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Previous Mental Illness Diagnoses Predict Perceptions of Current Mental Illness: A Cultural and Gender Differences Analysis of the United States and India

ABSTRACT: *The disparities in mental health care around the world have led to differences in the way mental illness is treated, diagnosed, and stigmatized. The studies conducted revealed in this article investigated differences between the United States and India in terms of their willingness to agree with a possible mental illness diagnosis. Each study was conducted online using FluidSurveys®. Participants were recruited via Amazon's® Mechanical Turk® (MTurk), which is a website that provides access to an online, highly diverse participant pool. For Study 1, we hypothesized that there would be significant differences in agreement rates between the two countries and that there would be a positive relationship between agreement rates and the number of previous diagnoses. The three main hypotheses for Study 2 were that there would be a significant difference in agreement rates for the United States and India, the gender of the target individual would have a main effect, and the gender of the participant would have a main effect. The first study was focused on how the number of previous diagnoses would affect agreement rates and how that effect differed*

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between the two countries. The second study looked specifically at how the gender of the participant as well as the gender of the target individual would affect agreement rates. Study 1 yielded significant differences between the United States and India for agreement rates when no previous diagnosis was presented. There was also evidence that as the number of previous diagnoses went from zero, to three, to five, agreement rates also increased. Study 2 also yielded significant differences between the two countries. There was a main effect of participant gender on agreement rates, but no main effect found for target gender.

Introduction

Attitudes toward people with mental illness, availability of mental health professionals, the nature of rehabilitation regimens, and the cultural beliefs of society all greatly influence the way mental illness is perceived. The current study was specifically designed to explore differences between Americans and Indians in their diagnostic behaviors in reference to mental illness. Research has shown that the prognosis for those living in the United States, despite having more resources and trained professionals, is worse than those living in India with mental illness [1]. In this paper, possible factors contributing to this disparity will be investigated.

Stigma of Mental Illness in the United States

Link and Phelan [2] conceptualize the vaguely defined concept of stigma as "the co-occurrence of its components-labeling, stereotyping, separation, status loss, and discrimination." Stigmatization occurs when an individual "constructs cognitive categories and links those categories to stereotyped beliefs" [2]. The stigma associated with mental illness is a reality that affects people across cultures in different ways. Stereotypes associated with mental illness differ based on cultural beliefs and the ways in which symptoms are interpreted by a community. Stigmatization of individuals with mental health disorders can result in fear and physical distance from the individual who has been diagnosed or is thought to have a mental illness, and even more so when cultural factors are considered [3].

In the United States, people with mental illness are typically represented in the media as violent, uncontrollable, and incapable of being a productive part of society [4]. Stigmatization hinders successful treatment because it can cause those in need to become wary of seeking help. The stigma attached to such a label can lead to difficulties finding work, maintaining a job, and remaining independent [5]. After receiving psychiatric care, patients reported not being able to get health benefits, being denied housing, and earning less income [5]. Americans affected by mental illness find themselves homeless, which only adds to the negative connotation associated with psychological disorders [6].

One way to address stigma in the United States is to examine the impact of industrialization on American thought processes. According to the industrialization hypothesis, first introduced by D. J. Treiman in 1970, people living in industrialized communities are less supportive and more intolerant of people with mental illness and engage in more rejection, isolation, and segregation behaviors [7]. In the United States, the ability to live independently and take responsibility for oneself is valued. Those individuals with mental illnesses are considered incapable of doing so, and are usually treated as such. Rehabilitation for mental illness is heavily focused upon helping individuals reenter society and live on their own [1]. They are taught to take responsibility for their illness in order to take control of it.

In the United States, families may have little to no involvement in rehabilitation, and many who are involved describe care as an "overwhelming burden" [8]. In general, when suffering from severe mental illness, an individual is expected to be *sent away* to receive care. These procedures may endorse feelings that people with mental illness should be cast out and not regarded as a part of society. Stereotypes associated with mental illness have persisted despite the influx of knowledge available about various disorders. Research has shown that the majority of people still have a "not in my backyard" mentality when it comes to interacting with people with mental disorders [9]. Social distance has been correlated with perceptions of violence and perceived severity of the mental illness [9]. For example, persons diagnosed with paranoid schizophrenia are subject to the greatest levels of stigma because they are presumed to have more violent tendencies than, for instance, someone with depression.

Stigmatization in India

There is a difference in stigmatization between rural and urban areas in India. A study conducted by Jadhav et al. [7] found that the population of Indians living in rural areas showed greater stigma toward people with mental illness. However, there was a conceptual divide between attitudes and actions toward people with mental illness. Because of the agrarian nature of many Indian communities, people with psychological disabilities living in rural areas were given opportunities to work despite their condition. Urban Indians had less stigmatizing attitudes but were less willing to work with people suffering from mental illness. Indian women have a particular aversion to mental illness, both in regards to projecting stigma and being a victim of it [10]. Patel et al. [11] showed that nearly half of the people who attended primary care in India had common mental disorders, and that such disorders were associated with poverty and female gender.

Indian forms of treatment incorporate a familial aspect into every step of the rehabilitation process. The entire family is expected to take an active role in ensuring the patient's well-being and to provide care when a family

member is mentally ill [1]. Although family members of persons with mental illness within the Indian culture are generally more accepting, mental illness can still greatly hinder opportunities for marriage [12]. Many Indians believe that the cause of mental illness is a curse, karma, or simply the will of God. Unlike in the United States, there is no pressure for Indians with mental illness to take personal responsibility for the illness and live independently. Instead, society focuses on ways to provide these individuals with a type of environment that will still allow them to contribute to the community [1].

Stigmatization is not only evident in society, but is also present within the structural make-up of both the United States and India. In America, there are several laws and policies that are openly discriminatory against people with mental disabilities. They have limited rights when it comes to voting, remaining married, custody of children, and so forth. [13]. Persons affected by mental illness are not eligible to stand for elections and are limited by the types of jobs they are able to perform. In India, structural stigmatization is evidenced by a lack of resources dedicated to assisting the mentally ill. The number and size of training hospitals in India have not been adjusted to meet the needs of those in need of psychological services [1].

Disparities in Care between India and the United States

One important factor that differentiates care for the mentally ill in India from that in the United States is that in India, a general consensual social responsibility is engrained into the moral code. In a study on the perception of social responsibility, the majority of American participants viewed non-life-threatening breaches of social responsibility in personal-moral or personal-choice, rather than in moral, terms [14]. Americans do not feel obligated to assist those individuals who cannot care for themselves, but this responsibility is emphasized in the Indian culture. This method of thought may explain why integrative treatment models have been successful in rural Indian communities. Despite the lack of resources and trained psychologists/psychiatrists, these Indian communities have been able to integrate many mentally ill patients successfully back into society by providing them with meaningful roles and healthy relationships.

Another major difference between the United States and India is the availability of professional psychological assistance. There are an estimated 93,000 practicing psychologists in the United States [15]. This number does not include clinical social workers, psychiatrists, or other individuals qualified to treat mental illness or prescribe psychotropic medications. Even for those individuals considered to be at the poverty level, psychological assistance may be available through state-funded programs. In developing countries such as India, a limited number of resources are being invested into mental health. As a result, India has a severe shortage of trained individuals able to assist those with mental illnesses [16]. Indians are more

likely to consult a religious leader about certain mental disorders before seeking help from a psychologist [17].

Religious doctrine has a marked effect on the ideas about causes of mental illness, manifestations of mental illness, as well as the prognosis of those with mental disorders. Rural Indians seem to have a lack of faith in biomedical interventions for severe mental illnesses [7]. Healing temples are a popular alternative to visiting a psychiatrist in India. Although the temples vary widely in their treatment methods, there is evidence that living in the temple (accompanied by a family member) has a positive effect on the mental health of the affected person [17]. A study conducted by Jiloha and Kishore [18] revealed that, out of a sample of 300 psychiatric patients, 55 percent of them attributed their disorder to supernatural forces.

Religion has a more subtle impact on psychological treatment in America. Curlin et al. [19] found evidence suggesting that religious physicians were less willing to refer patients to psychiatrists or psychologists and were more likely suggest they see a religious counselor. They concluded that psychiatrists are less religious than other physicians [19]. American psychologists tend to focus more on the biomedical causes of mental illness and seek forms of treatment that target those specific causes. One study found that the general public overestimates the effectiveness of psychotherapy and overestimates the negative effects of psychotropic medications [20].

There are a number of gender differences in reference to the manifestation of psychological symptoms, gender roles, and stigma when it comes to mental illness. American women are allowed to be more vocal about their emotions, while men are expected to deal with their issues on their own. An American man seeking psychological help may be viewed as weak and dependent, and this notion may deter him from seeking treatment [21]. Differences in help-seeking behavior may be due to the fact that women are better able to recognize certain symptoms as being problematic. An Australian study found that young women were able to identify depression and psychosis better than young men [22].

Study 1: Introduction

From the literature, evidence has been provided as to the various ways in which cultural attitudes affect the perception of mental illness. Differing opinions about the causes of mental illness change the way people think about treatment of people that deal with such issues. The concept of independence versus interdependence assigns the responsibility of care and rehabilitation of mentally ill persons to different people. Previous studies have been heavily based on outcomes for sufferers of mental illness. They often use social distance measures as a way to determine what effect stigma has on attitudes toward people with mental illness. The goal of the current study is to investigate the role of previous diagnoses on participants'

willingness to diagnose someone with a mental disorder. We will be looking at how willing people are to identify a problem, given the social factors that may discourage them from doing so. The diversity of the sample available on Mechanical Turk will allow us to look specifically at two countries of interest: The United States and India.

We carried out the two studies by presenting the participants with a vignette of a person with a culturally relevant name. After reading the vignette, participants were asked to rate how much they thought

1. the person was suffering from a mental illness;
2. the likelihood that the person would be diagnosed if he/she saw a mental health professional; and
3. to what degree they thought the person should seek professional help.

For Study 1, our first hypothesis is that agreement rates will increase as the number of previous diagnoses increases. Second, we hypothesized that those in the Indian population would agree more strongly than the American population. For Study 2, our three main hypotheses were that

1. there would be a difference of agreement rates between the two countries;
2. the gender of the target individual would affect agreement rates; and
3. there would be a difference in likelihood of agreement based on the gender of the participant.

Study 1: Method

Participants

One hundred and fifty-five (62 females) participants from the United States took part in the study. The mean age was 30.87 ($SD = 10.08$). One hundred and fifty-eight (55 females) participants from India took part in the study. The mean age was 30.06 ($SD = 8.88$).

Materials and Recruitment

The study was presented online using FluidSurveys®. Participants were recruited via Amazon's® Mechanical Turk® (MTurk). MTurk is a global online service that enables participants (Turkers) to participate in human intelligence tasks (HITs) in exchange for monetary compensation. Participation in any HIT is voluntary and anonymous. All participants were screened for English proficiency.

Procedure

Participants first signed an electronic consent form. They were then presented with the scenario about a target individual, which was specifically created for the purposes of this study:

> [Person's name] is an undergraduate student at a major university. Lately, [person's name] has been acting in a manner that is unlike his normal self. He has been spending more time in his dorm room than is usual. He has had a couple of non-violent outbursts in regards to matters that you think are not really that important. He has not responded to texts or emails as frequently as he used to, and has been absent in social media for the past few weeks

The person's name was culturally adjusted by using a variety of common names from India and the United States. In two additional conditions, the target individual was described as having been previously diagnosed with three or five different mental illnesses, but that he had been symptom-free for one year.

Following the storyline, participants were asked how strongly they agreed with the following three statements:

1. [Person's name] is currently suffering from a mental illness;
2. [Person's name] would likely be diagnosed with a mental illness if he saw a psychiatrist or psychologist; and
3. [Person's name] should seek mental health treatment because he is likely suffering from a mental illness.

Participants answered on a 7-point Likert scale from "extremely disagree" (−3) to "extremely agree" (+3), with a neutral option (0). Lastly, participants were asked for basic demographics and were debriefed and dismissed.

Study 1: Results

We first conducted a Cronbach's alpha test on the three dependent variables. The lowest score was .71, while the highest was .88, with a mean score of .80. Thus, the three questions were averaged and all following statistical tests employed that average score.

The data from the study are presented in Figure 1. A two-way ANOVA with Country (USA and India) and Number (number of previous diagnoses) as factors was conducted. There was a main effect of Country, $F(1, 307) = 13.40$, $p < .001$, $\eta p^2 = .04$; a main effect of Number, $F(2, 307) = 32.86$, $p < .001$, $\eta p^2 = .18$; and a significant interaction between the two factors, $F(2, 307) = 16.06$, $p < .001$, $\eta p^2 = .10$. Not surprisingly, there was a general monotonic increase in agreement likelihood as the number of previous diagnoses increased. What is interesting, however, is that the interaction between Country and Number reveals that the Indian participants were much more likely to agree with the statements when the target individual was not previously diagnosed with a mental illness ($p < .001$). This difference was not seen in the other two conditions ($p > .05$).

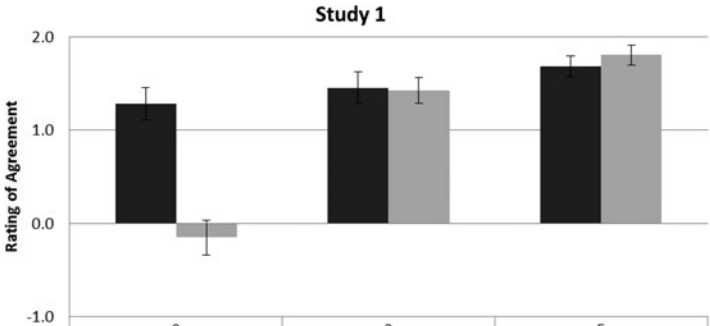
Study 1: Discussion

The data from Study 1 reveal some interesting findings. Our first hypothesis was that the number of previous diagnoses would affect agreement rates; specifically, more prior diagnoses would result in stronger opinions about mental illness. Not surprisingly, the data show this to be likely. Our second hypothesis was that participants from India would tend to agree more strongly about the possibly of mental illness in the target individuals. This was, indeed, the case; however, it appears to be limited to the zero-diagnosis condition. As Figure 1 shows, there was not an apparent difference between countries in the 3-diagnoses and 5-diagnoses conditions.

Study 2: Introduction

The purpose of Study 2 was threefold. First, we wanted to replicate the findings from the zero-diagnosis condition using a much larger sample size in order to determine a more accurate effect size. Second, we added a condition where a female target individual was described in order to determine if the gender of the target individual was important. We hypothesized that there would be a difference, but we did not have a directional hypothesis for this condition, given that the literature is ambiguous about this issue. Third, we wanted to look at gender differences of the participants. In the first study, there were not enough participants in each condition to make statistical conclusions about gender differences of participants; by increasing the sample size, we made this possible.

Figure 1
Differences in Agreement Rates as A Function of Number of Previous Diagnoses and Country of Origin (SE bars are included)



	0	3	5
India	1.28	1.46	1.68
USA	-0.15	1.42	1.81

Again, we did not have a directional hypothesis, but simply hypothesized that there would be a difference.

Study 2: Method

Participants

Four hundred and four (158 females) participants from India and the United States took part in the study. The mean age was 30.61 ($SD = 9.50$).

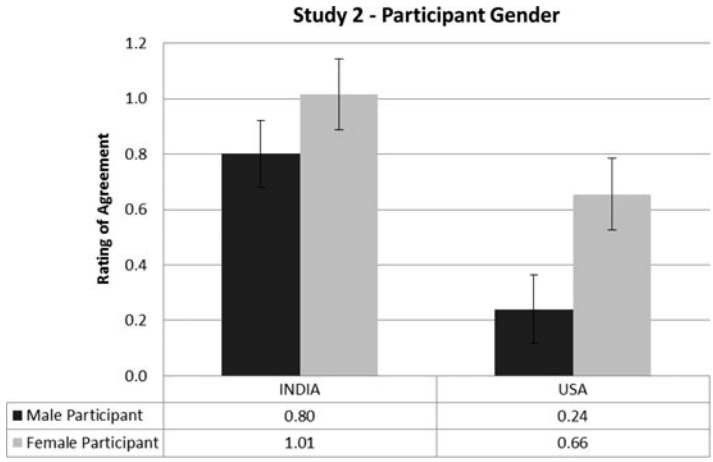
Materials, Procedure and Design

Study 2 was identical to Study 1 except for the following changes. First, only the zero-diagnosis condition was analyzed. Second, the gender of the target individual was manipulated in a separate condition.

Study 2: Results

We first conducted a Cronbach's alpha test on the three dependent variables. The lowest score was .77, while the highest was .88, with a mean score of .82. Thus, the three questions were averaged and all following statistical tests employed that average score. The data from the study are presented in Figure 2. A three-way ANOVA with Country (USA and India), TargetGender (whether the target individual was female or male), and ParticipantGender (gender of the participant) as factors was conducted.

Figure 2
Differences in Agreement Rates as A Function of Country of Origin and Gender of Participants (SE bars are included)



There were main effects of Country, $F(1, 396) = 12.89$, $p < .001$, $\eta p^2 = .03$; and ParticipantGender, $F(1, 396) = 6.28$, $p = .01$, $\eta p^2 = .02$. There were no other significant differences in the data.

Study 2: Discussion

The data from Study 2 replicate Study 1 in that there was a significant difference in agreement rates based on country of origin, which supports our first hypothesis. As Figure 2 shows, Indian participants, compared to American participants, were more likely to agree that the target individual was mentally ill. The effect size was smaller than found in Study 1, which is not surprising given the larger sample size. Interestingly, the gender of the target individual in the story did not have an effect on agreement rates. This disconfirmed our second hypothesis but allows us to make some generalizations about the data. The other significant finding was that the gender of participants had an effect on agreement rates; specifically, female participants, compared to male participants, from both countries were more likely to agree that the target individual was mentally ill. This data supported our third hypothesis.

General Discussion

The purpose of this line of research was to investigate differences between India and the United States with regards to willingness to diagnose a psychological disorder. Furthermore, we included methodology that would allow us to look specifically at gender differences within the two countries. In the two studies, we hypothesized that agreement rates would be influenced by the number of previous diagnoses, that participants from India would agree more strongly about the possibility of mental illness, and that the gender of the target individual and the gender of the participant would both affect agreement rates.

Our first overall hypothesis was that agreement rates would be influenced by the number of previous diagnoses. Data from Study 1 corroborated this prediction for both the United States and India. In general, it appears that the more previous diagnoses of which participants are aware, the more likely they are to agree that the target individual has a mental illness. There are two interesting aspects to this data. First, the gap between three and five previous diagnoses is not very large, indicating that there might be an asymptote effect happening in the data. We offer the possibility that adding more previous diagnoses (beyond five) might not have much of an effect on participant perception; however, more research needs to be conducted in order to corroborate this prediction.

The second interesting aspect to the data from Study 1 relates to the second overall hypothesis, which stated that agreement rates would be

influenced by the country of the participant. This was clearly the case in Study 1, in the zero diagnosis condition. While the gap between the agreement rates in the three and five previous diagnoses conditions was not statistically significant, the large gap between agreement rates in the zero diagnosis condition raises some interesting questions. Why are Indians so much more inclined to assume mental illness on the part of a target individual who is acting unsociable?

Different beliefs about the causes of mental illness could have an effect on the willingness of a person to accept/diagnose a psychological disorder. The locus of control varies greatly between the American and Indian culture. Many Americans have a sense that everything is manageable with the proper resources [23]. Indians tend to have a more externalized locus of control. Religious influence gives them a sense that the events of life are predestined. For this reason, they may be better able to accept a diagnosis because they do not have to take responsibility for the symptoms [1].

As stated before, there is an emphasis on family involvement in the care of patients with mental illness. Less attention is devoted to the glorification of the self and more time is dedicated to the caring for family in the Indian culture. Sinha and Watson [24] suggested that Indian students may be more sensitive to psychological symptoms because of the heightened emphasis on physical and psychological health by each person's social network. The differences uncovered in the present studies may be due to an increased level of sensitivity to the symptoms outlined in the vignette. Coming from a cultural background that is deeply rooted in interdependence, Indians may be more susceptible to see withdrawing from family and friends as major evidence for a psychological disorder. As for Americans, who generally value independence, these symptoms may not be as alarming when there is no evidence that they are causing a problem.

The third overall hypothesis was that the gender of the target individual would affect agreement rates. The data did not show this to be the case. Apparently, it did not matter what gender the target individual was; participants were just as likely to assess mental illness in female target individuals as they were in male target individuals. This may be due to the fact that there are disparities in the expectation of how disorders will manifest themselves in men versus women. Women are more likely to be diagnosed with depression and are more likely to be prescribed psychotropic drugs; men are more likely to receive treatment for alcohol dependence [25]. The symptoms presented in this vignette can be associated with an array of different diagnoses. Without a specific label, the participants may not have made the association with any particular gender.

The fourth overall hypothesis was that the gender of the participant would affect agreement rates. The data supported this prediction. As Study 2 revealed, female participants from both India and the United States were more likely to assess mental illness in the target individual compared to males. Social

stigma may be a contributing factor to this difference. Stereotypically, women are thought to be more prone to emotional distress, and men are thought to be more capable of dealing with such issues on their own [25]. The masculine ideology that men are supposed to be strong and competitive and emotionally inexpressive has been shown to be detrimental to both their physical and mental health [26]. These gender roles may play a part in men's overall unwillingness to report such stressors as well as decrease the likelihood of them to identify potential symptoms of a mental illness in others.

Gender differences were also found between men and women regarding help-seeking behaviors for mental health issues. In a sample of men and women experiencing equivalent levels of distress, men failed to recognize symptoms as an emotional problem [27]. This suggests that not only are men unwillingly to report when they are experiencing psychological stress, but they may not even be aware they are in need of help. If men only had higher rates of agreement when the target was a female, this would indicate that masculinity was the driving force behind the inequity. However, the fact that American men were less likely to diagnose a disorder, regardless of whether the target individual was male or female, suggests that recognition of a problem may be the real issue.

Limitations

As with any research study, there are limitations that we should address. First, this study only collects data from two different nationality bases. In order to obtain a more accurate and globalized generalization of consumers' perceptions, more data should be collected to include a more diverse group of nationalities. Second, the sampling of participants was limited to those who participate on Amazon's® Mechanical Turk®. While this population has been shown to provide reliable data [28], it is not representative of the entire population of either country. Third, the data was collected via hypothesized scenarios and not real-world situations, something that is currently impossible to do. It may be worthwhile to analyze the questions separately to see if differences emerge for each statement. Possibly, each statement represents a different domain, and by combining them, we may have missed more sensitive disparities. Another helpful modification would be to investigate whether labeling the disorder will have an effect on agreement rates.

Social Implications

This study is a reminder of the impact culture has on the representation and understanding of mental health. The socioeconomic status of the

country, availability of care, and familial structure all affect the way people respond to and deal with mental illness. When diagnosing an individual with a mental illness in the United States, clinicians refer to the *Diagnostic and Statistical Manual*, or the DSM-V. The nomenclatures in this manual provide clinicians and other practicing mental health professionals with "incorporate diagnostic modalities, clinical evaluation approaches, definition of scope of disorder, measures of severity, and level of functioning" [29]. Despite known differences in the manifestation of psychological disorders that depend on one's culture, the DSM has been adopted as a universal method for the diagnosis of mental illness.

Prior to widespread use of the DSM, many countries had their own set of classified symptoms and nomenclature for the most prevalent disorders in their region. The diagnoses were more reflective of the culture and more sensitive to the religious beliefs of the people being diagnosed. For example, acute psychotic episodes were traditionally handled by healers, but now the same patients are labeled and diagnosed as schizophrenic—and bear all the stigma that comes with it [12]. The issue of labeling may also be contributing to the stigmatization. Stigmatizing mental illness can be a barrier to treatment because it may introduce expectations of symptoms that are not necessarily present, but fit a specific diagnosis.

The results of the present study also highlight the fact that when investigating the impact of mental illness in different domains, such as culture and gender, different approaches are more effective than others. Evidence has shown that a holistic approach has better outcomes for people with mental illness. This means that in treatment, one cannot ignore the cultural impact in the manifestation and rehabilitation of a disorder. For Americans, one study showed that emphasizing the biological basis for mental illness is helpful in reducing stigma [30]. In India, the level of stigma was mainly determined by the level of violence expected from people with mental illness. The study found that exposure to people with mental illness was helpful in reducing stigma [31]. In terms of gender differences, it is necessary to utilize this information to minimize the gap in mental health care between men and women. The socialization of males tends to have a negative effect on their help-seeking behavior. One way to address this problem would be to present mental illness in a different light. Men may view a mental disorder as a sign of weakness and feel isolated because of beliefs that other men do not have such problems. Raising awareness about the prevalence of mental illness in both men and women and creating a sense of empowerment rather than helplessness can alleviate some of the gender disparities. Overall, society must become more conscious of the ways in which mental illness in the media, government policies,

the workplace, and at home is addressed to ensure that those who need help, receive it.

Conclusions

The results of these studies will hopefully bring more appreciation to the cultural differences between developed and developing countries. It is a reminder that one's cultural experiences are a major part of one's identity and worldview. The gender differences uncovered in regards to rate of agreement also warrant further investigation to explain why these patterns emerge. We must not attempt to drown out cultural and gender differences through globalization and generalization, but rather use our differences to generate more effective strategies for everyone.

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