Mental Health Literacy and Prevailing Attitudes in the Educated Population of Urban India

Esha S. Thakran

Abstract

Mental health, a critical part of overall healthcare, refers to activities related to mental well-being, such as prevention, treatment and rehabilitation of people affected by mental disorders. Devising an effective mental health strategy requires a clear understanding of the prevalence, awareness and attitude towards mental health in any given section of society. My research focused on these aspects amongst the educated population of urban India. The findings clearly indicate that while the incidence of mental health is quite high in this group, the level of awareness of what actually constitutes a mental health problem is very low. Furthermore, the lack of awareness, social stigma and trivialization of mental health issues leads to very few people actually seeking help when they need it. These findings hold true across different age groups (15–30-year-olds and 40+-year-olds). Further research would need to include the urban poor and the rural populations. If India wishes to achieve its social goals and realize its economic potential, mental health needs to be a top priority for both the public and private sectors. These findings further embolden the call for action for more mental health literacy and a comprehensive mental health strategy for India.

Introduction

Mental health is a vital component of human well-being. It is defined by the World Health Organization (WHO) as "a state of well-being in which every individual realizes [their] own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community." (World Health Organization, 2020). With the advent of the mental health movement, the degree of severity of mental illness has become a global concern. Economic and epidemio-

logical estimates point to the burden of mental illness on not just health and welfare, but global economic structures (Arias et al., 2022). The World Health Organization (WHO) research indicates that nearly half of the world's population is affected by some form of mental illness, incurring a global cost of nearly $2.5 trillion, projected to rise over $6 trillion by 2030 (Trautmann, S. et al, 2016). These include direct costs (33.34%), including medical costs of care, hospitalisations, and outpatient visits, as well as indirect costs (66.67%), including income loss and declining productivity associated with disability (Trautmann, S. et al, 2016). Mental illness is estimated to contribute to 16% of the total Disability Adjusted Life Years (DALYs) lost for Years Lived with Disability, that is, approximately 418 million DALYs (Arias, D. t al. 2022). Recent years have seen an increase of mental disorders contributing to DALYs in India, jumping 2.2% in the past two decades (Srilakshmi et al. 2020), creating an increased risk of disability and premature mortality in nearly every measure of sociodemographic development (Arias, D. t al. 2022). These statistics will be further exacerbated by the detrimental psychiatric and psychological effects of the COVID-19 pandemic. Further, the prevalence of environmental pathogens in India may increase the risk of epigenetic mental disorders associated with genetic polymorphisms.

Not unlike other eastern countries, understanding attitudes towards mental illness in India is not straightforward. The doctrine of *cultural relativism* is critical in assessing attitudes towards mental illness in India, which comprises a diverse set of cultural and philosophical mechanisms that are not compatible with the western schools of thinking (Michelle et al, 2010).

This hinders India from forming a consistent model of mental health. Aside from the biomedical foundation underlying western thinking, several Indians subscribe to Ayurveda, a traditional system of medicine which ascribes mental illness to an imbalance of humours (Michelle et al, 2010). Hindu cultural psychology supported a system of values and attitudes that prioritized family, caste, and one's responsibilities (Michelle et al, 2010). A local support and healing system protected and confined those with mental illness, supplemented by academic physicians, village practitioners of magical and religious medical arts, and priests and monks stationed in regional temples and religious institution (Fàbrega, 2001)s. Charaka Samhita, one of the foundational texts of traditional Indian medicine mentions mental illness and health, details a moral (karma and *dharma)*, spiritual and theosophical substructure with regards to physiology, pathogenesis, embryology, therapeutics, and medical practice physiology, pathogenesis, embryology, therapeutics, and medical practice (Fàbre-

ga, 2001). In these texts, organic constituents and somatic conditions (i.e., medical and surgical diseases) include mental and behavioral manifestations (Fàbrega, 2001). Five varieties of mental illness are described: four endogenous or constitutional insanities (involving the humours) and one exogenous or accidental insanity (caused by outside forces and spirits). Branches of Ayurveda were dedicated to the treatment of mental illness, namely *bhitavidya, apasmara* and *unmada* (Fàbrega, 2001). These terms, that translate to 'mental illness', 'insanity', and 'study of spirit possession' have significantly negative connotations.

Consequently, attitudes towards mental illness in India today are still very negative. The incidence of mental illness in India remains undoubtedly significant, with about 10 million suffering from mental illness nationwide (Weiss *et al*., 2001; Khandelwal *et al*., 2004; Math *et al*., 2007). However, it is estimated that nearly 70% of these people do not seek help for these disorders, and cannot recognise it in others (Srilakshmi et al. 2020). There are two plausible, and potentially interdependent factors that may contribute to this phenomenon.

First, a lack of Mental Health Literacy (MHL). First introduced by Jorm et al. in 1997, MHL refers to "knowledge and beliefs about mental disorders, which aid in their recognition, management and prevention" (Jorm, A.F., et al. 1997). Few studies in India have explored MHL.

Second, a substantial stigma or taboo around the topic of mental health. In India, mental disorders are understood through a blend of biomedicine, traditional medical practices, and supernatural beliefs (Fàbrega, 2001). These varying perspectives shape the way mental disorders are perceived, expressed, and treated, including the levels of stigma and discrimination surrounding the disorders. Negative attitudes towards mental illness are often linked to seeking treatment through allopathic methods, while a more positive outlook is associated with seeking informal help (Rahul S., et al. 2013). Stigma can cause families to hide the affected individual and their condition, leading to delayed or prevented access to appropriate treatment due to shame or beliefs about the cause of the disorder, such as perceived sins or wrongdoing (Rahul S., et al. 2013).

Method

Conceptually, conducting a survey would aid in gathering information regarding the level of awareness and also help gather data regarding the attitude/views of the educated urban population, who have no dearth of

information regarding mental issues, especially in this day and age, given the deep penetration of internet access in this segment of Indian society. Keeping in mind the above-mentioned points, the following research questions were formulated.

Q1. What is the level of awareness about what constitutes mental health illness?

Q2. How many have actually experienced mental health related issues?

Q3. How many of those who recognize and acknowledge their mental health condition actually seek help/treatment?

Q4. What stops them from seeking help/treatment?

Q5. Do the level of awareness and the attitudes about mental health vary across different age groups?

To answer the research questions, the study was conducted in three stages. The sample was collected through convenience sampling. In the first part of the study, participants were asked to participate in an interview with open ended questions, and consisted of N = 31 and focused on the first four questions. The participants varied in age from 18 to 72 years (M = 45, SD = 18.65) and consisted of 7 males and 24 females. An a priori power analysis was conducted using G*Power version 3.1.9.7 to determine the minimum sample size required to test the hypothesis. The results indicated that the sample size yielded an effect size (Cohen's d) of 0.50 with an observed power of 0.82. This would be considered a medium effect study. A significance criterion of $\alpha = 0.05$, was $N = 31$ for an independent samples T-test. Thus, the obtained sample size of $N = 31$ is adequate.

The contents and format of the interview included questions pertaining to only three conditions – low self-esteem, performance anxiety and sleep problems. The reason for focusing on these three conditions was simply that they are better understood (as opposed to more complex conditions such as PTSD or schizophrenia). Furthermore, low self-esteem, performance anxiety and sleep problems can often indicate more significant underlying psychological issues. They are well accepted in society as common conditions without always being classified as "mental illnesses", and hence were expected to help remove the chance of answers being biased due to social stigma.

Second, based on the lack of promising results from the first phase of the study, we administered the Mental Health Literacy Scale. The variation used in this study is MHLq-YA, which includes 29 items and tests 4 dimensions, (1) knowledge of mental health problems, (2) erroneous beliefs/ stereotypes, (3) help-seeking and first aid skills, and (4) self-help strategies. These items are measured on a Likert scale (ranging from 1=Strongly Disagree to 5=Strongly Agree). Cronbach's Alpha for the total scale in the adaptation study was 0.84.

After analysing the results of the first survey, an independent t-test was designed to help determine the association between personal experience and education with attitudes towards mental health. For this purpose, we surveyed two age groups of only well-educated urban-dwellers from the National Capital Region (NCR) of India: 15-to-30-year-olds (N = 104), and those over the age of 40 (N = 101). A sufficient gap was intentionally left between the two age groups to ensure there was no overlap. The participants of this survey included both men (45%) and women (55%) from a wide variety of professions. Both samples of 104 and 101 participants would have a power of 0.99 to detect an effect size of 0.50, and are therefore sufficient for the present study. An online survey was created to collect data from the sample. The survey consisted of 6 sections – ethical information and informed consent, demographic information (age and gender), descriptive questions, and a debriefing section. The survey consisted of 6 sections – ethical information and informed consent, demographic information (age and gender), a vignette describing a hypothetical situation, a character description vignette, questions assessing the dependent variables, and a debriefing section.

Procedure

The interviews were taken in the participant's homes. Beginning at a mutually agreed upon time and following rapport formation, the questions were asked. The survey was circulated via email and text. It was self-administered, and was preceded by ethical information and participants' consent. Once collected, the categorical data obtained coded ordinally to meet the requirement of continuous data for analysis using the statistical software, Jamovi, version 2.3.21.

Ethical Guidelines

The study adhered to design and procedural ethical standards. The questionnaire was designed to prevent distress to participants. Participants

were assured anonymity as no personally identifying information was collected. Participants were informed of their right to withdraw their participation at any point, and their informed consent to use their responses for the study was obtained.

Results

The 31 subjects in the interview round were asked questions to assess their awareness of the incidence and recognition of mental health illness. The 31 participants of this survey included 27% who were below 25 years of age, and 73% above 25 years; 77% were women, and 23% men; all were urban dwellers, based in the National Capital Region (NCR); 29% were students and 71% adults from all walks of life. The findings of this survey revealed that the level of awareness about whether these three conditions (low self-esteem, performance anxiety and sleep problems) constitute a mental health issue is relatively low across different age groups, with an average of 43% of participants able to identify one of the three given factors as indicators of mental illnesses *(Table4)*. A higher number of participants in the younger group have actually experienced two of the three conditions, low self-esteem, performance anxiety and sleep problems (47% versus 34%) *(Table1)***.** Both older and younger populations claimed to be open to seeking professional help if they were experiencing any of these three conditions *(Table 5)*. However, only half of the sample who reportedly experienced mental health problems had actually sought help when they actually experienced any of these conditions *(Table 3)*. Further:

(a) The level of awareness of what constitutes mental health illness is very low. Very few people (29%) were able to articulate a reasonable definition of mental health illness; the remaining 71% either left the question blank or provided vague/incorrect definitions. 24% failed to identify anxiety, 46% failed to identify Post-Traumatic Stress Syndrome (PTSD) and 34% failed to identify Attention Deficit/Hyperactivity Disorder (ADHD) as mental health issues.

(b) The incidence of mental health illness is quite high. A majority of the participants (68%) admitted to having experienced at least one of the 12 mental health issues that were listed in the survey. Interestingly, 90% of the respondents claimed to know others who had experienced a mental health illness *(Table 2)* (Note: the survey did not attempt to determine the severity of the illnesses.)

(c) However, few actually sought help for the issue they had faced. Only 37% of those who admitted to having faced a mental health challenge had actually sought help, implying that 67% were left untreated. Of those that sought help, only 25% reached out to professionals, and the rest relied on non-professional resources (such as family, friends and self-help books). Contrast this with people who face even non-life-threatening physical conditions (a persistent cough, high fever, etc.) for which almost 100% of the people would seek professional help/consultation.

(d) Lastly, the participants cited a number of factors that contribute to the failure to seek help for mental illnesses. The three biggest drivers of this phenomena seem to be the failure to recognize/admit that they were facing a mental health issue (cited by 70% of the participants), social stigma about mental illnesses (cited by 60%), and the trivialization of the issue (cited by 50%). Other contributing factors included lack of resources such as money, time, availability of qualified professionals, etc. (cited by 27% of the respondents), and apathy regarding the condition (also cited by 27%).

The Mental health Literacy Scale was administered to the same sample of 31 participants consisting of adults aged 18-72. The range of scores obtained were 20 to 50 with mean score for the sample was 35 out of a possible 100, with standard deviation of 7. According to the scales norms, M = 3 and SD = 7 indicate limited knowledge and understanding of mental health issues.

Next, an independent sample t-test was done to determine whether:

H1: Personal experience with mental illness is positively associated with more accepting attitudes towards mental health.

H2: Education level is positively associated with more positive attitudes towards mental health.

The independent variables (IV) were **personal experience with mental illness and education level**, and the dependent variable (DV) was **positive attitude towards mental illness.**

Before proceeding with the T-tests, assumption checks were carried out. To check for normality and equality of variances, Shapiro-Wilk and Levene's Tests were conducted for both DV's, guilt and punishment. In both cases Levene's Test was insignificant (p=0.76 and p=0.99 respectively), suggesting no violation of homogeneity of variance. Moreover, the stan-

dardised residuals aligned along a Q-Q plot.

However, in both cases, the Shapiro-Wilk Test was significant (W=0.941, p<0.001 for perceived guilt and W=0.907, p<0.001 for positive attitude towards mental illness), implying that the assumption of normality was violated. Due to this, the non-parametric Mann-Whitney U test was conducted in both cases and the hypotheses were modified to compare medians instead of means.

H1: Personal experience with mental illness is positively associated with more accepting attitudes towards mental health.

The results of the test were significant: U=552, p=0.002, r=0.385. This implies a significant difference in the medians of personal experience with mental health and accepting attitudes towards mental health.

Therefore, the null hypothesis that there exists no positive association of personal experience and accepting attitudes towards mental illness was rejected. The effect size r=0.385, calculated through the Rank-Biserial Correlation due to the non-normal data, indicates a moderate effect of the independent variable (personal experience with mental health) on the dependent variable (accepting attitudes towards mental health).

H2: Education level is positively associated with more positive attitudes towards mental health.

The results of the test were not significant: U=851, p=0.675, r=0.051. This implies no significant difference in the medians of education and positive attitudes towards mental health.

Therefore, the null hypothesis that there exists no relationship between education and positive attitudes towards mental health could not be rejected. The effect size r = 0.051, calculated through the Rank-Biserial Correlation due to the non-normal data, indicates a negligible effect of the independent variable (personal experience with mental health) on the dependent variable (accepting attitudes towards mental health).

Discussion

Mental health is vital for humans to flourish both individually and as a society. This makes the global threat of increasing mental illness a critical issue to solve. This fact is further solidified when taking India's example,

as demonstrated by the present study. In addition, the younger generation is exposed to new stresses, driven by the ever-increasing use of social media, trend towards nuclear families and heightened competition.

The first segment of the study showed a lack of literacy regarding mental illness, and discrepancies in reported actions taken against the same, perhaps due to social-desirability or acquiescence inherent in self-report measures. The awareness of stage fright/performance anxiety as a psychological condition was particularly low in both groups, but especially in the younger population. Lack of awareness, insufficient facilities and resources for treatment, and an unhelpful attitude (even in the well-educated segments of society) could be making the problem much worse. Various attributes of specific individuals (ability to manage one's thoughts, emotions, behaviours and interactions with others) are determinants of mental health (WHO, 2019). Further analysis of such attributes could definitely provide an insight into the onset of mental health issues among individuals. These findings are congruent with previous research work which clearly indicates that many members of the general public are unable to identify the various psychological disorders and signs of distress (Jorm, 2000).

Most participants reported having experienced some form of deviation from normal mental health, and recounted others they knew were experiencing mental illness as well. However, this was truer for younger populations. This indicates that the incidence of these conditions, and potentially more serious underlying conditions, may be higher among the younger age group. This, in turn, would indicate that the problem might be a growing one in the general population.

Further, though 40% to 50% of people of all age groups were open to seeking help in the incidence of mental illness, only half that number had actually sought help when faced with a problem. This again seems to indicate that some combination of trivialization of mental health issues, apathy, and social stigma might be deterring people from seeking help. The results could also indicate that the perception of individuals regarding the skills and abilities of mental health professionals may not be clear and could be one of the causes for not seeking help. Similar conclusion was also drawn by Saha (2018).

Next, the Mental Literacy Scale also did not produce promising results. The implications of the low mental health literacy score are that the group may have difficulty recognizing and managing mental health issues, and

may be less likely to seek help when needed. This highlights the need for increased education and awareness about mental health in this population.

The independent t-test study aimed to understand how personal experience with mental illness and education can influence attitudes towards mental illness. The results indicated that the difference between personal experience and attitudes towards mental illness was significant. However, the difference between education and attitudes towards mental illness was insignificant.

As mentioned above, the difference in education and positive attitudes towards mental health was insignificant. This may be attributable to the societal, theological and cultural ideologies surrounding mental illness. Mental illness has shared negative connotations even in traditional Indian medicine. Further, the community-based structure of Indian society creates pressure for 'keeping-up appearances', creating a culture of constantly presenting one's best self in society. This might also contribute to the tendency to conceal mental illnesses and resist seeking help.

However, the difference between personal experience and attitudes towards mental illness was significant. This may be due to a sense of empathy that arises when one has experienced mental illness themselves, making them more understanding and sensitive regarding the issue.

Limitations

The study used self-report measures. These are subject to social desirability bias, where individuals may respond in a way that they believe is socially desirable rather than truthful. Secondly, self-report measures may be subject to memory biases, where individuals may not accurately recall past experiences or events. Thirdly, self-report measures may suffer from response bias, where individuals may respond in a way that is influenced by how the questions are phrased or framed.

Data was collected through convenience sampling, and thus represented part of the population belonging to the same demographic. This might have led to nonresponse and under coverage bias, wherein the sample was not representative of the population of interest as they were not covered by the sampling frame of the survey (Cobben et al., 2005), decreasing the validity of research results, and potentially leading to researcher bias in systemic investigation (Formplus, 2020). However, these differences of

attitudes in different demographics are beyond the scope of this study, which focused on the urban population. Future studies should focus on urban populations of other areas in India.

The participants who were included in the t-test did so in varying environments, and there was no control for priming and participants could have been distracted by external factors during the survey. Future research could consider conducting the study in a controlled setting to strengthen internal validity. Further research can also aim to use a more diverse sample to improve external validity. This would address the problem of unrepresentative data due to under coverage bias, and account for demographic differences in attitudes towards mental health, hence giving more generalisable results.

Furthermore, it should be noted that my research focused on only the well-educated urban population; exclusion of the uneducated urban poor or the rural population was maintained. These populations face tremendous economic and social stresses, yet have virtually no access to mental health resources. People migrating from rural to urban areas in search of a livelihood, who form a large component of the "economically weaker section" in urban areas, may be especially vulnerable. Such ideas would have to be explored in further research since the domains of urban vs rural, educated vs uneducated sections, and well-off vs economically weaker sections function under different mechanisms.

Conclusion

Mental health, a critical part of overall healthcare, refers to activities related to mental well-being, such as prevention, treatment and rehabilitation of people affected by mental disorders. The results indicate low MHL in the urban population of India. Increasing MHL should become a priority for India to ensure personal and societal welfare.

This unrecognized and largely untreated mental health problem in urban India could potentially grow into a much bigger crisis over time. The findings of my research highlight the need for conducting further studies to help develop a comprehensive mental health strategy.

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Appendix

Table 1

Experience with either mental health issue

	10 to 30 year age group	40+ age group
Low self-esteem	56%	30%
Performance anxiety	47%	30%
Sleep problems	38%	42%

Table 2

Personally know others (family/friends) who have experienced the given conditions (low self-esteem, performance anxiety and sleep problems)

	10 to 30 year age group	40+ age group
Yes - know others	73%	67%
No – don't know others	27%	33%

Table 3

Percentage of those who actively sought help when faced with mental illness

	10 to 30 year age group	40+ age group
Yes – would seek help	26.5%	26%
No – would not seek help	73.5%	74%

Table 4

Percentage of those aware of whether these conditions constitute a mental health issue

	10 to 30 year age group	40+ age group
Low self-esteem	52%	54%
Performance anxiety	5%	24%
Sleep problems	58%	65%

Table 5

Percentage of those open to seeking professional help if they were experiencing any of the given conditions

	10 to 30 year age group	40+ age group
Low self-esteem	43%	41%
Performance anxiety	47%	36%
Sleep problems	50%	52%