with strong social welfare (Alegria et al., 2018). Poor working conditions raised depression rates. Bidirectional effects exist: depression impairs economic stability, increasing poverty risk and fueling a vicious cycle (Jin et al., 2020). Breaking these cycles is vital for social justice (Kirkbride et al., 2024).

2. Access to Mental Health Care: Several included studies and reports addressed how access to services affects mental health outcomes. A recurring theme, especially in gray literature and policy reports (e.g. WHO, mental health atlases), is that limited access to mental health care can worsen outcomes for those with mental conditions. In many low- and middle-income countries, upwards of 75%–90% of people with mental disorders receive no treatment (the "treatment gap") (Magakwe et al., 2025). One included WHO report noted that in resource-poor settings, this massive treatment gap leads to prolonged illness duration, more frequent relapse and hospitalization, and higher risk of mortality (including suicide). Even in high-income countries, disparities in access exist for marginalized groups. For instance, a U.S. study found racial-ethnic minorities and low-education individuals were less likely to receive adequate mental health care, contributing to worse clinical outcomes. While our review focused on psychosocial determinants, access to care can be seen as a social determinant in its own right, influenced by factors like health insurance, geographic location (urban vs. rural care availability), and stigma (willingness to seek help). Stigma in particular was highlighted as a barrier: fear of labeling often prevents individuals from accessing care, which in turn exacerbates their condition. During the COVID-19 pandemic (not the primary focus of this review but noted in some 2020–2021 studies), the rapid expansion of tele-mental health improved access for some, suggesting that innovative service delivery can mitigate access-related disparities (Yoon, 2024). Overall, the evidence suggests that improving access to affordable, culturally competent mental health services is critical, especially for disadvantaged communities; doing so can reduce chronicity and improve recovery rates, thereby indirectly breaking part of the link between psychosocial adversity and poor outcomes.

3. Family Environment and Childhood Adversity: Family context profoundly influences mental health from early life. Adverse childhood experiences (ACEs) such as physical, sexual, or emotional abuse, neglect, domestic violence, and parental mental illness/substance abuse significantly raise the risk of later mental health problems (Alegria et al., 2018). Meta-analyses show a dose-response relationship: individuals with four or more ACEs have markedly higher odds of adult depression, anxiety, PTSD, and suicide attempts compared to those without ACEs (Hughes et al., 2017). For instance, 4+ ACEs triple depression risk and nearly septuple alcohol use disorder risk, highlighting the overlap of mental health and substance use. Even fewer ACEs moderately increase risk, indicating lasting trauma effects. Mechanisms involve chronic childhood stress dysregulating neurobiology and ACEs contributing to poorer educational and social outcomes, worsening mental health.

Positive family factors warmth, support, and connectedness are linked to better youth mental health (Alegria et al., 2018). Adolescents feeling supported report lower depression and risk behaviors. A U.S. longitudinal study of Mexican-American youth found authoritative,

involved father figures predicted fewer internalizing and externalizing issues (Alegria et al., 2018). Conversely, family dysfunction, conflict, and harsh or inconsistent parenting are associated with increased aggression and anxiety. Neglectful fathering correlated with more psychiatric symptoms than authoritative parenting (Alegria et al., 2018).

In adulthood, relationship quality not marital status alone affects mental health. Supportive marriages reduce stress and depression, while high-conflict marriages worsen mental health beyond being single (Santini et al., 2015). UK data link conflictual relationships with increased mental health problems and suicide risk in older adults, consistent with attachment theory's emphasis on secure relationships as buffers against stress (Santini et al., 2015).

4. Social Support, Community, and Social Capital: Social ties beyond immediate family play a crucial role in mental health. Strong social support networks consistently protect against depression and anxiety, while social isolation increases risk (Alegria et al., 2018). UK national surveys identified low perceived social support as a key predictor of common mental disorders (Santini et al., 2015). Loneliness has been termed an "epidemic," with lonely individuals having 2–3 times greater odds of depression, highlighting the impact of perceived social disconnection. This supports the concept of cognitive social capital trust and belonging as protective factors. Areas with higher social capital show better mental health outcomes (Santini et al., 2015; Kemppainen & Timonen, 2024). Systematic reviews find a strong inverse association between cognitive social capital and depressive symptoms (Kemppainen & Timonen, 2024). Neighborhoods with greater social cohesion report lower mental health problems, regardless of economic deprivation (Santini et al., 2015). Older adults in cohesive communities show fewer depressive symptoms over time.

Community environment factors also influence mental health. Urban-rural differences vary: some studies find higher mental illness prevalence in rural areas due to isolation and limited services, while urban stressors like crowding and crime also affect mental health (Alegria et al., 2018). Safety perceptions matter feeling unsafe or exposure to violence correlates with anxiety and depression, as seen in urban Chinese residents (Alegria et al., 2018). Physical and social community characteristics, including housing, green spaces, and social cohesion, shape mental well-being, consistent with the Socio-Ecological Model (Magakwe et al., 2025).

5. Discrimination, Stigma, and Marginalization: Experiences of discrimination consistently harm mental health across marginalized groups, including racial/ethnic minorities, immigrants, LGBTQ+ individuals, and people with mental illness (Alegria et al., 2018). For example, African asylum-seekers in Hong Kong reporting higher discrimination showed increased depressive symptoms, and Iraqi refugees in Sweden with discrimination experiences had poorer well-being (Alegria et al., 2018). UK longitudinal data revealed that cumulative ethnic discrimination predicted rising psychological distress, especially among Pakistani minorities (Alegria et al., 2018). Multifactorial discrimination based on intersecting identities was described as a "fundamental cause" of depression, reflecting layered social disadvantage (Alegria et al., 2018).

Mental illness stigma a form of discrimination also negatively impacts recovery. Public and internalized stigma reduce self-esteem, promote social avoidance, delay help-seeking, and worsen outcomes (Farrelly et al., 2015; Maunder & White, 2019). Thornicroft et al. (2016) noted stigma may at times harm more than the illness itself. Modified Labelling Theory suggests anticipated rejection leads to withdrawal and symptom worsening. Qualitative

evidence shows patients fearing the "crazy" label isolate themselves, exacerbating depression and anxiety. Cultural stigma may further delay treatment as families hide affected members.

Some individuals with strong ethnic identity or community support show resilience against discrimination's mental health effects. Nevertheless, evidence overwhelmingly supports reducing stigma and discrimination through education, anti-stigma campaigns, and policy to improve population mental health (Stangl et al., 2019; Maunder & White, 2019).

6. Culture and Ethnicity: Culture significantly shapes exposures and responses related to mental health. Included sources, such as cross-cultural reviews and seminar content, emphasize that cultural beliefs influence perceptions of mental illness, coping strategies, and help-seeking behavior. In cultures with strong stigma or supernatural explanations, individuals may avoid psychiatric care and turn to spiritual healers, delaying effective treatment. For example, some Asian groups tend to express distress through somatic symptoms (e.g., headaches, fatigue), leading to under-recognition of conditions like depression in clinical settings (Adebayo et al., 2024; Jimenez et al., 2022).

Support systems also vary culturally: collectivist societies often rely on extended family networks, which can protect mental health but may also impose stigma if illness is seen as shameful. Immigrant and minority ethnic groups frequently face acculturative stress, linked to higher anxiety and depression, especially among first-generation immigrants. However, maintaining cultural identity and community ties often buffers mental health risks. A study among Latino immigrants in the U.S. found cultural community involvement improved mental health despite socioeconomic stress.

Culture intersects with gender norms affecting mental health. In societies with rigid gender roles, women may experience distress from disempowerment or conflicting expectations, while men may be discouraged from expressing emotions or seeking help, contributing to substance abuse or suicide. Astbury (2006) highlighted that gendered experiences, such as women's exposure to sexual violence and men's pressure to appear "tough," shape mental health problems and access to support.

Overall, culture frames how psychosocial factors influence mental health, either mitigating or magnifying risks. Culturally tailored approaches like community programs involving cultural or religious leaders to reduce stigma and promote care are recommended.

7. Gender: Epidemiological surveys consistently show women have higher rates of internalizing disorders like depression and anxiety, while men exhibit higher rates of externalizing issues such as substance use disorders and have higher suicide mortality (Solan & Sandt, 2006). Women are about twice as likely as men to experience major depression, with this gap emerging in adolescence and persisting into mid-life. Causes include biological factors (hormonal changes, peripartum effects) and environmental/social stressors like caregiving burdens and gender-based violence, alongside lower socioeconomic power (Solan & Sandt, 2006). Women also report more severe life events, which can trigger depression. Gender socialization may cause women to internalize distress, whereas men externalize or avoid acknowledging it, influencing symptom presentation and detection.

Men's suicide death rate is 3-4 times higher than women's, despite women attempting suicide more often. This difference may be due to men using more lethal means and facing stigma around help-seeking, leading to untreated distress. Promoting mental health care among men

and challenging toxic masculine norms are crucial for suicide prevention. For women, empowerment through education, economic opportunities, and protection from violence can reduce disparities. The review also highlighted transgender individuals face extremely high risks of depression and suicidality, primarily driven by societal stigma and discrimination.

8. Migration and Acculturative Stress: Migrants, refugees, and ethnic minorities face unique psychosocial stresses impacting mental health. Studies on migrant workers (e.g., in Singapore) and refugees show high rates of mental health problems due to exploitation, social isolation, and trauma (Alegria et al., 2018). Migrant laborers in exploitative conditions experience much higher serious mental illness rates than the general population. Refugees often have PTSD and depression prevalence of 30–50%, stemming from pre-migration trauma and post-migration challenges like uncertainty and discrimination. However, migrants integrating into supportive communities' fare better; some evidence points to a "healthy migrant effect" with initial resilience that may diminish over time due to socioeconomic difficulties.

Common issues include language barriers, unemployment, and loss of social status causing acculturative stress. A U.S. study of Latino immigrants found perceived discrimination and language challenges strongly linked to depression, but strong ethnic community ties reduced symptoms (Alegria et al., 2018). Culturally sensitive mental health services, including interpreter access and refugee programs, are recommended to improve outcomes.

9. Religion and Spirituality: A subset of studies examined religiosity and spirituality's role in mental health, generally finding protective effects. Higher religious involvement such as regular service attendance, prayer, or strong faith associates with lower depression and substance abuse rates, especially in the U.S. and religious regions. A meta-analysis found religiosity linked to greater well-being and coping ability during stress. Another meta-analysis on suicide reported that strong religiosity reduced suicide risk by more than half (odds ratio ~0.4) (Wu et al., 2015). Protective mechanisms include social support from religious communities, existential meaning buffering despair, and religious prohibitions against suicide and substance use (Wu et al., 2015).

However, nuances exist. Certain beliefs like viewing mental illness as punishment or moral failing may increase self-stigma and delay help-seeking. Alienation from religious communities, such as LGBTQ+ individuals in non-affirming settings, can worsen mental health. Thus, spirituality is a double-edged sword: beneficial when fostering community and meaning, harmful when coupled with guilt or exclusion.

Some mental health interventions incorporate spirituality (faith-based counseling, collaborations with faith leaders). Systematic reviews indicate these approaches show promise in improving depression outcomes for religious patients (Marques et al., 2022).

10. Personal Psychological Resources (Self-esteem, Coping, Resilience): Lastly, our review touched on *intra*-personal psychosocial factors that can modulate mental health: namely, self-esteem, coping skills, and resilience. As noted with the Buecker et al. (2025) meta-analysis, low self-esteem is a significant risk factor for adverse outcomes like suicidal ideation (Buecker et al., 2025). Longitudinal studies suggest low self-esteem in adolescence predicts higher depression in adulthood, supporting a "vulnerability model" of self-esteem (though some debate remains about reverse causation). Meanwhile, effective coping skills (problem-solving, emotional regulation) and trait resilience (the capacity to bounce back from adversity) emerged as protective factors in several studies, often moderating the impact of stress. For

example, one study of disaster survivors found those with higher resilience scores had much lower PTSD and depression, despite experiencing the same traumatic events, compared to less resilient peers. Coping strategies that are active and adaptive (seeking support, reframing challenges) were associated with better psychological outcomes than avoidant coping (denial, substance use). These personal resources are fostered by both individual traits and social environments (e.g. supportive upbringing can instill coping skills and confidence). Some included interventions from the gray literature such as community resilience-building programs indicate that bolstering these psychosocial skills at individual and community levels can mitigate the negative effects of external stressors.

In sum, psychosocial factors collectively exert a profound influence on mental health. The evidence from this decade (2015–2025) reinforces earlier knowledge while providing new insights into interactions and context-specific nuances. The results consistently support a model in which mental health is shaped by a web of interrelated social determinants: economic hardship, social isolation, and trauma push outcomes in a negative direction, whereas social support, inclusion, and empowerment push towards positive mental health. These findings corroborate theoretical frameworks like the Biopsychosocial model and Social Determinants of Health approach, demonstrating that to understand and improve mental health, one must look well beyond biology to the societal and community levels.

DISCUSSION

This systematic review set out to synthesize international evidence from the past decade on how psychosocial factors impact mental health outcomes. The findings provide robust confirmation that mental health is deeply embedded in social context: who we are, where we live, how we relate to others, and what we experience in daily life all leave a significant imprint on our psychological well-being. In this discussion, we interpret the key results in light of theoretical frameworks, consider the implications for practice and policy, and acknowledge the limitations of the current evidence base. We also propose directions for future research, aiming toward a more integrative understanding of mental health one that bridges individual and society.

Integration with Theoretical Frameworks: The findings align with the Biopsychosocial model, which views mental health as the result of interactions among biological, psychological, and social factors. Our review highlights the social dimension, socioeconomic deprivation and social trauma act as external stressors triggering psychological distress and biological stress responses. Individual traits like resilience modulate these effects, reflecting the dynamic interplay Engel's model describes. This emphasizes that effective mental health care must address social determinants such as housing, income, and relationships, alongside psychological treatment and medication, to fully support mental well-being.

Social Causation vs. Social Selection: Our findings largely support Social Causation theory: adverse social conditions like poverty, unemployment, and discrimination contribute to mental health problems (Alegria et al., 2018). Prospective studies show baseline hardships predict future disorders, and events like recessions link to suicide spikes. However, Social Selection is also evident mental illness can cause social decline, such as job or income loss (Jin et al., 2020). Jin et al.'s Chinese cohort showed depression eroding economic stability, creating a feedback loop. Thus, a bi-directional view is essential, with interventions targeting both prevention and support to break this cycle.

Social Cognitive Theory (SCT): SCT highlights how learned behaviors, self-efficacy, and reciprocal determinism influence mental health. Supportive environments foster active coping and confidence, reducing stress-related psychopathology. Conversely, chronic uncontrollable stressors like discrimination can lower self-efficacy, increasing depression risk. Our findings reflect these dynamics. Interventions based on SCT, such as community programs teaching coping skills and cognitive-behavioral techniques enhance individuals' abilities to manage adversity. Documented successes of such programs support SCT's view that modifying cognitive and behavioral responses can improve mental health, even when external stressors persist.

Social Capital Theory: Our findings on social connectedness reflect Social Capital Theory, which asserts that social networks benefit health. Communities with high social capital marked by trust, mutual aid, and engagement show better mental health (Santini et al., 2015). Lower depression rates appear where people feel belonging and trust neighbors or religious groups. Social capital provides emotional support, practical help, healthy norms, health information, and reduces stigma around help-seeking. Investing in community-building (communal spaces, support groups) promotes mental health. During crises like COVID-19, strong community ties fostered resilience and mitigated mental distress rises (Snel et al., 2022), highlighting social capital's protective role.

Labelling Theory: Our findings support Labelling Theory, showing that being labelled "mentally ill" in stigmatizing societies leads to internalized "spoiled identity," social withdrawal, and possibly self-fulfilling negative outcomes (Maunder & White, 2019). Modified Labelling Theory highlights that anticipating stigma causes shame and secrecy, hindering recovery. This underscores the importance of anti-stigma interventions. National campaigns like England's Time to Change and India's community education modestly improve attitudes and reduce social distance (Stuart, 2016; Stangl et al., 2019). Expanding such efforts can increase early treatment seeking, reduce exclusion, and improve psychosocial outcomes for people with mental illness.

Diathesis-Stress Model: Our findings align with the Diathesis-Stress model, where psychosocial factors act as "stress" triggering mental illness in genetically predisposed individuals. For example, those with a genetic vulnerability to depression may remain healthy in low-stress environments but develop illness when exposed to stressors like childhood maltreatment, job loss, or migration (Alegria et al., 2018). Reducing stressors or enhancing coping skills (e.g., resilience training, therapy) can prevent illness. This model connects with others, showing that resilience counters diathesis and social support lowers stress, highlighting multi-level interventions to balance stress and coping.

Implications for Policy and Practice: The evidence that social conditions fundamentally shape mental health calls for a preventive, public health approach. Traditional care often treats disorders after onset, but poverty, violence, and isolation drive many cases, necessitating social policy interventions. Governments should integrate mental health impact into housing, education, labor, and social protection policies. Anti-poverty programs, livable wages, and job security measures act as mental health interventions. Evidence shows improving financial security reduces psychological distress (Magakwe et al., 2025). Community investments in safe spaces, violence prevention, and social cohesion also promote mental well-being.

Clinicians should routinely assess psychosocial factors like financial strain, social support, and discrimination, linking patients to social services and peer supports. Psychosocial

interventions supported employment, family therapy, community groups address these determinants. Family involvement is key, especially in youth and couples therapy. Training in anti-stigma and cultural competence can enhance care for marginalized groups.

Public health programs targeting high-risk populations parenting support to prevent childhood trauma, resilience curricula in schools are recommended. Preventing or buffering Adverse Childhood Experiences (ACEs) through early childhood investments can substantially reduce mental illness prevalence (Hughes et al., 2017). Overall, multisectoral strategies addressing social determinants alongside clinical care are essential for effective mental health promotion.

The Need for Intersectional Approaches: Our findings highlight that psychosocial factors often intersect, compounding risks. For example, a low-income immigrant facing racial discrimination and language barriers experiences multiple overlapping challenges. Addressing one factor alone is insufficient; comprehensive, multi-level strategies improving neighborhoods, providing individual therapy, and community support are more effective. Intersectionality also recognizes that impacts vary by gender, culture, and life stage. Policies should be tailored accordingly, such as focusing on identity issues for unemployed men or offering childcare and community support for unemployed single mothers. This nuanced approach better addresses complex mental health needs.

Limitations of Evidence: Despite consistent findings, limitations exist. Much evidence is observational and cross-sectional, limiting definitive causal conclusions. While social factors are often viewed as causes of mental health outcomes and some longitudinal studies support this reverse causation and unmeasured confounding remain concerns. For example, genetic predispositions or personality traits might influence both lower SES and mental illness. Twin and family studies outside our review suggest modest genetic overlap between social and mental health factors. Although some quasi-experimental and longitudinal studies strengthen causal inference, more research of this type is needed to clarify these relationships.

Another limitation is potential publication bias: studies finding significant links between psychosocial factors and mental health might be more likely to get published, whereas null findings may be underreported. We tried to mitigate this by including gray literature, where sometimes more nuanced or null results (like certain cultural comparisons) appear. Additionally, most studies relied on self-reported measures of both psychosocial factors and mental health (e.g. questionnaires for income or perceived support and symptom checklists for distress), which can introduce common-method bias. Objective measures (like clinical diagnoses or administrative data on income) were less common. However, the convergence of self-report and clinical data in various studies gives some confidence in the relationships.

There are also contextual gaps: the majority of research still comes from Western, high-income countries, even though we included many international studies. Certain regions (e.g. Central Asia, Middle East, parts of Africa) remain under-represented in the literature. Cultural variations mean findings cannot be one-to-one generalized globally, local determinants (like caste in South Asia or clan systems in other societies) might also be important but weren't much captured in our sources. We note that the international scope of our review is a strength, yet within that, more than half the studies were from North America/Europe, which may bias the overall interpretations toward those contexts. Future research should deepen focus on low-income settings and indigenous perspectives on mental health.

Another needed direction is mechanistic research: Mechanistic research is needed to clarify biological and psychological pathways linking psychosocial factors to mental health such as how discrimination leads to depression via stress-related inflammation, cognitive patterns, or social isolation. Interdisciplinary studies combining sociology, psychology, and neuroscience could unravel these complex links (e.g., childhood trauma's effect on stress hormone regulation). Understanding mechanisms enables targeted interventions (e.g., sleep treatments to mitigate loneliness-related depression).

Intersectionality requires further study to examine how combined factors (like unemployment, gender, and culture) affect mental health differently. Research focusing on vulnerable subgroups ethnic minorities, LGBTQ+ youth, refugees will refine tailored support.

Ongoing monitoring is vital, especially given recent events (economic shifts, COVID-19, social justice movements) that shape psychosocial determinants. The concept of "syndemics" highlights interacting epidemics (e.g., depression and substance use amid unemployment and pandemic stress), emphasizing the need for integrated, multifaceted solutions.

***Conclusion (with Theoretical and Practical Convergence)*:** This review reinforces that mental health is as much a social issue as a medical one. Evidence from 2015-2025 clearly shows that poverty, education, community, and stigma are central determinants of mental well-being. The Biopsychosocial and Social Determinants models provide validated frameworks: fostering mental health requires addressing basic needs (SES), building inclusive communities (social support and cohesion), protecting from violence and discrimination, and nurturing hope through meaningful roles or spirituality.

Clinicians should expand assessments beyond symptoms to include social contexts, advocating for interventions that improve living conditions and relationships. Policymakers must recognize that improving mental health involves social policies poverty reduction, education, and anti-discrimination not just clinical funding. For researchers, the complex interplay of factors calls for nuanced, interdisciplinary methods to address mental health's multifactorial reality. Together, these perspectives offer a comprehensive approach to enhancing population mental health.

In summary, psychosocial foundations are the bedrock on which mental health stands. When that bedrock is stable characterized by economic stability, supportive relationships, equity, and respect for dignity individuals and communities can flourish mentally and emotionally. When the psychosocial foundation is cracked or eroding – through adversity, isolation, injustice, we inevitably see the cracks manifest as psychological distress and disorder. By repairing and strengthening these foundations, we can make great strides toward a mentally healthier and more resilient global society.

Limitations and Future Directions

This review, while comprehensive, has limitations. Primarily, it relies on observational studies, limiting causal inference. More longitudinal and experimental research is needed to confirm causality and evaluate interventions. Geographic gaps exist, with limited data from some low-income regions and cultural contexts, so findings should be generalized cautiously. We did not formally assess study quality or publication bias, relying on qualitative evidence synthesis; future meta-analyses could improve precision. Search and selection bias are possible despite thorough methods, especially missing non-English or very recent 2025 studies. Space constraints prevented detailed coverage of all studies, potentially losing nuance.

Lastly, focusing on 2015–2025 captures recent trends but excludes earlier foundational work; we included older theoretical references where relevant, but this review complements rather than replaces prior syntheses by updating the last decade's evidence.

Future research directions emerging from this review include:

- Conducting interventional studies that modify psychosocial conditions (e.g. randomized trials of cash assistance, housing mobility programs, anti-stigma campaigns) and measuring mental health outcomes, to directly test causality and inform policies.
- Incorporating mixed methods - qualitative research can deepen understanding of how individuals interpret and cope with psychosocial stressors (e.g. stigma or cultural conflict), adding context to quantitative patterns.
- Exploring biological mediators of psychosocial effects (through psychoneuroimmunology, epigenetics, etc.), bridging the social and biological levels of analysis.
- Emphasizing intersectional analyses to capture how overlapping identities (like race, gender, and socioeconomic status together) create unique mental health challenges or resilience factors.
- Monitoring the long-term mental health impacts of global crises (pandemics, climate change, displacement) which can be considered large-scale psychosocial stressors, and evaluating community resilience factors that mitigate these.

In practice, future efforts should also focus on translating this wealth of evidence into concrete action: implementing multi-sectoral collaborations (between mental health, social services, education, and justice systems) to tackle the roots of mental health problems. Research into implementation *science* will be valuable to see how psychosocial interventions can be scaled in real-world settings.

CONCLUSION

This systematic review confirms mental health is fundamentally shaped by psychosocial factors. Economic hardship, social inequality, educational disadvantage, unstable employment, childhood trauma, toxic relationships, isolation, stigma, and cultural marginalization actively determine mental well-being (Kirkbride et al., 2024). Conversely, financial security, quality education, meaningful work, supportive families and communities, acceptance, and culturally sensitive care promote positive outcomes. Our synthesis of 2015–2025 data validates longstanding theories like the Biopsychosocial and Social Determinants models while highlighting new insights on multiple stressors and biological embedding (Kirkbride et al., 2024).

Mental health strategies must shift from treating disorders in isolation to preventing psychosocial risks. Policy interventions (socioeconomic safety nets, anti-discrimination laws, education equity), community efforts (building social capital, reducing violence, fostering inclusion), and individual supports (psychosocial therapies, empowerment) are vital. These must be culturally tailored (Magakwe et al., 2025).

Addressing psychosocial foundations embraces mental health as more than absence of illness it fosters thriving individuals and communities. This review offers a roadmap for health and social sectors: investing in social justice, community development, and early interventions is essential. As WHO states, "there is no health without mental health," and we add no mental health without attention to psychosocial roots (Kirkbride et al., 2024).

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