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Acculturation, shame, and stigma towards mental illness among Asian Indians: a cross-national perspective

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Pepperdine University
Graduate School of Education and Psychology

ACCULTURATION, SHAME, AND STIGMA TOWARDS MENTAL ILLNESS AMONG
ASIAN INDIANS: A CROSS-NATIONAL PERSPECTIVE

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Soumita Sen,

September, 2018

Natasha Thapar-Olmos, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Soumita Sen

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

The study explored the impact of acculturation on the stigma associated with mental illness and the relationship of shame with stigma towards mental illness in an Asian Indian sample. The participants of the study were college students residing in the USA and India who responded to one of two randomly assigned vignettes describing a hypothetical cousin who was either experiencing the symptoms of moderate depression or schizophrenia. Correlation, multivariate analysis, and regression analysis were conducted on the acquired data. The results indicated that level of acculturation had a statistically significant relationship with stigma in both samples. However, when specific aspects of stigma were examined, such as expected consequences, disclosure, concealment and help-giving attitudes, no significant relationships were found. Exploratory analyses were conducted to examine associations between other variables and it was found that expected consequences and shame were strongly related.

Key words: Asian Indians, Acculturation, Stigma, Shame, Mental Illness

Chapter 1: Introduction

Overview and Rationale

In the past few decades, researchers have postulated several theories of stigma (Link & Phelan 2001; Weiss, Ramakrishna & Somma, 2006). Stigma is present in our societies towards various groups and conditions, and it is directly related to the social and cultural norms of each society (Howarth, 2006), forensic background (Owens, 2009), physical illness (Logie & Gadalla, 2009), and physical disability (Burkhard, 2011). However, stigma towards persons with mental illness is the most pervasive form of stigma (Corrigan, 2004; Cooper, Corrigan, & Watson, 2003; Paschos, 2006; WHO, 2008). The mental health community is making efforts to understand the impact of stigma, how to reduce it, and improve the quality of life for individuals suffering from mental illness. The stigma associated with mental illness is heavily influenced by preexisting attitudes about mental illness (Loya, Reddy, & Hinshaw, 2010), perceived societal discrimination (Corrigan, 2004), and familiarity about mental health issues (Corrigan, 2001). Likewise, an association has been found between the level of acculturation among ethnic minorities and their views on mental illness. Specifically, lower levels of acculturation are associated with more negative views on mental illness and mental health treatment among various groups of U.S. ethnic minorities, including Asian Americans (Gim, Atkinson, & Whiteley, 1990; Kim & Omizo, 2010), Asian international students (Yakunina & Weigold, 2011), as well as Hispanic Americans (Pomales & Williams, 1989), including Mexican Americans (Miville & Constantine, 2006) and Puerto Rico and Cuban Americans (Rojas-Vilches, 2011). Asian Indians in the U.S., the population of interest in this dissertation, are a significantly understudied ethnic minority population (Alegria, & Chen, 2012; Das & Kemp, 1997; Durvasula & Mylvaganam, 1994; Tummala-Narra, Loya, Reddy, & Hinshaw, 2010), and

some researchers have indicated that this population endorses stigmatized attitudes towards mental illness (Akutsu & Chu, 2006; Das & Kemp, 1997; Loya et al., 2010). The present study aims to explore the impact of acculturation on stigma and shame in a sample of Asian Indians living in the United States and India.

Asian Indians in the United States

Asian Indians are the third largest Asian population group in the United States, representing 16.2% of the Asian population in the United States (U.S. Census Bureau, 2004). The Asian Indian population in the United States, which is among the fastest growing ethnic groups in the country, more than doubled between 1990 and 2000, from approximately 800,000 to more than 1.65 million persons (U.S. Census Bureau, 1993; U.S. Census Bureau, 2004). Much of this growth stems from recent immigration, such that approximately 75% of Asian Indians now living in the United States are foreign born (U.S. Census Bureau, 1993; U.S. Census Bureau, 2004). Even though Asian Indians are a fast-growing ethnic minority group, the psychological and social issues related to Asian Indians in the United States of America have largely been invisible in the research literature, mainly because in the sociology and psychology literature Asian Indians have been categorized broadly as Asian.

Asian Indians have never identified with the term *Oriental*, which was traditionally used to identify individuals originating from Far Eastern countries (e.g., China, Japan, Korea). Therefore, Asian Indians do not typically identify with the current Western term *Asian*, which has replaced the term *Oriental* (Durvasula & Mylvaganam, 1994). Asian Indians are demographically and historically distinct in a number of ways from other Asian immigrant groups in the United States. When compared to other Asian groups in the United States, Asian Indians have the greatest percentage of individuals who speak English “very well” (76.9%), the

highest educational attainment (63.9% of Asian Indians have a bachelor's degree or more), and the greatest percentage of employment in management, professional, and related occupations (59.9%) (U.S. Census Bureau, 2004).

Ethnographic studies have indicated that Asian Indians have a different minority identity development process compared to other Asian Americans; specifically, that they selectively acquire and maintain values and practices of both the host culture and the origin culture (Patel, Power, & Bhavnagri, 1996). Similar to other Asian immigrant groups, Asian Indians are perceived as “model minorities,” whose American experience is defined by occupational, educational, and economic achievement (Sue, Sue, Sue, & Takeuchi, 1995). However, Asian Indians also retain a strong ethnic identity, resulting in a unique combination of individualistic and collectivist traits. This pattern of both acculturation and enculturation among Asian Indian immigrants may provide a unique framework for understanding how perceptions of mental health and illness vary with the selective shift, modification, retention, or alteration of values and practices (Patel et al., 1996).

The flexibility of Asian Indian immigrants to operate effectively in both cultures may be due to their exposure to Western values, beliefs, and customs resulting from their history of colonization by the British (Ibrahim, Ohnishi, & Sandhu, 1997). Through years of colonial rule, many Indians are fluent in English and have had exposure to Western values, yet their interaction with the British failed to alter their basic customs, traditions, and cultural identity. This enculturation pattern has extended to Asian Indian immigrants who affirm their ethnicity by reinventing Asian Indian culture in their host country (Dasgupta, 1998). Frequently, Asian Indian immigrants appear to retain a sense of culture that is more traditionally “Indian” in many respects than the culture that currently exists in India (Farver, Narang, & Bhadha, 2002).

Although the research regarding the mental health of Asian Indians is scarce, a recent study on Asian Indian graduate and undergraduate students in the United States revealed that even with prior exposure to Western cultures and proficiency over the English language, participants were at a greater risk of psychological difficulties (Zhang & Goodson, 2011). Similarly, other studies on Asian Indian international students have indicated that societal differences between the United States and India, with Indian culture featuring generally more traditional gender roles and attitudes (Deosthale & Hennon, 2008), strong reliance on interdependence and connectedness with family members throughout the lifespan (Verma & Triandis, 1999), and expectations of maintaining a deferential and non-confrontational stance toward teachers (Milner, 2009), may uniquely affect Asian Indian international students' expectations while studying in the United States. As mentioned at the beginning of this section, 75% of Asian Indians living in the United States are foreign born, and there appears to be a corresponding increase in the number of Asian Indians seeking mental health services, irrespective whether they were born in the United States or migrated from India (Das & Kemp, 1997; Durvasula & Mylvaganam, 1994; Loya et al., 2010; Tummala-Narra, Alegria, & Chen, 2012).

Investigations of the mental health status of Asian Americans have primarily focused on Chinese and Japanese Americans (Das & Kemp, 1997; Durvasula & Mylvaganam, 1994; Loya et al., 2010; Tummala-Narra, Alegria, & Chen, 2012). The tendency to generalize findings of Asian subgroups to all Asian Americans fails to account for the distinctive aspects of particular Asian cultures. These cultural variations include patterns of acculturation and enculturation, conceptualizations of mental illness, stigma towards mental illness, and treatment-seeking behaviors (Farver, Narang, & Bhadha, 2002; Rao, 2006). As cultural and personal experiences come to influence an individual's beliefs, attitudes, and preferences, the failure of researchers

and clinicians to understand cultural differences between Asian population groups may result in potential errors in diagnosis and difficulties engaging patients from these population groups in treatment (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006).

Acculturation and Models of Acculturation

The concept of acculturation developed in the early 19th century to study the social changes and cultural contact between different communities such as peasants and Native American communities (Redfield, Linton, & Herskovits, 1936). Redfield and colleagues (1936) postulated the first authoritative definition of acculturation as the phenomenon in which groups of individuals from different ethnic backgrounds and cultures come into continuous firsthand contact, with subsequent changes in the original cultural patterns of either or both groups. Hence, acculturation can occur in any intercultural contact (Schwartz et al., 2010). However, for ethnic minorities and immigrants, acculturation is most often considered as cultural socialization to mainstream culture, whereas enculturation is the retention of or cultural socialization to one's culture of origin (Berry, 1994; Kim & Abreu, 2001; Kim, Atkinson, & Umemoto, 2001). Graves (1967) coined the concept of "psychological acculturation" to refer to the fact that this phenomenon involves not only group changes (ecological, cultural, social, institutional, etc.), but also individual changes, that is, changes in attitude, conduct, way of life, values, identity, etc. in persons and groups that come into contact (Sabatier & Berry, 1996).

As immigrants have prolonged contact with people and social systems in a host country, there will inevitably be changes in attitudes, behaviors and values. This process is referred to as acculturation (Berry, 1997; Berry et al., 2006; Kim and Abreu, 2001). Earlier research on acculturation tended to assume that as individuals adopt the host culture's values, attitudes and behaviors, they disengage from those of their culture of origin (Gordon, 1964). However,

empirical evidence accumulated over the years supports the bi-linearity of acculturation; this model acknowledges both adopting attributes of the host culture and retaining or enhancing those of the culture of origin; the latter is referred to as enculturation (Berry, 1997; Cuellar, Arnold, & Gonzalez, 1995; Kim & Abreu, 2001; Lee, Sobal, & Frongillo, 2003, 2006; Miller, 2007, 2010; Ryder, Adlen, & Paulhus, 2000; Stephenson, 2000). Acculturation and enculturation are multidirectional and multifaceted processes that continuously change over time and across different domains of the individual's life (Roosa, Dumka, Gonzales, & Knight, 2002). For example, acculturation may simultaneously occur across such levels as the following: (a) changes in the consumption of foods and the use of media; (b) changes in behaviors that are at the core of an individual's social life; and (c) changes in the values and norms that define an individual's perception of the world and interpersonal relationships. The simultaneous occurrence of acculturation and enculturation processes may determine an individual's cultural orientation and ability to develop bicultural competence. Bicultural competence is the ability in which the individual is able to incorporate the values and norms of the host culture, simultaneously keeping and integrating the values and norms of the origin culture (Kumar & Nevid, 2010).

One early model of acculturation proposed by Gordon (1964) uses a uni-dimensional model of assimilation to illustrate immigrant acculturation. Immigrants' experience is portrayed on a continuum, with one pole being maintenance of the original culture and the other pole adaptation to the host culture, at the cost of losing the original culture. The underlying assumption of a uni-dimensional assimilation model, which is also called a linear bipolar model, is that immigrants lose their original cultural identity as they acquire a new identity in a second culture (Gordon, 1964; LaFromboise, Coleman, & Gerton, 1993). Associated with the development of a new

identity is the loss of social support from the original culture, combined with an initial inability to use the assets of the newly acquired culture (LaFromboise et al., 1993). This can lead to alienation, stress and anxiety. Although for many decades the uni-dimensional model was the dominant framework used to account for immigrants' acculturation processes, it is not an influential model anymore because it fails to take into account that the host majority culture is also transformed by the presence of culturally distinctive immigrants (Sayegh & Lasry, 1993), and that adoption of host values does not necessarily mean the loss of values from the culture of origin.

This perspective has also come under criticism because it does not explain the adaptation pattern exhibited by many ethnic minorities. For example, with the exception of white Protestants, Gordon (1964) maintained that true assimilation had not been achieved in the United States, a point also emphasized by Lambert and Taylor (1988). These researchers reported that Hispanics, Asians and other ethnic minorities do not exhibit the same linear assimilation patterns that are observed among people from northern and western Europe (Lambert & Taylor, 1988). This indicates that the 'melting pot' approach depicted by a linear bipolar model is not generalizable to many ethnic groups (Kim, Laroche, & Tomiuk, 2001).

Studies with Asian, Latin American, and Middle Eastern immigrants in the United States (Rueschenberg & Buriel, 1989; Triandis, Kashima, Shimada, & Villareal, 1986), have led to more complex models in which acculturation is a multidimensional process that includes an orientation or 'attitude' toward one's own ethnic group and the larger society, *as well as* toward other ethnic groups (Berry, Kim, Power, Young, & Bujaki, 1989). In these models, changes in values relative to the host culture are not necessarily related to changes in values relative to the culture of origin. According to Berry's model of acculturation (i.e., Berry, 1980; Berry, Kim, &

Boski, 1988; Berry et al., 1989), there are four ways ethnic group members can associate with their host culture and their own culture. Individuals can assimilate (identify solely with the host culture and sever ties with their own culture); marginalize (reject both their own and the host culture), separate (identify solely with their own group and reject the host culture); and integrate (become 'bicultural' by maintaining characteristics of their own ethnic group while selectively acquiring those of the host culture). Berry's acculturation framework considers contextual influences and their interplay with individual factors. Berry identified these influences in both the society of origin (e.g., political situation) and the society of settlement (e.g., attitudes towards immigration or social support; Berry, 1997; Berry & Sam, 1996).

Some researchers have tried to expand the principles of Berry's models by including other relevant variables that could influence the acculturation process (Navas, Garcia, Sanchez, Rojas, Pumares, & Fernandez, 2005). Two of these models are the *Interactive Model of Acculturation (IAC)* by Bourhis, Moird, Perreault, & Senecal (1997) and the *Concordance Model of Acculturation (CMA)* by Pointkowski, Rohman, & Florack (2002). Both models have explored the consensual, problematic or conflictual nature of intercultural relations, which is derived from the match/mismatch between different perspectives. Bourhis et al.'s (1997) model focuses on the match/mismatch between immigrants' and hosts' point of views and proposes three types of intercultural relations that are adopted at an intergroup level of analysis. The analysis focuses on the immigrants' desire to maintain their culture of origin, the extent of adoption of the host culture, and host groups' perceptions about the immigrants' maintenance of the culture of origin and adoption of the host culture. Researchers like Zagefka & Brown (2002) and Zagefka, Brown, Broquard, & Martin (2007) adopt an interpersonal level of analysis in which there is a comparison between the attitude towards acculturation choice (what immigrants should do) and

perception of the host groups' attitude towards the acculturation strategies.

Despite their utility for capturing the multidimensional nature of acculturation, these models present with a number of limitations. First, they give little consideration to the range of intercultural relations that may result from the interactions between immigrant and host perceptions (Navas, Rojas, Garcia, & Pumares, 2007). Second, these models do not measure the contextual nature of acculturation, usually referring to acculturation processes in general or to the fields of values, language, culture and social relations (e.g., Arens-Tó th & van de Vijver, 2003, 2004; Berry, 1990; Berry & Sam, 1997; Birman, Trickett, & Vinokurov, 2002; Bourhis et al., 1997; Horenczyk, 1996; Navas et al., 2007; Nguyen, Messe, & Stollak, 1999; Trimble, 2002).

Navas and colleagues (2005) developed the Relative Acculturation Extended Model (RAEM) (Navas et al., 2005; Navas, Fernandez, & Rojas, 2006) to fill in the gaps of the earlier models. They incorporated components from Berry's, Bourhis's, and Piontkowski's models (Berry, 2001; Bourhis et al., 1997; Piontkowski et al., 2002) and added more dimensions and domains to explain the acculturation strategies and attitudes preferred by both the host and immigrant populations in different acculturation planes. Navas et al. (2005) carried out studies in the province of Almeria, Spain with two group of immigrants, Maghrebis and Sub-Saharan Africans. This study showed that the acculturation process is complex (different acculturation options can be adopted and preferred at the same time) and relative, because the same strategies are not always used or the same options preferred when the interaction with other cultures takes place in different domains (i.e., work, family relationships, religious beliefs and customs) (Navas et al., 2005). Indeed, although previous authors have acknowledged the importance of dividing the general acculturation context into different domains (e.g., Berry & Sam, 1997; Horenczyk, 1996), the RAEM postulates that there is no single or general acculturation attitude as inferred

from some of the traditional models (e.g., Berry et al., 1989).

Navas and colleagues (2005) highlighted the five fundamental points of the RAEM model. The first point is the consideration of the acculturation strategies of the immigrant group and of the host population, since it is the confluence of both groups' strategies which can lead to consensual, problematic, or conflictive intergroup relationships. Second is the differentiation of various immigrant groups by ethnocultural origin. Third, the modulating influence of psychosocial variables (in-group biases, perceived cultural enrichment, in-group identification, perceived in-group and out-group similarities) and several behavioral indicators (linguistic practices, use of communication media, political participation) on acculturation are examined. The fourth is the distinction between the ideal and real situation. An ideal situation for immigrant is the option they would choose, if they could. For the host, the ideal situation is the acculturation options that the members of the host society would like to see adopted by immigrant groups. On the other hand, the real situation, in the case of immigrants, comprises those acculturation strategies that they actually put into practice. For the host culture, the real situations include their perceptions of the acculturation strategies employed by the immigrant group. Moreover, seven areas are distinguished in the model, from the nearest to the world's material or peripheral elements (political, work, economic), to those farthest away, such as symbolic representation, ideology or religion (religious beliefs and customs, ways of thinking— principles and values) with intermediate areas (social and family relationships) (Navas et al., 2007).

Acculturation and Asian Indians. Of the few studies on strategies of acculturation in Asian Indians, the results suggest that Asian Indian immigrants show a tendency to adopt a bicultural/integrated model of acculturation (Dosanjh & Ghuman, 1997; Krishnan & Berry, 1992; Kurian & Ghosh, 1983). Patel and colleagues (1996) hypothesized that biculturalism is a

more adaptive acculturation strategy for members of the Asian Indian community, as it allows individuals and groups to practice the values and beliefs of the Indian culture and also provide the opportunity to integrate the norms of the host culture. The bicultural/integrated model of acculturation is in keeping with the strategy used by many Asian Indians, of combining the adoption of the host culture at work with the maintenance of the traditional cultural ways in the home and has been found to be associated with the least amount of stress (Berry, 2003). Kurian & Ghosh (1983) suggested that the bicultural pattern of adaptation employed by Asian Indians is due in part to their experience with the British colonial rule of India. Many Asian Indian immigrants also have prior knowledge of the English language, as it is now one of the national languages of India (Prathikanti, 1997). Likewise, other studies have shown that higher levels of education (Ibrahim, Ohnishi, & Sandhu, 1997), exposure to the host culture via various media outlets (Raman & Harwood, 2008), high socio-economic status, length of stay in the host culture, employment status, strong sense of self-identification with the natal culture, and embracing the host culture are contributors to the bicultural pattern of adaptation by Asian Indians (Farver, Narang, & Bhadha, 2002). However, Mehta (1998) reported that more positive mental health outcomes among Asian Indian immigrants in the United States were associated with higher levels of acculturation to mainstream culture and negatively associated with adoption of a more traditional cultural orientation. A study examining factors relating to the psychological well-being of Asian Indian immigrants reported similar findings in showing that the adoption of either a bicultural or a more American cultural identity was associated with less depression among older Asian Indian immigrants than was a more traditional cultural identity (Diwan, Jonnalagadda, & Balaswamy, 2004). Farver, Narang, and Bhadha (2002) reported higher levels of family conflict among Asian Indian immigrant parents and their adolescent children when

parents were separated or marginalized from the mainstream culture. Unlike early models of immigration that described assimilation as a unidirectional process that occurs when immigrants replace the customs, beliefs, and values of their old culture with those of the new culture, these findings indicate that the ability to acquire and/or maintain characteristics of both cultures may be integral to the mental health of Asian Indian immigrants.

Acculturation scales and Asian Indians. As mentioned above, Asian Indians tend to adopt a bicultural/integrated model of acculturation (Dosanjh & Ghuman, 1997; Krishnan & Berry, 1992; Kurian & Ghosh, 1983) Although Asian Indians comfortably accommodate and adjust to the Western culture, at the same time, they tend to hold firmly to the Indian cultural values (Farver, Narang, & Bhadha, 2002). Likewise, it was noted that Asian Indians' preferences for food, dresses, and use of languages varies depending on the setting, such as in-home Asian Indian prefers ethnic wear, traditional food and like to speak in the native language whereas when outside they prefer western clothing, food, and like to speak in English. Interestingly, these choices do not depend on the education level or length of stay in the United States of America (Sodowsky & Carey, 1988; Ghuman, 1997). Unfortunately, the studies focused on acculturation in Asian Indians have modified various acculturation scales developed for other ethnic groups such as Mexicans (Lee, Yoon, & Liu-Tom, 2017; Cuellar, Arnold, and Maldonado, 1995), Asians (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987), and Africans (Landrine & Klonoff, 1994). The Acculturation Scale for Asian Indians (ASAI) (Parekh, 2000), the scale used in this study to assess acculturation, was developed by a doctoral student for her dissertation tailored after the African American Acculturation Scale (AAAS) (Landrine & Klonoff, 1994). Parekh (2000) developed the scale to understand the relationship between the acculturation and psychological and health adjustment in Asian Indian population settled in the United States of

America. The scale is divided into eight domains that measure Traditional Asian Indian Family Structures and Practices, Preferences of Things Asian Indians, Preparation and Consumptions of Traditional Foods, Interracial Attitudes/Cultural Mistrust, Traditional Asian Indian Health Beliefs, Traditional Asian Indian Religious Beliefs and Practices, Traditional Asian Indian Childhood Socialization, and Superstitions. Seven Asian Indian from diverse geographical locations of United States generated 129 items regarding beliefs, practices, rituals, foods, games, and superstitions help by Asian Indians and by large unknown to Caucasians in the USA. These items rated on the Likert scales ranged from 1 (totally disagree, this is not true for me at all) to 7 (totally agree, this is absolutely true of me). The high score on the scale implies traditionalism, and high immersion in one's own native culture and low scores were indicative of high acculturation, low immersion in one's own native culture. In the round one, these 129 items were administered to 145 Asian Indian participants and 145 non-Asian Indian participants to exclude items that did not differentiate between the two groups. After the preliminary administration, four items were dropped, the remaining 125 items were re-evaluated to assess the degree to which Asian Indians agreed with the items. The items were 50 percent or more of Asian Indian agreed to it were retained, and others were excluded from the final set of items. After dropping 33 more items from the list, the final set of items in ASAI consisted of 92-items measuring eight theoretically determined subscales identified in AAAS. The split-half reliability of the whole scale is $r = .92$, and the reliability of each subscale ranged from .79 to .97. All the right subscales were strongly correlated with the total ASAI scores. Significant correlations were found among the eight domains which were appeared to be theoretically appropriated such as Preference for Asian Indian things most correlated ($.872; p < .001$), Traditional Family Structures ($.848; p < .001$), and Preparation and Consumption of Traditional food ($.830; p < .001$) with the total score

on ASAI. Relatedly, no significant relationship between has been noted between the total scores on ASAI and language fluency, education level. Hence, the ASAI assess acculturation in the Asian Indian by focusing on the cultural shifts rather than the socioeconomic shifts, by going more in-depth than the assimilation process.

Asian Indians and Mental Illness

Prior research suggests that the conceptualization and recognition of mental illness may be influenced by cultural factors as well as by processes of acculturation and enculturation among members of ethnic minority groups. Recently, investigators have begun to explore perceptions of mental illness among South Asian population groups. For example, Karasz (2005) compared two conceptual models of depression among South Asian immigrant women and European American women in New York City using a qualitative vignette methodology. These models differed in their explanatory emphases on the biopsychiatric versus situational origins of depression. European American women displayed a greater tendency than South Asian immigrant women to interpret depressive symptoms as a disease, rather than as a feeling state. The disease orientation of depression was associated with greater perceptions of severity, a chronic or deteriorating timeline, and necessity of professional treatment seeking. The disease orientation of depression was also associated with greater acculturation in the South Asian immigrant women.

Patel, Pereira, and Mann (1998) examined somatic and psychological models of common mental disorders (i.e., anxiety and depressive disorders) among primary care patients in India. Although somatic symptoms were the most common form of presentation in primary care settings, psychiatric interviews revealed that patients were also aware of the emotional components of their illnesses. The investigators suggested that a patient's conceptualization of a mental disorder might evolve from somatic to psychological models as the illness progresses in

severity and across time. Their theory is supported by findings of a study that explored the cultural variables influencing the manifestations and attributions of depression among Asian Indian patients and their families from the perspective of mental health practitioners in the United States (Conrad & Pacquiao, 2005). These investigators found that somatic complaints from patients were common early clinical manifestations that were often ignored by the patients themselves as well as by members of their families. Family members markedly delayed professional treatment seeking until clear psychotic features emerged in the affected family members. In contrast to depressive and anxiety disorders, schizophrenia and bipolar disorder have traditionally been recognized as mental disorders by Asian Indians (Thara, Padmavati, & Srinivasan, 2004).

Stigma

Stigmatization involves specific social-cognitive processes, including stereotyping, prejudice, and discrimination. Augoustinos, Ahrens, & Innes (1994) defined stereotypes as knowledge structures or cognitive schemas that are learned by members of a social group. As such, stereotypes enable people to process information more quickly (Macrae, Milne, & Bodenhausen, 1994) and to generate quick impressions and expectations about others (Hamilton & Sherman, 1994). In this sense, stereotypes may serve a useful and adaptive purpose.

However, when a person endorses a strong negative stereotype regarding another person based on his or her social group, a negative emotional reaction (i.e., prejudice) is triggered. Put another way, prejudice is the affective component triggered upon the endorsement (conscious or unconscious) of a negative stereotype (Allport, 1954; Devine, 1995; Hilton & von Hippel, 1996; Krueger, 1996). This is followed by discrimination, the behavioral component involved when a person acts upon his or her prejudice (Crocker, Major, & Steele, 1998). One common

discriminatory behavior involves socially distancing oneself or “not associating with people from the out-group,” which further leads to isolation and negative self-perception (Ben-Zeev, Young, & Corrigan, 2010, p. 319). In summation, one way that stigma arises is from the social-cognitive process of negative stereotyping, which leads to prejudice and discrimination.

The construct of stigma has been differentiated into several subtypes such as courtesy stigma, affiliate stigma, family stigma, public stigma, and self-stigma. Public stigma denotes the general population’s endorsement of stigma towards a given target (Corrigan, 2004), whereas self-stigma denotes an individual’s internalized stigma as a consequence of his or her experience of persistent stereotyping, prejudice, and discrimination. Several studies have shown that experiences of public stigma predict lowered self-esteem even after controlling for depressive symptoms (i.e., Link, Struening, Neese- Todd, Asmussen, & Phelan, 2001; Markowitz, 1998; Rüsçh, Lieb, Bohus, & Corrigan, 2006). Other consequences of stigma found in the literature include slower recovery rates (Ilic et al. 2012) and difficulties forming intimate attachments with loved ones (Segalovich, Doron, Behrbalk, Kurs, & Romem, 2013). Collectively, the impact of stigma on self-esteem impacts other areas of functioning among persons with mental illness.

The World Health Organization (WHO), the World Federation for Mental Health, and other health-focused organizations worldwide have recognized the negative effects of stigma on people suffering from mental illness, even calling it a global health issue (WHO, 2008). Ten years ago, in the U.S., this prompted the establishment of The President’s New Freedom Commission on Mental Health (2003), whose goals were to: (a) advance the message that mental illness is real, highly prevalent, and treatable; (b) eliminate barriers to accessing mental health services; and (c) reduce public and professional stigma associated with mental illness. By seriously addressing this issue, researchers and policymakers alike are designing interventions to

educate and reduce the stigmatization of mental illness.

The stigma of mental illness involves many underlying stereotypes. Hinshaw (2007) pointed out that people with mental illness are easily stigmatized because they are likely to be perceived as socially disruptive, irrational, inconsistent, and unpredictable. One common stereotype is that these people are incompetent or incapable of independent living (Corrigan et al., 1999; Corrigan, 2000; Weiner, Perry, & Magnusson, 1988). Hayward and Bright (1997) identified four common misperceptions or negative stereotypes regarding persons suffering from mental illness: (a) they are dangerous, (b) their prognosis for recovery is poor, (c) they are difficult to interact with socially, and (d) they are responsible for their condition. The belief that they are responsible for their condition has been noted by many other researchers (Corrigan et al., 1999; Corrigan, 2000; Weiner et al., 1988).

Impact of mental illness stigma. In a systematic review of mental illness stigma, Hinshaw (2007) pointed out that all cultures are driven to identify specific groups within their society who are stigmatized and oppressed. Rao, Feinglass, and Corrigan (2007) confirmed Hinshaw's assertion that mental health diagnoses are formed and given based on deviations from sociocultural or behavioral norms of the society; and therefore, mental illness is a concept deeply tied to culture. Research has shown that stigma towards mental illness is one of the few stigmas that is universal and prevalent in all cultures. To name just a few, evidence of mental illness stigma has been found in Germany (Angermeyer & Matschinger, 2003), Norway (Hamre, Dahl, & Malt, 1994), China (Li, Gao, Long, Bai, & Zhao, 2010), India (Raguram, Raghu, Vounatsou, & Weiss, 2004), Brazil (Piza Peluso, & Blay, 2011), and the U.S. (Kobau, Dilorio, Chapman, & Delvecchio, 2010). Nonetheless, views on mental illness do differ among various cultural groups, and what qualifies as socially deviant also varies among cultures (Hinshaw, 2007).

In some cultures, negative views towards mental illness are founded upon religious beliefs or historical stigmas, such as the notion that mental illness is indicative of a weakness of character or deformity such as a scar or physical disfigurement (Pescosolido, Martin, Lang, & Olafsdottir, 2008). However, Sue (1999) asserted that it is important to note that although stigma towards mental illness has been looked at through the variables of race and ethnicity, those variables are demographic indicators. That is, they are not the direct cause of the stigma or the differences in views among groups. Rather, there are other aspects of these respective cultures (such as intrapersonal-interpersonal orientation, values, beliefs, religion etc.) that are responsible for these differences. These variables are the closest indicators available for measuring cultural and contextual factors underlying group differences (APA, 2003).

To illustrate the point that the stigma associated with mental illness is culture-related, Angermeyer, Buyantugs, Kenzine, and Matschinger (2004) conducted a comparative study assessing the similarities and differences in mental illness views among respondents in Germany, Russia, and Mongolia. The participants were presented with two vignettes of a psychiatric case history depicting individuals with schizophrenia, among which one of the vignettes was explicitly labeled “schizophrenia,” while the other vignette was not labeled. It was observed that the respondents in both Germany and Russia tended to describe the individual in the labeled vignette as being more dependent on others. In Russia and in Mongolia, but not in Germany, the respondents attributed greater dangerousness to the individual in the labeled vignette. Angermeyer et al.’s (2004) results lend support to other studies that have demonstrated that the effects of labeling on mental illness are culture-specific, and media’s portrayal of mental health disorder and awareness about mental health issues plays a crucial role. A similar study was conducted by Whaley (1997) in the United States, looking specifically at African Americans,

Asian Americans, Latino Americans, and Native Americans, comparing the attitudes among these ethnicities towards homeless persons and generally homeless persons who also suffered from a mental illness. Results showed that Asian American and Latino American populations perceived mentally ill homeless persons to be significantly more dangerous than did other groups.

In another study with a similar participant pool, Saetermoe, Scatone, and Him (2001) compared American students from African, Asian, Latino, and Caucasian backgrounds and measured the participants' desired social distance from persons with physical/mental disabilities compared to persons with mental illness. The results showed that the African American, Latino American, and Caucasian American students had a greater desire for social distance from mentally ill persons compared to physically/mentally disabled persons. In contrast, the Asian American students had the greatest desire for social distance from both physically/mentally disabled persons and mentally ill persons, indicating that Asian Americans did not discriminate between the two stigmatized groups. In a study conducted a few years later, Rao et al. (2007) found that African American and Asian American respondents reported the most stigmatized attitudes towards mental illness, followed by Caucasian Americans, and lastly by Latino American respondents. Other studies have looked primarily at Asian Americans. Cheon and Chiao (2012) compared Asian American to Caucasian American respondents and found that Asian American respondents reported more stigmatizing attitudes towards mental illness. Also, comparing Asian American college students—in this case South Asian Americans—to Caucasian American college students, Loya, Reddy, and Hinshaw (2010) found that South Asians harbored more negative attitudes towards psychotherapy in general than did Caucasian Americans. In yet another study of college student, Miville and Constantine (2006) found that

among Asian American female college students, greater Asian cultural values were associated with greater stigma towards counseling. Similarly, Cheng, Kwan, and Sevig (2013) found that the more robust the sense of ethnic identity among Asian Americans and Latino Americans (or the greater their awareness of cultural values and practices, cultural pride, and affective attachment to the culture), the greater their tendency to stigmatize mental illness. These studies suggest that members of U.S. ethnic minority groups tend to exhibit more stigmatized views and attitudes towards mental illness than members of the majority culture based on their cultural values and belief system.

Not surprisingly, these negative attitudes towards individuals suffering from mental illness often result in a number of negative consequences for the individuals and their families. For one, merely labeling a person as mentally ill can result in social rejection (Link, 1987). Indeed, many researchers have found a direct correlation between the degree of stigmatization and the degree of social distance desired from people diagnosed with mental illness reported by research participants (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Penn, Guynan, Spaulding, Garbin, & Sullivan, 1994). Put together, the impact of social rejection and the public's stigma towards mental illness in general can result in experiencing self-stigma, and consequentially, lowered self-esteem (Corrigan, Faber, Rashid, & Leary, 1999) and self-efficacy (Bandura, 1989). For example, the individual with a mental illness may take on an attitude of "why try" (Corrigan, Larson, & Rusch, 2009) because the individual has lost confidence in the future and his or her ability to succeed in the world (Corrigan, 1998; Holmes & River, 1998). This lack of faith in one's abilities and one's future may also impact one's future prospects for employment. In fact, studies have shown that people who are diagnosed with mental health disorders are less likely to have obtained employment or found housing as a result of self-stigma (Corrigan, Powell, &

Rüsch, 2012; Ozmen, Ogel, Aker, Sagduyu, Tamar, & Bortatav, 2004; Wahl, 1999). Additional studies have further substantiated the adverse impact of public stereotypes and prejudice on self-esteem, help-seeking behavior, medication adherence, employment, overall recovery, and the level of hostility, intolerance and lack of support they experience when they interact with the members of general public or community. (Baldwin & Johnson, 2004; Link, 1987; Scheid, 2005; Stuart, 2006a; Wahl, 1999;).

Researchers have also found that the more a person ascribes responsibility or blame to an individual with a mental illness, the more likely he or she is to react negatively towards that person, either through anger, avoidance, or refusal to help. Such a person is also more likely to support mental health services that are coercive towards the individual diagnosed with mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Those endorsing the dangerousness stereotype are also more likely to support the coercion and segregation of people with mental illness (Angermeyer, Beck, & Matschinger, 2003). Thus, this stigma of mental illness not only harms the self-esteem and self-efficacy of the individual suffering with mental illness, but it can also create a climate and belief system that permeates legal and legislative bodies, impacting the laws and policies that pertain to this group.

However, the most deleterious impact of stigmatized attitudes towards people with mental health diagnosis has resulted in inhibiting treatment-seeking behaviors (Cooper et al., 2003; Corrigan, 2004). Of note, Schomerus, Matschinger, and Angermeyer (2009) found that self-stigma (but not public stigma) negatively predicted an individual's choice to seek treatment for his or her mental illness—in other words, self-stigma impeded treatment-seeking behaviors due to the shame or fear of rejection associated with disclosure. Likewise, self-stigma also correlates with noncompliance to pharmacotherapy (Sirey, Bruce, Alexopoulos, Perlick, Taue, Friedman &

Meyers, 2001). Some researchers have referred to this noncompliance as “label avoidance”—that is, people who are suffering from mental health disorders avoid mental health treatment because they want “to avoid the egregious impact of a stigmatizing label” (Ben-Zeev et al., 2010, p. 319). Label avoidance also often leads to the premature termination of mental health treatment (Sirey et al., 2001). In fact, Feldman and Crandall (2007) argued that stigma alone can exacerbate mental illness and that it may negatively influence treatment availability, which consequently also negatively impacts their chances of successfully managing their symptoms through treatment.

The mental illness diagnosis also factors into the degree of stigmatization. Luty, Fekadu, Umoh, and Gallagher (2006) developed a valid and reliable measure known as the Attitudes Towards Mental Illness Questionnaire (AMIQ). Luty et al. (2006) randomly surveyed 879 people in the U.K., offering four separate vignettes depicting hypothetical persons with different diagnoses. The results showed that opiate dependence was ranked as most stigmatized, followed about equally by schizophrenia and alcohol abuse, and lastly by depression with self-harm. Other studies using the AMIQ have shown that a schizophrenia vignette elicits more stigmatization than an alcohol dependence vignette (Luty, Umoh, & Nuamah, 2009; Luty, Umoh, Sessay, & Sarkhel, 2007). Luty et al. (2009) explained the greater stigmatization of schizophrenia as compared to alcoholism by referring to the impact of the negative and often violent portrayal of schizophrenia in the media. Another explanation offered is the fact that people are more likely to have a personal experience of alcoholism than schizophrenia simply because alcoholism is known to be far more prevalent. Rao et al. (2009) also conducted similar study among health professional at four National Health Services at South East England and noted similar results that there was much greater stigmatization towards a hypothetical person diagnosed with

schizophrenia than a person diagnosed with a brief psychotic episode.

The level of familiarity or actual contact a person has with mental illness has also been well researched, and researchers have found that this familiarity influences the degree to which a person stigmatizes mental illness. Such familiarity ranges from one extreme—seeing an individual with mental illness portrayed in a movie—to the other—living with a person with mental illness (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). In this regard, researchers found that the more familiarity or contact a person has with mental illness, the less stigma exists (Corrigan et al., 2003; Desforges, Lord, Ramsy, Manson, Van Leeuwen, West, & Lepper, 1991; Penn et al., 1994). Corrigan, Edwards, Green, Diwan, and Penn (2001) commented that familiarity with mental illness, either through school learning or experience with peers and family members, reduces the prejudicial attitudes in individuals. In their studies, Corrigan, Green, Lundin, Kubiak, and Penn (2001) also demonstrated that respondents with greater familiarity or contact with mental illness were less likely to endorse the stereotype that all persons with mental illness tend to be dangerous. Similarly, they were also less likely to fear and socially avoid people with mental illness. In a similar study, Anagnostopoulos and Hantzi (2011) found that participants reporting more familiarity with mental illness tended to be less prejudiced and supported greater social care for individual suffering from mental illness. Likewise, a recent study in India noted the positive change in participants' perceptions about mental disorders and attitudes towards people with mental disorders (e.g. marrying someone with mental illness is not a big issue for them) after they gained knowledge about mental health disorder through anti-stigma campaign which used pamphlets, posters, dramas, and promotional video to spread awareness regarding issues like depression, domestic violence, stress, suicide, and the need of treatment. (Maulik, Devarapalli, Tewari, Chilappagari, Koschorke, & Thornicroft, 2017)

A number of recent studies have also shown that exposure to, or contact with, individuals with mental illness diagnoses reduces stigmatized views (i.e., Nguyen, Chen, and O'Reilly, 2012). Luty, Kumar, and Stagiias (2010) noticed a stigma-reducing effect when participants in their study were exposed to treatment-seeking individuals diagnosed with opiate dependence. A large meta-analysis was conducted by Corrigan, Morris, Michaels, Rafacz, and Rüsç (2012) examining the effects of various stigma reducing interventions using a participant pool of 38,364 adults from 14 countries. The researchers found that increasing participants' face-to-face contact (as opposed to contact by video) was more effective in reducing stigma than providing education on mental illness.

Shame

Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow (1996b) conceptualized shame as an intense, negative feeling of powerlessness, inferiority, self-consciousness, and a desire to conceal the deficits. Similarly, Brown (2006), after interviewing 215 women, defined shame as a feeling of being flawed and is unworthy of any acceptance and relationships. These definitions underline the idea that the feeling of shame is directly associated with the perceptions of being defective (Greenberg & Goldman, 2008). Fundamentally, shame comprises of emotional, cognitive, and behavioral components. When an individual experiences the feeling of shame, the individual scrutinizes and negatively evaluates the entire self, which results in the feelings of being exposed in front of a real or imagined audience, feeling small, and a strong desire to escape the situation (Tangney, 1993; Wicker, Payne, & Morgan, 1983). Withdrawal, avoidance of others, and hiding the self are usually the behaviors that are associated with the feeling of shame (Mills, 2005). Shame is a self-conscious emotion that involves a self-referential process in which the individual evaluates oneself against some societal or cultural standards (Tangney, 1995).

At times, shame and guilt are frequently used as synonyms in the literature, as there is an overlap between the concepts of these emotions. Both shame and guilt are a self-conscious process and involve a self-referential action. Shame and guilt are also moral sentiments as they have a role in regulating one's behavior and both include the experience of negative affect (Tangney, 1995). Even though there is a similarity in the experience of negative affect, fundamentally shame and guilt differ in the manner by which an individual understands and perceives a situation and then experiences the self-relevant negative events (Tangney, 1995; Tangney, Miller, Flicker, & Hill-Barlow, 1996a).

However, it is important to note here that the majority of the literature available on shame is from a western cultural perspective. Although shame and guilt are believed to be universal emotions, some research suggests that there may be cultural differences in how shame and guilt are experienced and expressed (Bedford, 1994), because cultural beliefs and values shape emotional experiences. Historically, some scholars who studied cultural differences in shame and guilt argued that cultural differences in these two affects exist between Western and Eastern countries (Benedict, 1946; Kluckhohn, 1960). Western countries are typically described as guilt cultures. These cultures advocate individualism, not bending to power, continuously seeking self-control, and self-supervision. Freedom is the most important component for these cultures, and Western individualism is premised on the concept of personal rights, rather than personal duties or social goals. The dominant values are concepts like: you are responsible for yourself; follow your own conscience, and meet your own needs (Triandis, Bontempo, Villareal, Asai & Lucca, 1988). Therefore, individuals are expected to internalize a sense of proper behavior in congruence with social norms. Guilt, by focusing on internal standards and control, is naturally associated with these values.

On the other hand, Asian and other non-Western cultures are typically described as shame cultures. These cultures emphasize collectivism, which pays much more attention to the relationships among people, and emphasizes hierarchical organization. Interpersonal harmony is more important than freedom in a collectivistic culture (Tinsley & Weldon, 2003). Non-Western cultures emphasize concepts like bringing honor to your group; being loyal to your family, nation, and company; showing respect to elders and seniors; and not criticizing others publicly (Triandis et al., 1988). Shame, with its focus on others' negative evaluation, is hypothesized to be more consistent with these collectivistic values. Thus, it is proposed that cultures differ in the extent to which people in them experience guilt as opposed to shame.

Other research suggests that there may be different triggers for guilt and shame in Eastern cultures and Western cultures. In Eastern cultures the concept of shame is similar to “loss of face” (Zane & Yeh, 2002); whereas, the concept of guilt in these cultures may be related to failure of responsibility and failure to achieve positive goals (De Vos, 1974; Lebra, 1988), or particular capabilities that Westerners do not recognize (Bedford, 1994). In Chinese and Japanese cultures, guilt may be elicited by a lack of capability in fulfilling responsibilities towards family. Both the Chinese and Japanese people experience a strong sense of duty and obligation to family and group, which is not typically observed to be a cause of guilt in Western culture (Bedford & Hwang, 2003; De Vos, 1974; Lebra, 1988). Thus, there is reason to believe that guilt and shame may play a broader role in Eastern than Western cultures.

Shame in South Asian community. In South Asian cultures, the equivalent concept of shame is *sharam* or *izzat*, whereas *sharam* is analogous to shame (Gilbert, Gilbert, & Sanghera, 2004) but *izzat* refers to family honor (Rastogi & Wadhwa, 2006). These feelings are deep rooted in the South Asian identity and the fundamental ideology is that the actions of an individual

reflect not only on one's self but on the entire family (Rastogi & Wadhwa, 2006); their impact is felt intensely in all aspects of their lives (Gilbert et al., 2004; Kay, 2012). In a qualitative study exploring the impact and meaning of *izzat*, shame, and subordination on mental health service use of South Asian women in the United Kingdom, Gilbert et al. (2004) presented various life scenarios to women who identified themselves as South Asian (primarily from Pakistan and the Indian sub-continent), who struggled with cultural and language difficulties in Britain. Gilbert et al. (2004) found that *izzat and sharam* were directly associated with family's social status, and were at times used to subordinate South Asian women. The theme of subordination was closely linked to that of *izzat* and in particular, being the carrier of family honor and obeying the cultural rules of family hierarchy (Gilbert et al., 2004). The study found that shame was experienced both internally, through negative self-perceptions and feelings, and externally, through negative perceptions of how others think and feel about the self. *Izzat*, described as reflected shame and honor, was brought to others by one's own behavior, which in turn led to feelings of individual personal shame (Gilbert et al., 2004). Shame, honor, and respect, which are measured and maintained at the individual, familial, and community levels, are built and destroyed by the actions of the self, the family, and the community (Gilbert et al., 2004).

A similar study by Kay (2012) exploring moral reasoning revealed the deep and pervasive nature of such internalized forms of stigmatization. Kay (2012) explored the construct of family honor in Hindu Indian-Americans by studying how it is reinforced in diaspora and the patterns of reasoning and judgment about family honor and its related practices. The qualitative study conducted by Kay (2012) included 128 first- and second- generation Indians and it revealed that 91% of first- and 68% of second-generation participants believed extramarital sex would harm their family and group honor. Additionally, 87% of first- and 52% of second- generation

participants believed marrying someone of another religion would damage their honor. A failure to conform to traditional cultural values and the loss of honor were seen as a personal moral failing, and judgments about moral failing were harsher towards females. Kay (2012) found that the family honor is a significant concern within the Hindu Indian-American community and that concerns with honor are indeed linked to self-image of the Hindu culture and Hindu family in an American context. For some, family honor maintenance appears to be of moral significance and associates the family honor to identify with the group.

Additionally, in the small pool of literature on Asian Indians and South Asians, it has been observed that the burden of maintaining familial and community respect lay disproportionately on the woman, inflating power dynamics in an already highly gendered society (Brar, 2012; Gilbert et al., 2004; Kay, 2012; Raval, 2009; Srinivasan, 2001). Some studies have found that these gender differentials were leveraged against women through community policing; women were watched, monitored, and judged against cultural and community expectations (Brar, 2012; Gilbert et al., 2004; Srinivasan, 2001). The literature also suggests that there is an expectation for South Asian women to be gentle, submissive, moral, chaste, self-sacrificing, devoted to family, and pure because of their gendered roles as keepers of family tradition and culture (Deepak, 2005; Durham, 2004; Gilbert et al., 2004). Failure to meet these expectations resulted in punishment in the form of social exclusion and/or limitations of freedoms (Brar, 2012; Gilbert et al., 2004; Srinivasan, 2001). As a result, South Asian women have become victims of socialized oppression through the control of their sexuality and bodies, which must always reflect appropriate familial and community respect (Brar, 2012; Gilbert et al., 2004; Srinivasan, 2001). *Izzat*, then, was also associated with fulfilling stereotypical role expectations, and a failure to do so would bring shame to oneself and the family (Brar, 2012; Gilbert et al., 2004).

Stigma and Shame Associated with Mental Health in Asian Indian Community

Asian Indians have long been aware of mental illness. The ancient Vedic texts dating back to 1100 BC, and the Indian epics: the Ramayana and the Mahabharata, include references to disorganized thinking and psychotic states (Kumar & Nevid, 2010). However, also longstanding among Asian Indians is the stigma of mental illness, which is evident in the historical and religious discourse surrounding the meaning of mental illness. The deeply entrenched belief in reincarnation found in Hinduism and other religions of the Indian subcontinent leads some Asian Indians to view mental illness as a punishment resulting from sins or bad deeds from a previous life (Raguram, Raghu, Vounatsou, & Weiss, 2004). Other beliefs include the view that symptoms of psychosis are indicative that a person has been possessed by evil spirits or that a person has been influenced by certain planetary alignments (Padmavati, Thara, & Corin, 2005).

In modern-day India, the limited research on mental illness stigma indicates that it continues to be widely pervasive (Bell, Aaltonen, Airaksinen, Volmer, Gharat, Muceniece, & Chen, 2010; Raguram et al., 2004; Thara & Srinivasan, 2000; Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001). Even though awareness about mental illness has been present in India for a long time, in the present it appears that there is limited knowledge and understanding of what constitutes mental illness (Bhattacharya, 2002; Maulik et al., 2017). Disorders that present with more severe and overt symptoms, such schizophrenia and bipolar disorders, have been recognized as mental disorders, whereas depression and anxiety have not (Thara, Padmavati, & Srinivasan, 2004).

The stigma of mental illness among Asian Indians is deeply tied to shame: The general view is that a person with mental illness is responsible for his or her condition and hence to blame. Additionally, because mental illness is understood to be heritable, the presence of mental illness

in one family member tends to “shame” the entire family and decrease the family’s social status (Ahmed & Lemkau, 2000). Sadly, mentally ill persons are usually avoided within their communities and deemed ineligible for marriage or for education (Raguram et al., 2004). Loganathan and Murthy (2011) found that males with schizophrenia in India “were ridiculed, feared losing their job, and had concerns of being passed over for promotion” as a consequence of their condition (p. 580).

Given how the stigma and shame associated with mental illness permeates the entire family, it is not surprising that Asian Indians tend to be very private about mental illness. This need to maintain privacy and prestige is tied to the collectivistic (as opposed to individualistic) nature of the Asian Indian culture, which also emphasizes the importance of status. Das and Kemp (1997) theorized that the low rates of mental health treatment among South Asians may be due, in part, to the fact that the traditional goals of psychotherapy are individualistic (i.e., individual growth, self-expression, and self-determination), which stand in opposition to collectivistic cultural values. Padmavati, Thara, & Corin (2005) found that Asian Indians prefer to talk to close and extended family members, close friends, or religious figures and tend to believe that seeking mental health treatment—or even just discussing mental health issues with outsiders—would shame the family and endanger their societal prestige. Also, Asian Indian Americans’ interdependent cultural values lead them to prefer sharing mental health related issues within the family. Conversely, sharing outside the family elicits discomfort and a sense of awkwardness (Argo, 2009).

Stigma and shame related to mental illness have an adverse impact on the prognosis of an individual’s disorder as they inhibit the family and individual in seeking treatment early. Interviews with caretakers of family members with schizophrenia in India showed that stigma

motivated an effort to contain the illness within the home. Also, the families hoped the problems of the affected person would get better in time, and they chose to avoid the social disapproval anticipated from seeking help outside (Raguram et al., 2004, p. 743). Similarly, Daley (2004) found that Asian Indian parents of children with autism exhibited delays in symptom recognition and treatment-seeking. In a study conducted in a U.S. psychiatric hospital, cultural stigmatization of mental illness served as a barrier to the early recognition of symptoms and the early intervention for Asian Indian patients (Conrad & Pacquiao, 2005). Likewise, Mackenzie (2006) found that among South Asian caregivers for dementia patients in the U.K., shame was linked to concealment of the family member's illness.

Additionally, in the Indian culture, there is less of a distinction between the mind and the body compared to Western medicine, and as such, there is less distinction between mental or emotional distress and physiological distress. This also relates to Asian Indians having a greater potential to somaticize psychological distress in a variety of ways, which in a way takes away the shame and stigma associated with having a psychological distress. In fact, Holmes (2007) found that, among Asian Indians seeking professional help, the most common presenting concerns included somatic complaints involving underlying anxious or depressive symptoms. Of note, because of this strong connection between mind and body, Asian Indians are more likely to seek mental health treatment from general physicians (Padmavati et al., 2005), religious healers (Abdullah & Brown, 2011; Padmavati et al., 2005), or from traditional modes of healing, such as Ayurvedic medicine (Durvasula & Mylvaganam, 1994), yoga, or meditation (Nieuwsma, 2009).

Purpose and Rationale for this Study

Asian Indians residing in the U.S. have retained many of their stigmatized views towards mental illness (Loya et al., 2010). U.S. professionals who provided counseling to Asian Indians

have found that their clients exhibited negative attitudes due to the shame and stigma associated with counseling, the need to maintain a sense of pride, prestige, and privacy, and having limited knowledge about the field of counseling (Khanna, McDowell, Perumbilly, & Titus, 2009).

However, researchers do not yet fully understand Asian Indians' attitudes towards mental illness and the underlying variables influencing these attitudes. As such, more research in this area is warranted.

The present study aims to fill in some of the gaps in the literature regarding the relationships between shame, stigma and acculturation among Asian Indians, focusing specifically on a sample of college students who identified as South Asian living in either India or the United States. This study also explored how familiarity with mental illness impacts stigma, particularly among Asian Indian college students living in America. The impact of familiarity or contact with mental illness on stigmatization will be explored since past stigma research has demonstrated an inverse relationship between these two variables (Anagnostopoulos & Hantzi, 2011; Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Luty et al., 2010; Nguyen et al., 2012). The data used for this dissertation are derived from a dataset collected by Dr. Thapar-Olmos, and therefore the hypotheses and research questions were evaluated using existing data (i.e. no new data were collected as part of this study).

Hypotheses and Research Questions

1. In both the Indian and American samples, higher adherence to traditional values and beliefs (i.e. lower acculturation) will be associated with higher stigma and lower self-reported likelihood of help-giving. For the American sample, we reasoned that participants who have had more exposure to the topic of mental illness through peers, pamphlets, and campaigns in the university campus will have lower adherence to traditional values and beliefs. For the

Indian sample, we reasoned that participants who have been exposed to the issue of mental illness through academic experiences will also have a lower adherence to traditional values and beliefs.

2. We predict that level of adherence to traditional values and beliefs will not influence the attitudes of U. S. sample towards disclosure and concealment (which are measured as indicators of stigmatizing behaviors). Even though Asian Indians adopt the values of the host culture in the domains of work and politics, they tend to maintain the traditional beliefs and values in their personal life (Dosanjh & Ghuman 1997; Krishnan & Berry, 1992; Kurian & Ghosh 1983; Patel et al., 1996).

For the Indian participants, we expect that shame in response to an individual experiencing a mental illness will be high, and positively correlated with disclosure and concealment. This is because in the Asian Indian community, the shame related to the presence of mental illness in one's family member tends to bring shame to the whole family and decrease the family's social status in the community (Ahmed & Lemkau, 2000).

3. For the U.S. sample relationships between shame, disclosure and concealment will be explored, but no specific prediction is made. There is a paucity of literature that evaluates the relationship between shame and acculturation. Moreover, acculturation studies have shown that Asian Indian tends to hold on to their traditional beliefs and values in the personal domain. Hence, the relation between shame and acculturation is not known.
4. The relationship between adherence to traditional values and beliefs and the expected consequences of a family member's mental illness will be explored, but no specific predictions are made.

Chapter 2: Method

Participants

Two groups of participants were recruited for this study: (1) South Asian college students in Mumbai, India ($n = 55$), and (2) South Asian college students in Southern California ($n = 119$), resulting in a total sample size of 174 participants. The inclusion criteria for this study were as follows: (a) Self-identifying as Asian Indian in ethnicity and (b) Enrolled full-time as a college student at the undergraduate or graduate level in Southern California or India. Other South Asian, biracial and multiracial individuals were excluded.

Measures

Demographics. All participants were asked to report their country of residence, age, gender, ethnicity, level of school (undergraduate or graduate), and parental years of education (both mother and father). Socioeconomic status (SES) was coded by averaging of both parents' years of education for students (Appendix A & B).

Vignettes. Each participant was presented with one of two vignettes depicting a hypothetical cousin experiencing either psychosis or depression (see Appendix C). The vignettes were adapted from a previous study conducted by Hugo et al. (2003) and were modified to portray an equivalent level of illness severity and functional impairment to reduce the potential confounding effects of these variables. Psychosis and depression were chosen as the two disorders because of the overt differences in symptomatology, which were expected to elicit a wider range of ratings than if only one illness was included.

To ensure that the vignettes did indeed portray an equivalent level of clinical severity and functional impairment, a small pilot study was conducted with eight graduate students in clinical psychology at UCLA in 2008 by Dr. Thapar-Olmos. Four were given the depression vignette and

four were given the psychosis vignette. The graduate students were asked to rate both the severity and functional impairment of the vignette on a 5-point Likert scale, with 1 being mild, 3 being moderate and 5 being severe. Pilot participants rated both vignettes as depicting a moderate level of functional impairment (mean=3.75 for both) and rated the depression vignette as slightly less severe than the psychosis vignette (3.25 vs. 4), but both severity ratings were in the moderate range.

The vignettes were also piloted among four community residents in India and four in the United States, to elicit feedback on the clarity of the symptoms described in the vignette as well as the use of sibling as the target. In both countries, pilot participants stated that a sibling target would elicit a strong reaction and that as a result, participants may not be comfortable responding to the survey. Additionally, it was felt that it would be too hard to imagine “bad things” happening to a sibling. As a result, the target in the vignettes was changed to a “cousin” in order to maintain a family target, but one with reduced proximity to participants. When this option was presented to the pilot participants, all agreed that it would elicit a wider range of responses compared to using the sibling vignette. Study participants who did not have a cousin to imagine were instructed to imagine a close friend.

Shame/Embarrassment Scale. Two items were used to measure shame and embarrassment, as part of a longer 6-item measure of affect. The items were designed for this study based on measures of affect used in other studies examining stigma towards mental illness (Niv et al., 2007; Weiner, 2006). Participants were asked to rate the degree to which they felt ashamed and embarrassed towards the target on a 7 point Likert scale with 1 = *Not at all* and 7 = *Very much so* (see Appendix D).

Stigma Scale. This 14-item scale was developed for this study to measure (a) help giving, (b) disclosure, and (c) concealment in response to the target, as well as (d) expected negative social consequences (see Appendix E). It was developed by reviewing the literature of stigma among South Asians and consolidating behavioral indicators that were reported across multiple studies. However, a few of the behaviors indicating stigma which are reported in the literature were not included as items on the scale because they would be especially vulnerable to social desirability effects (example: punishing the target). Seven of the fourteen items measured stigmatizing behaviors such as: likelihood of providing emotional or financial assistance (Items 1 & 2), likelihood hiding the cousin's symptoms or taking him/her to a public place (Items 8 & 10) and likelihood of seeking professional, spiritual, or extended family members help (Items 9, 11 & 12). The remaining seven items measured the participant's concern about expected consequences, such as reduced chances of marrying for the target or other family members (Items 3, 4, 5(a), 5(b), 6, 7(a) & 7(b)).

Acculturation Scale for Asian Indians. The acculturation measure used in this study is a subset of items on the Acculturation Scale for Asian Indians (ASAI, see Appendix F) (Parekh, 2000). This scale was selected as opposed to using other more widely used acculturation scales because it focuses on values that are specific to Asian Indian culture and includes fewer behavioral items than more commonly used acculturation measures. Parekh (2000) developed the ASAI scale based on the African American Acculturation Scale (Landrine & Klonoff, 1994). The ASAI scale measures the traditional, cultural and societal values primarily, which is different from the other acculturation scales that emphasize the measurement of behaviors. The complete scale consists of 92 items assessing eight domains of Asian Indian values and beliefs, namely, *traditional family structure and practices, preference for things that are Asian Indian,*

preparation and consumption of foods, interracial attitude/cultural mistrust, traditional Asian Indian health beliefs and practices, traditional Asian Indian religious beliefs and practices, traditional Asian Indian childhood socialization, and superstition. The reliability for each subscale and the alphas ranged from .79 to .97 in the normative sample. The split half reliability of the entire scale was $r = .92$. Based on the reliability coefficient and split half reliability, the items in each subscale measure the same underlying constructs consistently and reliably. The items have good face validity and demonstrated good discriminant validity between Asian Indians born in the U.S. and those born in India (*Hotelling's* $T = .404$; *exact* $f(8,83) = 4.19$, $p < .001$).

Due to the concern about the length of the questionnaires in this study, the full scale was not used. Out of the eight domains, items from two domains (*traditional family structure* and *traditional health beliefs*) were used in this study for a total of 34 items. Higher scores on this measure indicate higher adherence to traditional beliefs and values, and in subsequent sections, we interpret higher adherence to mean lower acculturation.

Procedure

Both student samples were recruited via email and Facebook and all student participants completed study measures online. The recruitment emails are presented in Appendix G & H. In India, psychology professors were contacted via email and the study link was also sent to Indian student networking groups through Facebook. In Southern California, an email was sent to students at UCLA through the Registrar's office to invite them to participate in the study. The email was sent to all undergraduate and graduate students at UCLA who identified as East Indian or Pakistani.

Students who elected to participate were first presented with an informed consent form and then the study measures in the following order: Demographics, Vignette, Acculturation measure, Shame/Embarrassment measure and the Stigma scale. The survey engine randomly assigned the vignette conditions. After completing study measures, participants were given the option of providing their email address or mailing address to be entered into a raffle for one of five \$25 Amazon gift cards.

Chapter 3: Results

Data Screening and Cleaning Procedures

The data analyses were performed using the IBM SPSS statistical package software. The demographic information is presented in the Table 1. Prior to data analysis, participants who ethnically identified themselves other than Asian Indian were removed from the dataset. Afterward, data were screened for missing values. All participants responded to items about ethnicity and residing country. The extent of missing data on each measure was examined, and all missing data appeared to be missing at random. For these missing items, an expectation maximization process was used to impute the missing values. In this process, a missing data correlation matrix is formed by assuming the shape of distribution for the partially missing data (Tabachnick & Fidell, 2007). Skewness and kurtosis, homogeneity of variance-covariance matrices and multicollinearity and singularity were assessed to test the assumptions of multivariate analysis of covariance. All outcome variables were normally distributed. Furthermore, independent t-tests and bivariate correlations were performed to identify any potential covariates. There were no significant relationships between any of the demographic variables and outcome variables.

Hypothesis #1: In both the Indian and American samples, higher adherence to traditional values and beliefs (i.e. lower acculturation) will be associated with higher stigma and lower self-reported likelihood of help-giving

Our data provided partial support for this hypothesis as evidenced by a correlational analysis that revealed significant relationships between the total scores on the ASAI subscales and stigma scale in both the countries. For the Indian sample, the Pearson correlation coefficient for the

relationship between total ASAI scores and stigma scale scores was .292 ($p < .05$), and for the American sample it was .288 ($p < .01$) (see Tables 2 & 3).

Specific correlations between subscales were examined in both subsamples according to country. In the Indian sample, statistically significant relationships were found between the stigma scale and the ASAI subscale of tradition family structure ($r = .382$; $p < .01$), the ASAI subscale of traditional family structure and the stigma subscale of help-giving attitudes ($r = .289$; $p < .05$) and expected consequences ($r = .338$; $p < .05$). No significant relationships were noted between the total ASAI score and the subscales of the stigma scale. Relatedly, no relationships were observed between the ASAI subscale of traditional health beliefs and total score on stigma scale or the subscales of the stigma scales.

In the USA sample, the total scores on the ASAI scale were significantly correlated with the stigma subscales of expected consequences ($r = .283$; $p < .01$) and concealment ($r = .245$; $p < .01$). The total scores on the stigma scale were significantly correlated with the ASAI subscales of traditional health beliefs ($r = .236$; $p < .01$) and traditional family structure ($r = .278$; $p < .01$). Relatedly, the ASAI subscale of traditional family structure was significantly correlated with the stigma subscales of concealment ($r = .294$; $p < .01$) and expected consequences ($r = .243$; $p < .01$). Similarly, the ASAI subscale of traditional health beliefs was significantly correlated with the stigma subscales of concealment ($r = .198$; $p < .05$) and expected consequences ($r = .193$; $p < .05$). No relationship was found between the stigma subscale of help-giving attitude and the total score of ASAI or the subscales of the ASAI.

Hypothesis #2: In the American sample, the level of adherence to traditional values and beliefs will not influence attitudes towards disclosure and concealment

Multivariate analysis of variance was conducted in the full sample, and then again conducted the model separately according to country, to examine this research question. The results are noted in Table 4 and 5. In the first model (full sample), we included Country as a predictor variable to examine if the relationships among adherence to Indian beliefs and values, disclosure and concealment were impacted by Country. The results indicated that the model was significant based on Roy's Largest Root [$T = 3.81$, $F(45, 106) = 1.62$, $p = .035$]. An examination of between-subjects effects indicated that adherence to Indian beliefs and values predicted disclosure [$F(13, 106) = 1.58$, $p = .044$, partial eta squared = .788] but not concealment. When the models were examined in each subsample by country, the model was significant in only the American sample using Roy's Largest Root [$T = 3.34$, $F(39, 79) = 1.65$, $p = .043$]. However, an examination of between-subjects effects did not project any association between adherence to Indian beliefs and values and concealment and disclosure in the American sample. It should be noted that Tabachnick & Fidell (2007) caution that when there is more than one dependent variable, Wilks' Lambda, Hotelling's Trace, and Pillai's Trace are more robust than Roy's Largest Root. Hence, as no significant relationship was found using these more robust indicators, we interpret this finding with great caution.

Hypothesis #3: In the American sample, relationships among shame, disclosure and concealment will be explored

To examine this research question, we conducted a multivariate analysis of variance in the full sample, followed by conducting the models separately according to country. The results are noted in Table 6 and 7. In the first model (full sample), we included Country as a predictor variable to examine if the relationships among shame, disclosure and concealment were impacted by Country. The results indicated that the model was significant based on Roy's

Largest Root [$T = .181, F(13, 152) = 2.15, p = .016$]. An examination of between-subjects effects indicated that shame predicted concealment [$F(13, 173) = 2.05, p = .020$, partial eta squared = .149] but not disclosure. When the models were examined in each subsample by country, the model was significant in only the American sample using Roy's Largest Root [$T = .217, F(11, 107) = 2.11, p = .025$]. An examination of between-subjects effects indicated that in the American sample, shame predicted concealment [$F(11, 118) = 2.11, p = .026$, partial eta squared = .178] but not disclosure. As noted above in the hypothesis # 2, great caution is warranted when only Roy's Largest Root is significant in the absence of other robust indicators such as Wiki's Lambda, Hotelling's Trace and Pillai's Trace (Tabachnick & Fidell, 2007).

Hypothesis #4: The relationship between shame and expected consequences will be explored

A simple linear regression model was estimated with shame as a predictor and expected consequences as the outcome variable. The model was run three times, first in the full sample and then in each sub-sample according to country. The results are noted in Table 8. In the full sample, a significant regression equation was found [$F(1, 172) = 23.877, p = .001$] with a R^2 of .122. In the Indian sample, a significant regression equation was found as well [$F(1, 53) = 4.65, p = .036$] with a R^2 of .081. In the USA sample, a significant regression equation was found [$F(1, 117) = 20.93, p = .001$] with a $R^2 = .152$.

Chapter 4: Discussion

The purpose of the study was to explore the impact of acculturation on stigma and shame in a sample of Asian Indian college students living in the U.S.A. and India. Our results supported the hypotheses that in both the USA and Indian samples, participants who were less acculturated (as operationalized by higher adherence to traditional values and beliefs) reported higher stigma towards mental illness. Relatedly, per prediction, in the American sample, level of acculturation had no impact on the disclosing or concealing attitudes towards mental illness. Subsequently, the results of the study noted that in the American sample, there was no relationship between shame and disclosure or concealment, using a conservative interpretation of the statistical analysis. Lastly, results indicated that shame significantly influenced one's expectation of negative consequences on the family in both the American and Indian samples. These findings are discussed in more detail below.

The findings of this study confirm previous research suggesting an inverse relationship between acculturation and stigma (Kim & Omizo, 2010; Miville & Constantine, 2006; Rojas-Vilches, 2011). In both countries, higher adherence to traditional family structure and practices was positively correlated with stigma. However, when the relationships between acculturation and stigma were examined at the level of subscales, many were not statistically significant, and those that were varied by country. This suggests that there may be unique dynamics in each country sample between the specific elements of acculturation and stigma. In both samples, participants who endorsed beliefs and values related to traditional family values noted higher negative social consequences and overall higher stigma. As predicted, in the Indian sample, high emphasis on traditional family structure and practices was positively associated with high negative social consequences. However, it was noteworthy that in the Indian sample, high

emphasis on traditional family structure and practices were also positively associated with help-giving. This could be because of the communalistic, collectivistic, and family-oriented culture, where values of being dutiful and loyal to the family are more deeply ingrained as compared to Western counterparts (Srinivasan & Thara, 1999). Asian Indians prefer to identify themselves as “familial self” rather than “individual self” (Roland, 1988) and bestow more significance to the family (Rastogi and Wampler, 1999). In Indian family system, every member shares equal responsibility towards each other and towards the individual members with psychological problems (Rao et al., 1984). Living with extended families and community members fosters interdependency (Rastogi & Wampler, 1999; Sadowsky & Carey, 1987). Therefore, members of the families tend to deal with the issues of mental illness on their own rather than seeking services outside.

Subsequently, in the American sample, high emphasis on traditional family values and practice was positively correlated with concealment. Relatedly, strong beliefs in traditional health practices were positively associated with concealment and expected negative consequences. However, no relationship was noted between help-giving and adherence to Indian values and beliefs. This finding is inconsistent with the previous studies which noted inverse correlations between acculturation level and stigmatized views among Asian Indians in America (Panganamala & Plummer, 1998; Sharma, 1994). This finding can be attributed to the fact that Asian Indians in America tend to practice more traditional Indian values and beliefs in comparison to the culture and practices that currently exist in India (Farver, Narang, & Bhadha, 2002). Moreover, previous research has noted that Asian Indians living in America tend to hold a higher emphasis on family honor and their status in their respective community (Kay, 2012)

which may explain the higher expectation of negative consequences and tendency to conceal mental illness.

However, interestingly, despite a strong association acculturation and stigma in the American sample, when multivariate analyses were conducted, no significant relationships were noted between the acculturation and disclosure or concealment. Similarly, no significant relationship was noted in the American sample between shame and disclosure or concealment. The absence of differences may be due to the fact that the American participants of the study were university students, among which a majority grew up in the USA (68.37%), and the disclosure and concealment questions framed in the stigma scale were developed by adhering to the traditional Indian beliefs and practices such as seeking counsel from religious or spiritual leader. Previous studies have indicated that even though Asian Indians tends to adopt a bicultural acculturation strategy (Krishnan & Berry, 1992), the nature of biculturalism tends to differ based on a number of years spent in the host country (Faver et al., 2007). Asian Indian children who grew up or was born in the USA tend to have an ethnic identity which is influenced by not only by traditional values and beliefs but also the values and beliefs of the host culture (Faver et al., 2007). Srinivasan (2000) noted that people who are born in the USA tend to hold egalitarian values of USA as they are frequently interacting with their peers in school and college. Furthermore, the lack of relationship can be explained by the fact that Indian students who come to the USA for studies tend to holds higher affiliated stigma (Thapar-Olmos & Myers, 2017), which is further associated with shame, social distancing, and reduced possibility help-giving (Feldman & Crandall, 2007).

In the full sample, a significant relationship was found between shame and expected consequences. This effect remained when the data were analyzed by country. This finding

corroborates with past research which noted a strong association between stigma and shame in the Asian Indian community (Ahmed & Lemkau, 2000; Padmavati et al., 2005; Raguram et al., 2004). In the Asian Indian culture mental illness is considered as a heritable disease, and the presence of mental illness in the family tends to decrease the family social status (Ahmed & Lemkau, 2000). As a result, the whole family is a subject of ridicule (Loganathan & Murthy, 2011) and may experience difficulties getting marriage prospect, opportunities for education (Raguram et al., 2004) and job opportunities (Loganathan & Murthy, 2011). In Asian Indian culture, shame is known as “izzat,” which also mean family honor (Baig, Ting-Toomey, & Dorjee, 2014; Gilbert et al., 2004). “Izzat” or family honor is equally essential for the Asian Indians living in the USA and tend to engage in behaviors that maintain the family image in the community (Kay, 2012).

Limitations

There are number of limitations to this study that warrant consideration. Firstly, participants' data for this study is a subset of previously collect dataset (see Olmos, N. T. 2010). Hence, the sample size is relatively small, particularly the number of participants in the Indian sample. Also, the participants of the study are all students and therefore the findings cannot be generalized to other samples such as Asian Indians who are in the USA on work permit, older Asian Indians who are first generation immigrants and living in the USA for more than a decade, and middle age Asian Indians who were either born and raised in the USA, or came to the USA either education or work. Relatedly, the participants for the Indian sample were all from Mumbai and primarily college students thus, it also limits its generality to other regions of India and socioeconomic levels. Additionally, more than 60% of the participants were Hindus, hence the study cannot be generalized to the other religions observed by Asian Indians.

Secondly, participants who were recruited for the study may have had some prior exposure or experience regarding mental illness which could be responsible for self-selection biases. Moreover, due to the snowball sampling strategy used, the resulting sample of convenience may have been restricted in terms of adherence to cultural values and familiarity with the psychological constructs being measured. Relatedly, the measures were administered online which may have excluded the individual with limited access to internet or those who do not possess working knowledge of operating the computer and navigating the internet (Olmos, 2010).

Thirdly, the study is limited in its ecological validity as the dataset represent responses to hypothetical vignette depicting a cousin's struggle with mental illness. Moreover, the data does not provide any information about participants' actual behavior as it is a presentation of self-reported intentions, which does not substitute for actual behavior in an in-vivo situation (Olmos, 2010). Many stigma researchers have argued that though self-report measures may not mirror the actual behavior of the participants, behavioral proxy scales that are used in stigma studies are usually accepted as reasonable estimates of actual behaviors (Link et al., 2004). Although, research using live stimulations where an encounter with an actual mentally ill person could provide more information about real time stigma and peoples' attitudes. Similarly, information gathered by people who have an identified family member diagnosed with a mental health disorder will also be useful in providing information about people responses and behaviors toward mental illness.

Lastly, the measures used for this study were all self-report measures which may pose a limitation based on social desirability biases and other inaccuracies inherent in self-report (Olmos, 2010). Furthermore, as the measures were solely developed for this study, the

psychometric properties that demonstrated validity and reliability are not established for these measures. Even though the measures used in this study have high face validity, they may not capture the relevant indicators of the constructs for the study.

Recommendation for further research

This study indicated that levels of acculturation and shame have a significant relationship with stigma and its dimensions. However, further studies are required to understand the mechanism and process of acculturation in Asian Indians living in America, and how it impacts stigmatizing attitudes towards mental illness. Likewise, as the sample for this study is restricted, similar studies need to be conducted with more substantial and diversified sample where the various cultures, socioeconomic, education, age and other demographic factors of India are well represented and how these demographic factors impact the stigmatization of mental illness.

Relatedly, this study was unable to provide much information about how a particular diagnosis is perceived outside of the context of depression and psychosis. Hence, further studies need to be conducted to investigate if and how other diagnoses of mental illness are stigmatized. Additionally, as this study showed, shame is strongly related to one dimension of stigma. However, most studies on shame in the Asian Indian community conceptualize it in relation to marriage, family structure, domestic violence, and depression. Further studies are required to understand the role of shame in other mental health diagnoses such as substance use, other severe psychotic disorders, personality disorders, stress-related disorders, and autism spectrum disorders.

Finally, this study included only two questions related to help-giving behavior. However, there are other variables that can capture the different aspects of help-giving behavior, which would be important to identify. Similarly, even though this study included many variables of

stigma, there are two variables that were not included in this study - fear and dangerousness (Corrigan, Rowan, Green, Lundin, River, Uphoff-Wasowski, White, & Kubiak, 2002). Hence, further research is recommended to understand the how fear and dangerousness impact one's attitude towards mental illness.

Clinical Implications

The results of this study can assist clinicians to conceptualize and formulate a treatment plan for their Asian Indian clients by factoring in the role of shame and stigma. These considerations may improve treatment engagement and adherence. The results of this study confirm previous research showing that Asian Indians endorse negative stereotypes regarding mental illness and the experience of shame may compound the challenges for the clinician in tailoring a treatment plan for an Asian Indian client. This study demonstrated that higher adherence to traditional Indian beliefs and values was associated with higher stigma towards mental illness, and to reduce the stigma, the clinician may consider providing psychoeducation about the specific mental health disorder to correct any misconceptions regarding the illness. It should be noted, however, that clinicians consider any such interventions in the context of a culturally competent treatment plan.

Furthermore, this study has demonstrated that shame is a significant influencer in having perceived negative social consequences not only for the individual who is suffering from mental illness but also for the individual's family members. The notion of shame in Asian Indian and other South Asian cultures is embedded with the notion of family honor, and this can act as a barrier to problem identification, help-seeking behavior, and treatment adherence (Tonsing & Barn, 2017). Subsequently, previous studies in the area also demonstrated that family plays an integral part in an Asian Indian individual and they prefer to identify themselves as "familial

self” rather than “individual self” (Roland, 1988). Asian Indians bestow more significance to the family (Rastogi and Wampler, 1999) and may engage in concealment behavior to protect the status of the family in the community (Conrad & Pacquiao, 2005; Daley, 2004; Raguram et al., 2004, p. 74;). Hence, it is crucial to for the clinician working with Asian Indian clients to factor in the impact of shame in the treatment planning and be cognizant that Asian Individuals will be more likely to spend significant amount of time in sessions reflecting on the impact their mental illness on his/her family member.

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TABLES

Table 1.

Demographics Characteristics of the Sample and By Country.

	Full Sample	U.S.A	India
	<i>N</i> = 174	<i>N</i> = 119	<i>N</i> = 55
Age	2.89 (5.7)	23.53 (5.49)	24.69 (6.01)
Gender	Male = 85 (48.9%)	Male = 49 (41.2%)	Male = 36 (65.5%)
	Female = 88 (50.6%)	Female = 69 (58.0%)	Female = 19 (34.5%)
Education	Undergraduates = 93 (53.4%)	Undergraduates = 71 (59.7%)	Undergraduates = 22 (40.0%)
	Graduates = 80 (46.0%)	Graduates = 47 (39.5%)	Graduates = 33 (60.0%)
Vignette	Depression = 81	Depression = 54 (45.4%)	Depression = 27 (49.1%)
	Psychosis = 93	Psychosis = 65 (54.6%)	Psychosis = 28 (50.9%)
Country of growing up		Indian = 32 USA = 80 Middle East = 3 Others = 2	

Table 2.

Correlation Between Adherence to Indian Values and Beliefs and Stigma Towards Mental Illness in Indian Sample

Country		1	2	3	4	5	6	7	8
India	1. Total ASAI	1							
	2. Family structure	.926**	1						
	3. Health beliefs	.799**	.525**	1					
	4. Total stigma	.292*	.382**	.050	1				
	5. Help-giving attitudes	.225	.284*	.043	.410**	1			
	6. Expected consequences	.226	.338*	-.016	.926**	.206	1		
	7. Disclosure	.170	.176	.165	.562**	.272*	.306*	1	
	8. Concealment	.207	.209	.047	.557**	.059	.449**	.108	1

* $p < .05$

** $p < .01$

Table 3.

Correlation Between Adherence to Indian Values and Beliefs and Stigma Towards Mental Illness in USA Sample

Country		1	2	3	4	5	6	7	8
USA	1. Total ASAI	1							
	2. Family structure	.933**	1						
	3. Health beliefs	.851**	.613**	1					
	4. Total stigma	.288**	.278**	.851**	1				
	5. Help-giving attitudes	.108	.042	.167	.117	1			
	6. Expected consequences	.283**	.294**	.193*	.913	.085	1		
	7. Disclosure	-.033	-.047	.018	.457**	.009	.181*	1	
	8. Concealment	.245**	.243**	.198*	.549**	.142	.439**	.024	1

* $p < .05$

** $p < .01$

Table 4.

Relationship Between Level of Adherence to Indian Beliefs and Values and Attitudes Towards Disclosure and Concealment in USA Sample (Country is Included as Independent Variable).

		Value	F	df	sig.	partial eta squared	observed power
Total ASAI	Pillai's Trace	1.489	1.236	212.000	.126	.744	.999
	Wilk's Lambda	.063	1.238 ^b	212.000	.126	.749	.999
	Hotelling's Trace	6.108	1.239	212.000	.127	.753	.999
	Roy's Largest Root	3.814	1.619 ^a	106.000	.035	.792	.991
Country	Pillai's Trace	.065	1.542 ^b	2.000	.225	.065	.310
	Wilk's Lambda	.935	1.542 ^b	2.000	.225	.065	.310
	Hotelling's Trace	.070	1.542 ^b	2.000	.225	.065	.310
	Roy's Largest Root	.070	1.542 ^b	2.000	.225	.065	.310
TotalASAI*country	Pillai's Trace	.717	1.199	42.000	.235	.359	.935
	Wilk's Lambda	.410	1.177 ^b	42.000	.258	.360	.927
	Hotelling's Trace	1.128	1.155	42.000	.283	.361	.919
	Roy's Largest Root	.652	1.396 ^a	21.000	.172	.395	.801

a. the statistic is an upper bound of F that yields a lower bound on the significance level.

b. Exact statistics

Table 5.

Relationship Between Level of Adherence to Indian Beliefs and Values And Attitudes Towards Disclosure and Concealment in USA Sample (Country is Not Included as Independent Variable).

			Value	F	df	sig.	partial eta squared	observed power
India ASAI	Total	Pillai's Trace	1.813	1.212	96.000	.376	.907	.491
		Wilk's Lambda	.007	1.185 ^b	96.000	.412	.919	.412
		Hotelling's Trace	26.636	1.110	96.000	.481	.930	.317
		Roy's Largest Root	20.519	2.565 ^a	48.000	.118	.954	.536
USA ASAI	Total	Pillai's Trace	1.408	1.174	158.000	.215	.740	.993
		Wilk's Lambda	.083	1.185 ^b	158.000	.204	.711	.993
		Hotelling's Trace	5.106	1.196	158.000	.195	.719	.993
		Roy's Largest Root	3.342	1.650 ^a	79.000	.043	.770	.979

a. the statistic is an upper bound of F that yields a lower bound on the significance level.

b. Exact statistics

Table 6.

Relationship Between Level of Shame and Attitudes Towards Disclosure and Concealment in USA Sample (Country is Included as Independent Variable).

		Value	F	df	sig.	partial eta squared	observed power
Total Shame	Pillai's Trace	.202	1.312	26.000	.146	.101	.936
	Wilk's Lambda	.806	1.326 ^b	26.000	.137	.102	.939
	Hotelling's Trace	.232	1.339	26.000	.129	.104	.942
	Roy's Largest Root	.181	2.116 ^a	13.000	.016	.153	.941
Country	Pillai's Trace	.016	1.250 ^b	2.000	.290	.016	.269
	Wilk's Lambda	.984	1.250 ^b	2.000	.290	.016	.269
	Hotelling's Trace	.017	1.250 ^b	2.000	.290	.016	.269
	Roy's Largest Root	.017	1.250 ^b	2.000	.290	.016	.269
TotalShame*country	Pillai's Trace	.037	.412	14.000	.971	.019	.255
	Wilk's Lambda	.963	.411 ^b	14.000	.971	.019	.254
	Hotelling's Trace	.038	.409	14.000	.972	.019	.253
	Roy's Largest Root	.030	.650 ^a	7.000	.714	.029	.274

a. the statistic is an upper bound on F that yields a lower bound significance level.

b. exact statistic

Table 7.

Relationship Between Level of Shame and Attitudes Towards Disclosure and Concealment in USA Sample (Country is Not Included as Independent Variable).

			Value	F	df	sig.	partial eta squared	observed power
India Total Shame	Pillai's Trace		.250	.715	18.000	.787	.125	.472
	Wilk's Lambda		.763	.708 ^b	18.000	.795	.126	.465
	Hotelling's Trace		.293	.700	18.000	.803	.128	.458
	Roy's Largest Root		.209	1.043 ^b	9.000	.422	.173	.447
USA Total Shame	Pillai's Trace		.243	1.344	22.000	.146	.121	.905
	Wilk's Lambda		.769	1.355 ^b	22.000	.140	.123	.907
	Hotelling's Trace		.286	1.365	22.000	.135	.125	.910
	Roy's Largest Root		.217	2.111 ^a	11.000	.025	.178	.901

a. the statistic is an upper bound on F that yields a lower bound significance level.

b. exact statistic

Table 8.

Predictor of Self-Reported Expected Consequences in the Full Sample and By Country

	Expected consequences								
	Full Sample			India			USA		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Constant	12.91	.764		14	1.6		12.39	.85	
Total Shame	1.24	.254	.349**	1.21	.563	.284*	1.26	.27	.390**
<i>R</i> ²		.122			.081			.152	
<i>F</i>		23.87**			4.65*			20.93**	
ΔR^2		.117			0.63			.144	

p* < .05*p* < .001

APPENDIX A**Consent Form**

University of California, Los Angeles

CONSENT TO PARTICIPATE IN RESEARCH

You are being asked to participate in a research study conducted by Natasha Thapar Olmos, M.A. and Hector Myers, Ph.D., from the Department of Psychology at the University of California, Los Angeles. You were selected as a possible participant in this study because either you are enrolled as a full-time student at a university in Southern California or in India. Your participation in this research study is voluntary. For scientific reasons, this consent form does not include complete information about the study hypotheses and the research questions being tested. You will be provided with more information after completing the questionnaires.

PURPOSE OF THE STUDY

The purpose of this study is to investigate the attitudes of college students, and to better understand the cultural beliefs and values that influence these attitudes.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following:

First, you will be presented with a form asking you for some basic demographic information, such as your age, gender, and year in school. This form will take approximately 3 minutes to complete.

Then, you will be presented with a vignette describing someone. You will be asked several questions about your impressions of that individual. This will take approximately 10 minutes.

Finally, you will be presented a form asking you some questions about your values. You can skip any questions on the questionnaires that make you feel uncomfortable.

The entire study will take about 20 minutes of your time.

POTENTIAL RISKS AND DISCOMFORTS

The risks of participating in this study are minimal. You may experience some discomfort in completing the questionnaires, as some questions will ask you about your thoughts and feelings. Please remember that you can withdraw from the study at any time.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will not directly benefit from your participation in the research.

The results of the research may enhance our knowledge of how culture affects peoples' perceptions and attitudes. This research may also benefit others in the future.

PAYMENT FOR PARTICIPATION

For every completed questionnaire, \$0.50 (Rs. 22.5) will be donated to Minds and Souls, an Indian non-profit organization that provides education to disabled children and adults.

Also, after completing the survey, you will have the option of entering into a raffle for one of several \$25 (Rs. 1132) gift cards to www.amazon.com. If you choose to enter the raffle, you will be asked to provide an email address for notification and receipt of the award if you win. This email address will NOT be associated with your responses on the survey and will only be used to notify you of the raffle results. Once the raffle has been conducted, we will no longer have your email address on file.

CONFIDENTIALITY

Your participation in this research will be completely anonymous and confidential. Your responses will remain completely anonymous and will only be identified by a number that is randomly assigned by the survey engine. If you provide an email address to be entered into the raffle, it will not be associated with your responses on the questionnaires and it will not be used for any purpose other than to notify you of the raffle result if you are a winner, and send you the gift certificate. Once the raffle has been conducted and winners have received their prizes, we will no longer have your email address on file.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. You can also skip any questions you do not wish to answer. You may exit this online survey at any time without consequences of any kind.

IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact: Natasha Thapar Olmos, M.A., at (310) [REDACTED], [REDACTED] Franz Hall, Box 951563, Los Angeles, CA 90095-1563 or Hector Myers, Ph.D. at (310) [REDACTED], [REDACTED] Franz Hall, Box 951563, Los Angeles, CA 90095-1563. If the study design or the use of the information is to be changed, you will be informed and your consent re-obtained.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal rights because of your participation in this research study. If you have questions regarding your rights as a research subject, contact the Office for Protection of Research Subjects, UCLA, 11000 Kinross Avenue, Suite 102, Box 951694, Los Angeles, CA 90095-1694, (310) 825-8714.

BY CLICKING THE LINK BELOW TO CONTINUE TO THE SURVEY, YOU ARE PROVIDING YOUR CONSENT TO PARTICIPATE IN THIS RESEARCH. YOU ARE UNDER NO OBLIGATION TO PARTICIPATE AND MAY EXIT THIS SURVEY AT ANY TIME.

APPENDIX B

Demographic questionnaire for Indian Students

INSTRUCTIONS: Please answer the following questions as accurately as possible.

1. **Age:** _____

2. **Gender:** M F

3. **Please select the ethnic group(s) that best represents your ethnicity:**

- (a) Indian / Indian-American
- (b) Sri Lankan / Sri Lankan-American
- (c) Pakistani / Pakistani-American
- (d) Bangladeshi / Bangladeshi-American
- (e) Anglo / Anglo-American
- (f) Other. Please specify: _____

4. **Level of study:**

- ____ Undergraduate (Bachelor's degree program)
- ____ Graduate student (Master's degree program or higher)
- ____ I am not a student

5. **What is your father's highest level of education?**

- (a) No formalized education
- (b) Completed elementary school (Grades 1-6)
- (c) Completed high school (Grades 7-12)
- (d) Completed 2-year college (Associate's degree)
- (e) Completed 4-year college (Bachelor's degree)
- (f) Completed graduate school or other advanced degree (Ph.D., M.D., J.D.)

6. **What is your mother's highest level of education?**

- (a) No formalized education
- (b) Completed elementary school (Grades 1-6)
- (c) Completed high school (Grades 7-12)
- (d) Completed 2-year college (Associate's degree)
- (e) Completed 4-year college (Bachelor's degree)
- (f) Completed graduate school or other advanced degree (Ph.D., M.D., J.D.)

7. **In what country did you "grow up", or spend most of your childhood?**

8. What is your religious affiliation, if any?

- (a) Hinduism**
- (b) Buddhism**
- (c) Islam**
- (d) Christian/Protestant**
- (e) Catholic**
- (f) Agnostic**
- (g) Bahai**
- (h) Other. Please specify: _____**
- (i) I do not identify with any religious group.**

APPENDIX C

Demographic questionnaire for U.S. Students

INSTRUCTIONS: Please answer the following questions as accurately as possible.

1. Age: _____

2. Gender: M F

3. Please select the ethnic group(s) that best represents your ethnicity:

- (a) Caucasian
- (b) African American
- (c) Hispanic
- (d) East Asian (i.e. Chinese, Korean American, Filipino, etc.)
- (e) South Asian (i.e. East Indian, Pakistan-American, Bangladeshi, etc.)
- (f) Middle Eastern
- (f) Other. Please specify: _____

If you selected (e), please select which one or more of the following groups you identify yourself as:

- (a) Indian / Indian-American
- (b) Sri Lankan / Sri Lankan-American
- (c) Pakistani / Pakistani-American
- (d) Bangladeshi / Bangladeshi-American
- (e) Other. Please specify: _____

4. Level of study:

____ Undergraduate

____ Graduate student

____ I am not a student

5. What is your father's highest level of education?

- (a) No formalized education
- (b) Completed elementary school (Grades 1-6)
- (c) Completed high school (Grades 7-12)
- (d) Completed 2-year college (Associate's degree)
- (e) Completed 4-year college (Bachelor's degree)
- (f) Completed graduate school or other advanced degree (Ph.D., M.D., J.D.)

6. What is your mother's highest level of education?

- (a) No formalized education
- (b) Completed elementary school (Grades 1-6)

- (c) Completed high school (Grades 7-12)
- (d) Completed 2-year college (Associate's degree)
- (e) Completed 4-year college (Bachelor's degree)
- (f) Completed graduate school or other advanced degree (Ph.D., M.D., J.D.)

7. In what country did you “grow up”, or spend most of your childhood?

8. What is your religious affiliation, if any?

- (a) Hinduism
- (b) Buddhism
- (c) Islam
- (d) Christian/Protestant
- (e) Catholic
- (f) Agnostic
- (g) Bahai
- (h) Other. Please specify: _____
- (i) I do not identify with any religious group.

APPENDIX D

Vignettes

As you read this story, please imagine that it is describing the experiences of a cousin. If you do not have a cousin, imagine that it is describing the experiences of another family member.

Your cousin has begun to experience some distressing symptoms which have been going on for the past few months. He/she has been feeling very down and sad most of the time, and has not been able to function at work as well as before. He/she also has been feeling bad about himself/herself and seems to have stopped going out with friends and family as much as before. He/she has lost several pounds in the past few weeks and reports that he/she has no desire to eat. Your cousin says he/she is starting to feel hopeless about life, and you can see that these symptoms have interfered with his/her ability to concentrate on his/her job. Because of this, he/she has missed several deadlines on a big project at work. This is unusual because he/she has always done very well at his/her job.

Please indicate who you imagined in the story you just read:

- (a) Male cousin
- (b) Female cousin
- (c) Other family member. Please specify: _____

As you read this story, please imagine that it is describing the experiences of a cousin. If you do not have a cousin, imagine that it is describing the experiences of another family member.

Your cousin has begun to experience some distressing symptoms which have been going on for the past few months. You have noticed that he/she seems to be very anxious about his/her surroundings. He/she has withdrawn from his/her usual activities and his/her behaviors have changed. For example, he/she no longer spends time talking with friends and family on the phone or pursuing his/her hobbies. Instead, she/he keeps to himself/herself and often doesn't engage in conversation with others. At times, he/she talks about his/her suspicion that his/her friends can no longer be trusted and may be plotting to harm him/her in some way. He/she also frequently reports hearing sounds that others do not hear, and frequently speaks of an "alternative galaxy" where he/she expects to go soon. You can see that these symptoms have interfered with his/her ability to concentrate on his/her job and because of this, has missed several deadlines on a big project at work. This is unusual because he/she has always done very well at his/her job.

Please indicate who you imagined in the story you just read:

- (a) Male cousin
- (b) Female cousin
- (c) Other family member. Please specify: _____

APPENDIX G

Modified Acculturation Scale for Asian Indians (ASAI)

The following questions are items focusing on people's values and beliefs. Please read each statement carefully and **indicate the degree to which you agree or disagree** with the statement by circling the corresponding number. Please remember that the scale ranges from **1 (totally disagree) to 7 (totally agree)**.

1	2	3	4
5	6	7	
I totally disagree	I strongly agree	I sort of agree	
Not true at all	Absolutely true	Sort of true	

1. One should always respect one's elders.
2. When I was young, my cousin, aunt or grandmother or other relative often lived with me and my family for a while.
3. My parents always put their children first.
4. Arranged marriages within our family are considered to be appropriate.
5. My mother was always doting on my siblings and me.
6. A marriage is an alliance between two families.
7. I need my family to approve of my mate before I get married.
8. A child should never call a grown man or woman by his/her first name, they should always be called Uncle or Auntie.
9. When I was little I would often touch the feet of my elders as a sign of respect.
10. Many of the family friends I grew up with, I consider part of my family.
11. When a woman gets married her new in-laws become her new and primary family.
12. My parents prohibited me from dating.
13. My family has introduced me to eligible bachelors/bachelorettes for marriage.
14. It is important to marry someone that is from the same caste.
15. I know what caste I am from.
16. Growing up my mother would wear traditional Indian clothes.
17. The eldest son and his wife must always take care of one's family.
18. Divorce is never acceptable.
19. One's home is always open to extended family members.
20. My parents were always overprotective.
21. A daughter, once married, is no longer part of one's family.
22. One should not place one's aging parents in a nursing home.
23. You should not wear black to an auspicious occasion (e.g. wedding).
24. Mothers will place a black spot on the forehead of their babies in order to ward off evil spirits.
25. I believe in astrology.
26. It is unwise to plan festive occasions on inauspicious days.

27. It is bad luck to joke about one's own death or the death of another.

Appendix H

Recruitment Email for Indian Students

Hello! A research study on college students' perceptions of others is being conducted through the Department of Psychology at the University of California, Los Angeles in the United States. You have been selected as a potential participant. The study is **completely anonymous** and it will take approximately 20 minutes to complete. You are eligible to participate if you are Indian, Pakistani, Sri Lankan or Bangladeshi in ethnicity and are currently a college student.

The study entails reading a story about someone and completing a questionnaire about your impressions. You will also be given a few questionnaires which ask some questions about yourself.

Prizes:

- 1. For every questionnaire that is completed, Rs. 25 (USD 0.50) will be donated towards Minds and Souls, an Indian non-profit organization that provides education to disabled children and adults.**
- 2. Also, after completing the survey, you will be given the chance to enter a raffle for one of several gift cards to Amazon.com in the amount of Rs. 1250 (USD 25.00). Raffle winners will be notified and awarded their prize via email.**

[Click here to go to the study:](#)

<insert link to online survey>

Thank you for your time and consideration!

APPENDIX I

Recruitment Email for U.S. Students

Hello! A research study on college students' perceptions of others is being conducted through the Department of Psychology at the University of California, Los Angeles (UCLA). You have been selected as a potential participant. The study is **completely anonymous** and it will take approximately 20 minutes to complete. You are eligible to participate if you are Indian, Pakistani, Sri Lankan or Bangladeshi in ethnicity and are currently a college student.

The study entails reading a story about someone and completing a questionnaire about your impressions. You will also be given a few questionnaires which ask some questions about yourself.

Prizes:

- 1. For every questionnaire that is completed, \$0.50 will be donated towards Minds and Souls, an Indian non-profit organization that provides education to disabled children and adults.**
- 2. Also, after completing the survey, you will be given the chance to enter a raffle for one of several gift cards to Amazon.com in the amount of \$25.00. Raffle winners will be notified and awarded their prize via email.**

[Click here to go to the study:](http://www.hostedtest.com/taketest.asp?c=D_US)

http://www.hostedtest.com/taketest.asp?c=D_US

Thank you for your time and consideration!

APPENDIX J
IRB Documentation



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: January 12, 2018

Protocol Investigator Name: Soumita Sen

Protocol #: 17-10-652

Project Title: Acculturation, Shame, And Stigma Towards Mental Illness Among Asian Indians: A Cross-National Perspective

School: Graduate School of Education and Psychology

Dear Soumita Sen:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

APPENDIX K

Extended Review of Literature

Chapter 1: Introduction**Overview and Rationale**

In the past few decades, researchers have postulated several theories of stigma (Link & Phelan 2001; Weiss, Ramakrishna & Somma, 2006). Stigma is present in our societies towards various groups and conditions, and it is directly related to the social and cultural norms of each society (Howarth, 2006), forensic background (Owens, 2009), physical illness (Logie & Gadalla, 2009), and physical disability (Burkhard, 2011). However, stigma towards persons with mental illness is the most pervasive form of stigma (Corrigan, 2004; Cooper, Corrigan, & Watson, 2003; Paschos, 2006; WHO, 2008). The mental health community is making efforts to understand the impact of stigma, how to reduce it, and improve the quality of life for individuals suffering from mental illness. The stigma associated with mental illness is heavily influenced by preexisting attitudes about mental illness (Loya, Reddy, & Hinshaw, 2010), perceived societal discrimination (Corrigan, 2004), and familiarity about mental health issues (Corrigan, 2001). Likewise, an association has been found between the level of acculturation among ethnic minorities and their views on mental illness. Specifically, lower levels of acculturation are associated with more negative views on mental illness and mental health treatment among various groups of U.S. ethnic minorities, including Asian Americans (Gim, Atkinson, & Whiteley, 1990; Kim & Omizo, 2010), Asian international students (Yakunina & Weigold, 2011), as well as Hispanic Americans (Pomales & Williams, 1989), including Mexican Americans (Miville & Constantine, 2006) and Puerto Rico and Cuban Americans (Rojas-Vilches, 2011). Asian Indians in the U.S., the population of interest in this dissertation, are a

significantly understudied ethnic minority population (Alegria, & Chen, 2012; Das & Kemp, 1997; Durvasula & Mylvaganam, 1994; Tummala-Narra, Loya, Reddy, & Hinshaw, 2010), and some researchers have indicated that this population endorses stigmatized attitudes towards mental illness (Akutsu & Chu, 2006; Das & Kemp, 1997; Loya et al., 2010). The present study aim to explore the impact of acculturation on stigma and shame in a sample of Asian Indians living in the United States and India.

Asian Indians in the United States

Asian Indians are the third largest Asian population group in the United States, representing 16.2% of the Asian population in the United States (U.S. Census Bureau, 2004). The Asian Indian population in the United States, which is among the fastest growing ethnic groups in the country, more than doubled between 1990 and 2000, from approximately 800,000 to more than 1.65 million persons (U.S. Census Bureau, 1993; U.S. Census Bureau, 2004). Much of this growth stems from recent immigration, such that approximately 75% of Asian Indians now living in the United States are foreign born (U.S. Census Bureau, 1993; U.S. Census Bureau, 2004). Even though Asian Indians are a fast-growing ethnic minority group, the psychological and social issues related to Asian Indians in the United States of America have largely been invisible in the research literature, mainly because in the sociology and psychology literature Asian Indians have been categorized broadly as Asian.

Asian Indians have never identified with the term *Oriental*, which was traditionally used to identify individuals originating from Far Eastern countries (e.g., China, Japan, Korea). Therefore, Asian Indians do not typically identify with the current Western term *Asian*, which has replaced the term *Oriental* (Durvasula & Mylvaganam, 1994). Asian Indians are demographically and historically distinct in a number of ways from other Asian immigrant

groups in the United States. When compared to other Asian groups in the United States, Asian Indians have the greatest percentage of individuals who speak English “very well” (76.9%), the highest educational attainment (63.9% of Asian Indians have a bachelor’s degree or more), and the greatest percentage of employment in management, professional, and related occupations (59.9%) (U.S. Census Bureau, 2004).

Ethnographic studies have indicated that Asian Indians have a different minority identity development process compared to other Asian Americans; specifically, that they selectively acquire and maintain values and practices of both the host culture and the origin culture (Patel, Power, & Bhavnagri, 1996). Similar to other Asian immigrant groups, Asian Indians are perceived as “model minorities,” whose American experience is defined by occupational, educational, and economic achievement (Sue & Takeuchi, 1995). However, Asian Indians also retain a strong ethnic identity, resulting in a unique combination of individualistic and collectivist traits. This pattern of both acculturation and enculturation among Asian Indian immigrants may provide a unique framework for understanding how perceptions of mental health and illness vary with the selective shift, modification, retention, or alteration of values and practices (Patel et al., 1996).

The flexibility of Asian Indian immigrants to operate effectively in both cultures may be due to their exposure to Western values, beliefs, and customs resulting from their history of colonization by the British (Ibrahim, Ohnishi, & Sandhu, 1997). Through years of colonial rule, many Indians are fluent in English and have had exposure to Western values, yet their interaction with the British failed to alter their basic customs, traditions, and cultural identity. This enculturation pattern has extended to Asian Indian immigrants who affirm their ethnicity by reinventing Asian Indian culture in their host country (Dasgupta, 1998). Frequently, Asian Indian

immigrants appear to retain a sense of culture that is more traditionally “Indian” in many respects than the culture that currently exists in India (Farver, Narang, & Bhadha, 2002).

Although the research regarding the mental health of Asian Indians is scarce, a recent study on Asian Indian graduate and undergraduate students in the United States revealed that even with prior exposure to Western cultures and proficiency over the English language, participants were at a greater risk of psychological difficulties (Zhang & Goodson, 2011). Similarly, other studies on Asian Indian international students have indicated that societal differences between the United States and India, with Indian culture featuring generally more traditional gender roles and attitudes (Deosthale & Hennon, 2008), strong reliance on interdependence and connectedness with family members throughout the lifespan (Verma & Triandis, 1999), and expectations of maintaining a deferential and non-confrontational stance toward teachers (Milner, 2009), may uniquely affect Asian Indian international students’ expectations while studying in the United States. As mentioned at the beginning of this section, 75% of Asian Indians living in the United States are foreign born, and there appears to be a corresponding increase in the number of Asian Indians seeking mental health services, irrespective whether they were born in the United States or migrated from India (Das & Kemp, 1997; Durvasula & Mylvaganam, 1994; Loya et al., 2010; Tummala-Narra, Alegria, & Chen, 2012).

Investigations of the mental health status of Asian Americans have primarily focused on Chinese and Japanese Americans (Das & Kemp, 1997; Durvasula & Mylvaganam, 1994; Loya et al., 2010; Tummala-Narra, Alegria, & Chen, 2012). The tendency to generalize findings of Asian subgroups to all Asian Americans fails to account for the distinctive aspects of particular Asian cultures. These cultural variations include patterns of acculturation and enculturation, conceptualizations of mental illness, stigma towards mental illness, and treatment-seeking

behaviors (Farver et al., 2002; Rao, 2006). As cultural and personal experiences come to influence an individual's beliefs, attitudes, and preferences, the failure of researchers and clinicians to understand cultural differences between Asian population groups may result in potential errors in diagnosis and difficulties engaging patients from these population groups in treatment (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006).

Acculturation and Models of Acculturation

The concept of acculturation developed in the early 19th century to study the social changes and cultural contact between different communities such as peasants and Native American communities (Redfield, Linton, & Herskovits, 1936). Redfield and colleagues (1936) postulated the first authoritative definition of acculturation as the phenomenon in which groups of individuals from different ethnic backgrounds and cultures come into continuous firsthand contact, with subsequent changes in the original cultural patterns of either or both groups. Hence, acculturation can occur in any intercultural contact (Schwartz et al., 2010). However, for ethnic minorities and immigrants, acculturation is most often considered as cultural socialization to mainstream culture, whereas enculturation is the retention of or cultural socialization to one's culture of origin (Berry, 1994; Kim & Abreu, 2001; Kim, Atkinson, & Umemoto, 2001). Graves (1967) coined the concept of "psychological acculturation" to refer to the fact that this phenomenon involves not only group changes (ecological, cultural, social, institutional, etc.), but also individual changes, that is, changes in attitude, conduct, way of life, values, identity, etc. in persons and groups that come into contact (Sabatier & Berry, 1996).

As immigrants have prolonged contact with people and social systems in a host country, there will inevitably be changes in attitudes, behaviors and values. This process is referred to as acculturation (Berry, 1997; Berry et al., 2006; Kim & Abreu, 2001). Earlier research on

acculturation tended to assume that as individuals adopt the host culture's values, attitudes and behaviors, they disengage from those of their culture of origin (Gordon, 1964). However, empirical evidence accumulated over the years supports the bi-linearity of acculturation; this model acknowledges both adopting attributes of the host culture and retaining or enhancing those of the culture of origin; the latter is referred to as enculturation (Berry, 1997; Cuellar, Arnold, & Gonzalez, 1995; Kim & Abreu, 2001; Lee, Sobal, & Frongillo, 2003, 2006; Miller, 2007, 2010; Ryder, Adlen, & Paulhus, 2000; Stephenson, 2000). Acculturation and enculturation are multidirectional and multifaceted processes that continuously change over time and across different domains of the individual's life (Roosa et al., 2002). For example, acculturation may simultaneously occur across such levels as the following: (a) changes in the consumption of foods and the use of media; (b) changes in behaviors that are at the core of an individual's social life; and (c) changes in the values and norms that define an individual's perception of the world and interpersonal relationships. The simultaneous occurrence of acculturation and enculturation processes may determine an individual's cultural orientation and ability to develop bicultural competence. Bicultural competence is the ability in which the individual is able to incorporate the values and norms of the host culture, simultaneously keeping and integrating the values and norms of the origin culture (Kumar & Nevid, 2010).

One early model of acculturation proposed by Gordon (1964) uses a uni-dimensional model of assimilation to illustrate immigrant acculturation. Immigrants' experience is portrayed on a continuum, with one pole being maintenance of the original culture and the other pole adaptation to the host culture, at the cost of losing the original culture. The underlying assumption of a uni-dimensional assimilation model, which is also called a linear bipolar model, is that immigrants lose their original cultural identity as they acquire a new identity in a second culture (Gordon,

1964; LaFromboise, Coleman, & Gerton, 1993). Associated with the development of a new identity is the loss of social support from the original culture, combined with an initial inability to use the assets of the newly acquired culture (LaFromboise et al., 1993). This can lead to alienation, stress and anxiety. Although for many decades the uni-dimensional model was the dominant framework used to account for immigrants' acculturation processes, it is not an influential model anymore because it fails to take into account that the host majority culture is also transformed by the presence of culturally distinctive immigrants (Sayegh & Lasry, 1993), and that adoption of host values does not necessarily mean the loss of values from the culture of origin.

This perspective has also come under criticism because it does not explain the adaptation pattern exhibited by many ethnic minorities. For example, with the exception of white Protestants, Gordon (1964) maintained that true assimilation had not been achieved in the United States, a point also emphasized by Lambert and Taylor (1988). These researchers reported that Hispanics, Asians and other ethnic minorities do not exhibit the same linear assimilation patterns that are observed among people from northern and western Europe (Lambert & Taylor, 1988). This indicates that the 'melting pot' approach depicted by a linear bipolar model is not generalizable to many ethnic groups (Kim, Laroche, & Tomiuk, 2001).

Studies with Asian, Latin American, and Middle Eastern immigrants in the United States (Rueschenberg & Buriel, 1989; Triandis, Kashima, Shimada, & Villareal, 1986), have led to more complex models in which acculturation is a multidimensional process that includes an orientation or 'attitude' toward one's own ethnic group and the larger society, as well as toward other ethnic groups (Berry, Kim, Power, Young, & Bujaki, 1989). In these models, changes in values relative to the host culture are not necessarily related to changes in values relative to the

culture of origin. According to Berry's model of acculturation (i.e., Berry, 1980; Berry, Kim, & Boski, 1988; Berry et al., 1989), there are four ways ethnic group members can associate with their host culture and their own culture. Individuals can assimilate (identify solely with the host culture and sever ties with their own culture); marginalize (reject both their own and the host culture), separate (identify solely with their own group and reject the host culture); and integrate (become 'bicultural' by maintaining characteristics of their own ethnic group while selectively acquiring those of the host culture). Berry's acculturation framework considers contextual influences and their interplay with individual factors. Berry identified these influences in both the society of origin (e.g., political situation) and the society of settlement (e.g., attitudes towards immigration or social support; Berry, 1997; Berry & Sam, 1996).

Some researchers have tried to expand the principles of Berry's models by including other relevant variables that could influence the acculturation process (Navas, Garcia, Sanchez, Rojas, Pumares, & Fernandez, 2005). Two of these models are the *Interactive Model of Acculturation (IAC)* by Bourhis, Moird, Perreault, & Senecal (1997) and the *Concordance Model of Acculturation (CMA)* by Pointkowski, Rohman, & Florack (2002). Both models have explored the consensual, problematic or conflictual nature of intercultural relations, which is derived from the match/mismatch between different perspectives. Bourhis et al.'s (1997) model focuses on the match/mismatch between immigrants' and hosts' point of views, and proposes three types of intercultural relations that are adopted at an intergroup level of analysis. The analysis focuses on the immigrants' desire to maintain their culture of origin, the extent of adoption of the host culture, and host groups' perceptions about the immigrants' maintenance of the culture of origin and adoption of the host culture. Researchers like Zagefka & Brown (2002) and Zagefka, Brown, Broquard, & Martin (2007) adopt an interpersonal level of analysis in which there is a

comparison between the attitude towards acculturation choice (what immigrants should do) and perception of the host groups' attitude towards the acculturation strategies.

Despite their utility for capturing the multidimensional nature of acculturation, these models present with a number of limitations. First, they give little consideration to the range of intercultural relations that may result from the interactions between immigrant and host perceptions (Navas, Rojas, Garcia, & Pumares, 2007). Second, these models do not measure the contextual nature of acculturation, usually referring to acculturation processes in general or to the fields of values, language, culture and social relations (e.g., Arends-Tóth & van de Vijver, 2003, 2004; Berry, 1990; Berry & Sam, 1997; Birman, Trickett, & Vinokurov, 2002; Bourhis et al., 1997; Horenczyk, 1996; Navas et al., 2007; Nguyen, Messe, & Stollak, 1999; Trimble, 2002).

To fill in the gaps, Navas and colleagues (2005) developed the Relative Acculturation Extended Model (RAEM) (Navas et al., 2005; Navas, Fernandez, & Rojas, 2006) by gathering some elements from previous models (e.g., Berry, 2001; Bourhis et al., 1997; Piontkowski et al., 2002) and adding some new ones in order to offer new explanations for the acculturation strategies and attitudes preferred by both native and migrant populations in different acculturation domains. The most relevant contributions of the RAEM model are the consideration of different acculturation domains (politics, work, economics, family, social, religion, and ways of living) and the modulating attitudes and strategies employed by the immigrants in the different acculturation domains. Navas et al. (2005) carried out studies in the province of Almeria (Southern Spain), one of the province with the highest immigration rates in Spain, with two group of immigrants, Maghrebis and Sub-Saharan Africans. The authors reasoned that they chose these two group of immigrants because in spite of their mutual African origin, and majority Islamic religion, their customs are quite different, which they expect

will underscore the differences in acculturation strategies and attitudes. A total of 1523 person answered questionnaire that was prepared expressly for the study, out of which 740 were immigrants and 783 were Spaniard, in which several different items were included as indicators of the specific acculturation strategies and attitudes of domain (Navas et al., 2004, 2005). That is, four questions were used to measure the acculturation strategies and attitudes. The two questions that indicate the acculturation strategies (*real plane*) used by the immigrants are: the first question was pertained to degree to which one currently maintains his/her original culture in each domain. The second question focused on the degree to which one incorporates host culture in each of the domains. These two questions that indicate the acculturation attitude (*ideal plane*) are; the first question assessed the degree to which they would like to maintain their original culture in each one of the domains. The second question measured the degree to which they would like to incorporated the host culture in each domain. The result of the study highlighted that the acculturation strategies and attitudes derive from the position that immigrants and hosts take on the two dimensions of *maintenance* of the culture of origin and *adoption* of the host culture. Besides, in this model there is no one single acculturation strategy or attitude. The acculturation process is complex (different acculturation options can be adopted and preferred at the same time) and relative, because the same strategies are not always used or the same options preferred when the interaction with other cultures takes place in different domains (i.e., work, family relationships, religious beliefs and customs) (Navas et al., 2005). Indeed, although previous authors have acknowledged the importance of dividing the general acculturation context into different domains (e.g., Berry & Sam, 1997; Horenczyk, 1996), the RAEM postulates that there is no single or general acculturation attitude as inferred from some of the traditional models (e.g., Berry et al., 1989).

Navas and colleagues (2005) highlighted the five fundamental points to the REM model. The first point is the joint consideration of the acculturation strategies of the immigrant group and of the host population, since it is the confluence of both groups' strategies which can lead to a consensual, problematic, or conflictive intergroup relationships. Secondly, the differentiation of various immigrant groups by ethnocultural origin. Third, the psychosocial variables (in-group biases, perceived cultural enrichment, in-group identification, perceived in-group and out-group similarities) and several behavioral indicators (linguistic practices, use of communication media, political participation) to check their perspective ability and modulating influence on the acculturation attitudes of immigrants and host. The fourth, the distinction between the ideal and real situation. An ideal situation for immigrant is the option they would choose if they could. For the host, the acculturation options the members of the host society would like to see adopted by immigrant groups. On the other hand, the real situation, in the case of immigrants, those acculturation strategies that they actually put into practice and for the host culture, their perceptions of the acculturation strategies employed by the immigrant group.

In the RAEM, the adaptive process is understood to be complex (different options can be adopted and preferred at the same time), and relative, since the same strategies are generally not employed nor are the same options usually preferred, for interaction with persons from other cultures in different areas (e.g., in peripheral areas such as work versus private or core areas such as family relationships, religion or values). Because of this, seven areas are distinguished in the model, from the nearest to the world's material or peripheral elements (political, work, economic), to those farthest away, such as symbolic representation, ideology or religion (religious beliefs and customs, ways of thinking— principles and values—) with intermediate areas (social and family relationships) (Navas et al., 2007).

Acculturation and Asian Indians. Of the few studies on strategies of acculturation in Asian Indians, the results suggest that Asian Indian immigrants show a tendency to adopt a bicultural/integrated model of acculturation (Dosanjh & Ghuman, 1997; Krishan & Berry, 1992; Kurian & Ghosh, 1983). Patel and colleagues (1996) hypothesized that biculturalism is a more adaptive acculturation strategy for members of the Asian Indian community, as it allows individuals and groups to practice the values and beliefs of the Indian culture and also provide the opportunity to integrate the norms of the host culture. The bicultural/integrated model of acculturation is in keeping with the strategy used by many Asian Indians, of combining the adoption of the host culture at work with the maintenance of the traditional cultural ways in the home and has been found to be associated with the least amount of stress (Berry, 2003). Kurian & Ghosh (1983) suggested that the bicultural pattern of adaptation employed by Asian Indians is due in part to their experience with the British colonial rule of India. Many Asian Indian immigrants also have prior knowledge of the English language, as it is now one of the national languages of India (Prathikanti, 1997). Likewise, other studies have shown that higher levels of education (Ibrahim, Ohnishi, & Sandhu, 1997), exposure to the host culture via various media outlets (Raman & Harwood, 2008), high socio-economic status, length of stay in the host culture, employment status, strong sense of self-identification with the natal culture, and embracing the host culture are contributors to the bicultural pattern of adaptation by Asian Indians (Farver et al., 2002). However, Mehta (1998) reported that more positive mental health outcomes among Asian Indian immigrants in the United States were associated with higher levels of acculturation to mainstream culture and negatively associated with adoption of a more traditional cultural orientation. A study examining factors relating to the psychological well-being of Asian Indian immigrants reported similar findings in showing that the adoption of either a bicultural or a more

American cultural identity was associated with less depression among older Asian Indian immigrants than was a more traditional cultural identity (Diwan, Jonnalagadda, & Balaswamy, 2004). Farver and colleague (2002) reported higher levels of family conflict among Asian Indian immigrant parents and their adolescent children when parents were separated or marginalized from the mainstream culture. Unlike early models of immigration that described assimilation as a unidirectional process that occurs when immigrants replace the customs, beliefs, and values of their old culture with those of the new culture, these findings indicate that the ability to acquire and/or maintain characteristics of both cultures may be integral to the mental health of Asian Indian immigrants.

Acculturation Scales and Asian Indians. As mentioned above, Asian Indians tend to adopt a bicultural/integrated model of acculturation (Dosanjh & Ghuman, 1997; Krishan & Berry, 1992; Kurian & Ghosh, 1983) Although Asian Indians comfortably accommodate and adjust to the Western culture, at the same time, they tend to hold firmly to the Indian cultural values (Farver et al., 2002). Likewise, it was noted that Asian Indians' preferences for food, dresses, and use of languages varies depending on the setting, such as in-home Asian Indian prefers ethnic wear, traditional food and like to speak in the native language whereas when outside they prefer western clothing, food, and like to speak in English. Interestingly, these choices do not depend on the education level or length of stay in the United States of America (Ghuman, 1997; Sadowsky & Carey, 1988). Unfortunately, the studies focused on acculturation in Asian Indians have modified various acculturation scales developed for other ethnic groups such as Mexicans (Lee, Yoon, & Liu-Tom, 2017; Cuellar, Arnold, and Maldonado, 1995), Asians (Sunn, Rickard-Figueroa, Lew, & Vigil, 1987), and Africans (Landrine & Klonoff, 1994). The Acculturation Scale for Asian Indians (ASAI) (Parekh, 2000), the scale used in this study to assess

acculturation, was developed by a doctoral student for her dissertation tailored after the African American Acculturation Scale (AAAS) (Landrine & Klonoff, 1994). Parekh (2000) developed the scale to understand the relationship between the acculturation and psychological and health adjustment in Asian Indian population settled in the United States of America. The scale is divided into eight domains that measure Traditional Asian Indian Family Structures and Practices, Preferences of Things Asian Indians, Preparation and Consumptions of Traditional Foods, Interracial Attitudes/Cultural Mistrust, Traditional Asian Indian Health Beliefs, Traditional Asian Indian Religious Beliefs and Practices, Traditional Asian Indian Childhood Socialization, and Superstitions. Seven Asian Indian from diverse geographical locations of United States generated 129 items regarding beliefs, practices, rituals, foods, games, and superstitions help by Asian Indians and by large unknown to Caucasians in the USA. These items rated on the Likert scales ranged from 1 (totally disagree, this is not true for me at all) to 7 (totally agree, this is absolutely true of me). The high score on the scale implies traditionalism, and high immersion in one's own native culture and low scores were indicative of high acculturation, low immersion in one's own native culture. In the round one, these 129 items were administered to 145 Asian Indian participants and 145 non-Asian Indian participants to exclude items that did not differentiate between the two groups. After the preliminary administration, four items were dropped, the remaining 125 items were re-evaluated to assess the degree to which Asian Indians agreed with the items. The items were 50 percent or more of Asian Indian agreed to it were retained, and others were excluded from the final set of items. After dropping 33 more items from the list, the final set of items in ASAI consisted of 92-items measuring eight theoretically determined subscales identified in AAAS. The split-half reliability of the whole scale is $r = .92$, and the reliability of each subscale ranged from .79 to .97. All the right subscales

were strongly correlated with the total ASAI scores. Significant correlations were found among the eight domains which were appeared to be theoretically appropriated such as Preference for Asian Indian things most correlated (.872; $p < .001$), Traditional Family Structures (.848; $p < .001$), and Preparation and Consumption of Traditional food (.830; $p < .001$) with the total score on ASAI. Relatedly, no significant relationship between has been noted between the total scores on ASAI and language fluency, education level. Hence, the ASAI assess acculturation in the Asian Indian by focusing on the cultural shifts rather than the socioeconomic shifts, by going more in-depth than the assimilation process.

Asian Indians and Mental Illness

Prior research suggests that the conceptualization and recognition of mental illness may be influenced by cultural factors as well as by processes of acculturation and enculturation among members of ethnic minority groups. Recently, investigators have begun to explore perceptions of mental illness among South Asian population groups. For example, Karasz (2005) compared two conceptual models of depression among South Asian immigrant women and European American women in New York City using a qualitative vignette methodology. These models differed in their explanatory emphases on the biopsychiatric versus situational origins of depression.

European American women displayed a greater tendency than South Asian immigrant women to interpret depressive symptoms as a disease, rather than as a feeling state. The disease orientation of depression was associated with greater perceptions of severity, a chronic or deteriorating timeline, and necessity of professional treatment seeking. The disease orientation of depression was also associated with greater acculturation in the South Asian immigrant women.

Patel, Pereira, and Mann (1998) examined somatic and psychological models of common mental disorders (i.e., anxiety and depressive disorders) among primary care patients in India.

Although somatic symptoms were the most common form of presentation in primary care settings, psychiatric interviews revealed that patients were also aware of the emotional components of their illnesses. The investigators suggested that a patient's conceptualization of a mental disorder might evolve from somatic to psychological models as the illness progresses in severity and across time. Their theory is supported by findings of a study that explored the cultural variables influencing the manifestations and attributions of depression among Asian Indian patients and their families from the perspective of mental health practitioners in the United States (Conrad & Pacquiao, 2005). These investigators found that somatic complaints from patients were common early clinical manifestations that were often ignored by the patients themselves as well as by members of their families. Family members markedly delayed professional treatment seeking until clear psychotic features emerged in the affected family members. In contrast to depressive and anxiety disorders, schizophrenia and bipolar disorder have traditionally been recognized as mental disorders by Asian Indians (Thara, Padmavati, & Srinivasan, 2004).

Stigma

Stigma is a social construction that devalues people based on a distinguishing characteristic. The notable sociologist, Erving Goffman (1963), was the first to frame stigma as a sociological concept derived from the Greek word for spoiled identity. Researchers have demonstrated that in our society stigma exists towards a variety of groups and conditions based on cultural background (i.e., racial or ethnic, Howarth, 2006), forensic background (i.e., criminal offenders, Owens, 2009), physical illness (i.e., persons diagnosed with HIV/AIDS, Logie & Gadalla, 2009), and physical disability (i.e., cerebral palsy Burkhard, 20011). However, one of the most pervasive forms of stigma is directed towards persons with mental illness.

Stigmatized attitudes towards mental illness often result in dire consequences for the individuals diagnosed with mental illness and their families. For example, stigma may prevent the sufferer from seeking treatment (Cooper, Corrigan, & Watson, 2003; Corrigan, 2004). The World Health Organization (WHO) and World Psychiatric Association have both recognized that the stigma and discrimination attached to mental disorders are associated with suffering, disability, and poverty (Paschos, 2006; WHO, 2008).

As such, an ongoing effort within the mental health community has been made to study the various underlying factors contributing to stigma in order to design effective interventions aimed at reducing stigma towards mental illness in general and improving the quality of life for a person suffering from a mental illness. One such well-researched factor is the impact of racial or ethnic group identity (or cultural beliefs) towards mental illness. Asian Indians in the U.S., the population in question in this dissertation, are a significantly understudied ethnic minority population, and with respect to this study, their attitudes towards mental illness are not well understood. Although some researchers have suggested that this population endorses stigmatized attitudes towards mental illness, the present study will assess how such stigmatization compares to the American Asian Indian and Indian public and how this stigmatization varies based upon level of familiarity with mental illness and acculturation and the specific mental health diagnosis under consideration.

Defining stigma. Stigmatization, or the act of branding something or someone with stigma, involves specific social-cognitive processes, including stereotyping, prejudice, and discrimination. Augoustinos, Ahrens, and Innes (1994) defined stereotypes as knowledge structures or cognitive schemas that are learned by members of a social group. As such, stereotypes enable people to process information more quickly (Macrae, Milne, & Bodenhausen,

1994) and to generate quick impressions and expectations about others (Hamilton & Sherman, 1994). In this sense, stereotypes may serve a useful and adaptive purpose.

However, when a person endorses a strongly negative stereotype regarding another person based on his or her social group, a negative emotional reaction (i.e., prejudice) is triggered. Put another way, prejudice is the affective component triggered upon the endorsement of a negative stereotype (Allport, 1954; Devine, 1995; Hilton & von Hippel, 1996; Krueger, 1996). This is followed by discrimination, the behavioral component involved when a person acts upon his or her prejudice (Crocker, Major, & Steele, 1998). One common discriminatory behavior involves socially distancing oneself or “not associating with people from the out-group” (Ben-Zeev, Young, & Corrigan, 2010, p. 319). In summation, stigma arises from the social-cognitive process of negative stereotyping, which leads to prejudice and discrimination.

The construct of stigma has been differentiated into public stigma and self-stigma. Public stigma denotes a general population’s endorsement of stigma towards a given target (Corrigan, 2004), whereas self-stigma denotes an individual internalizing stigma as a consequence of his or her experience of persistent stereotyping, prejudice, and discrimination. Several studies have shown that experiences of public stigma predict self-esteem even after controlling for depressive symptoms (i.e., Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Markowitz, 1998; Rüsçh, Lieb, Bohus, & Corrigan, 2006). Ilac et al. (2012) used the well-known Rosenberg Self-Esteem Scale (revised German version, Collani and Herzberg, 2003) to find similar results, and further discussed how the negative influence of stigma on self-esteem adds an additional burden to recovery. A recent study showed that a significant relationship exists between the internalization of stigma among adults diagnosed with schizophrenia, and their self-reported scores on the Self-Esteem Scale (Segalovich, Doron, Behrbalk, Kurs, & Romem, 2013). This

study also found that the internalized stigma and lowered self-esteem among the participants also impacted their abilities to form intimate attachments with loved ones. Collectively, the impact of stigma on self-esteem in turn comes to impact other areas of functioning among persons with mental illness.

The stigma of mental illness involves many underlying stereotypes. Hinshaw (2007) pointed out that people with mental illness are easily stigmatized because they are likely to be perceived as socially disruptive, irrational, inconsistent, and unpredictable. One common stereotype is that these people are incompetent or incapable of independent living (Corrigan et al., 1999; Corrigan, 2000; Weiner, Perry, & Magnusson, 1988). Hayward and Bright (1997) identified four common misperceptions or negative stereotypes regarding persons suffering from mental illness: (a) they are dangerous, (b) their prognosis for recovery is poor, (c) they are difficult to interact with socially, and (d) they are responsible for their condition.

The belief that they are responsible for their condition has been noted by many other researchers (Corrigan et al., 1999; Corrigan, 2000; Weiner et al., 1988). However, the most damaging stereotype is the dangerousness stereotype or belief that all people who are suffering from mental illness have a propensity towards aggression and violence.

This misperception that people suffering from mental illness are violent or dangerous is pervasive (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Stuart, 2006a), and hence, a major source of prejudice and discrimination (Corrigan & Cooper, 2005). Some researchers have attributed this stereotype to the violent portrayal in various forms of media, including films, music, novels, and cartoons (Wahl, 1995). This stereotype is also perpetuated by news stories that focus exclusively upon certain traits associated with mental illness, such as unsociability and impulsivity, while

choosing to disregard stories that highlight recovery from mental illness (Wahl, Wood, & Richards, 2002). Stuart (2006b, p. 99) also emphasized that not only do these forms of media portray “overwhelmingly dramatic and distorted images of mental illness that emphasize dangerousness, criminality and unpredictability ... they also model negative reactions to the mentally ill, including fear, rejection, derision and ridicule.” Thus, this alarming stereotype is reinforced by the media’s focus on, and negative portrayals of people suffering from mental illness.

Some researchers, however, have argued that this stereotype that portrays a person with mental illness as dangerous is not a misperception at all, but rather, a fact based on objective statistics and real case histories published by agencies such as the Treatment Advocacy Center. Unfortunately, as Corrigan and Cooper (2005) noted, these single-focus portrayals oversimplify the inherently complex relationship between mental illness and violence, and further, fail “to identify specific symptoms or disabilities resulting from mental illness that cause violence” (p. 168). Thus, this widespread stereotype that people suffering from mental illness are violent and dangerous finds its source in both negative media portrayals and misinterpreted or oversimplified statistics.

Impact of mental illness stigma. Not surprisingly, these negative attitudes towards individuals suffering from mental illness often result in a number of negative consequences for the individuals and their families. For one, merely labeling a person as mentally ill can result in social rejection (Link, 1987). Indeed, many researchers have found a direct correlation between the degree of stigmatization and the degree of social distance desired from people diagnosed with mental illness reported by research participants (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Penn et al., 1994). Put together, the impact of social rejection and the public’s stigma

towards mental illness in general can result in experiencing self-stigma, and consequentially, lowered self-esteem (Corrigan, Faber, Rashid, & Leary, 1999) and self-efficacy (Bandura, 1989). For example, the individual with a mental illness may take on an attitude of “why try” (Corrigan, Larson, & Rusch, 2009) because the individual has lost confidence in the future and his or her ability to succeed in the world (Corrigan, 1998; Holmes & River, 1998). This lack of faith in one’s abilities and one’s future may also impact one’s future prospects for employment. In fact, studies have shown that the more people who are diagnosed with mental health disorder are less likely to have obtained employment, as a result of self-stigma (Corrigan, Powell, & Rüsche, 2012) or found housing (Ozmen et al., 2004; Wahl, 1999). Additional studies have further substantiated the adverse impact of public stereotypes and prejudice (Baldwin & Johnson, 2004; Link, 1987; Scheid, 2005; Stuart, 2006a; Wahl, 1999).

Researchers have also found that the more a person ascribes responsibility or blame to mental illness, the more likely he or she is to react negatively towards a person with mental illness, either through anger, avoidance, or refusal to help. Such a person is also more likely to support mental health services that are coercive towards the individual diagnosed with mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Those endorsing the dangerousness stereotype are also more likely to support the coercion and segregation of people with mental illness (Angermeyer, Beck, & Matschinger, 2003). Thus, this stigma of mental illness not only harms the self-esteem and self-efficacy of the individual suffering with mental illness, but it can also create a climate and belief system that permeates legal and legislative bodies, impacting the laws and policies that pertain to this group.

However, the most deleterious impact of stigmatized attitudes towards people with mental health diagnosis has resulted in inhibiting treatment-seeking behaviors (Cooper et al., 2003;

Corrigan, 2004). Of note, Schomerus, Matschinger, and Angermeyer (2009) found that self-stigma (but not public stigma) negatively predicted an individual's choice not to seek treatment for his or her mental illness—in other words, self-stigma impedes treatment-seeking behaviors due to the shame or fear of rejection associated with disclosure. Likewise, self-stigma also correlates with noncompliance to pharmacotherapy (i.e., the individual does not take medications as prescribed; Sirey et al., 2001).

Some researchers have referred to this noncompliance as “label avoidance”—that is, people who are suffering from mental health disorders avoid mental health treatment because they want “to avoid the egregious impact of a stigmatizing label” (Ben-Zeev et al., 2010, p. 319). Label avoidance also often leads to the premature termination of mental health treatment (Sirey et al., 2001). In fact, Feldman and Crandall (2007) argued that stigma alone can exacerbate mental illness and that it may negatively influence treatment availability, which consequently also negatively impacts their chances of successfully managing their symptoms (through treatment).

The World Health Organization (WHO), the World Federation for Mental Health, and other health-focused organizations worldwide have recognized the negative effects of stigma on people suffering from mental illness, even calling it a global health issue (WHO, 2008). Ten years ago in the U.S., this prompted the establishment of The President's New Freedom Commission on Mental Health (2003), whose goals were to: (a) advance the message that mental illness is real, highly prevalent, and treatable; (b) eliminate barriers to accessing mental health services; and (c) reduce public and professional stigma associated with mental illness. By seriously addressing this issue, researchers and policymakers alike are designing interventions to educate and reduce the stigmatization of mental illness.

Mental illness and ethnic/racial/cultural/diagnostic background. Researchers of mental illness stigma have found that an individual's demographic characteristics or psychosocial traits also impact his or her views of mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA) underscored the importance of looking at these variables, stating, "How mental illness is experienced, expressed, and treated often varies according to an individual's age, gender, race, or ethnic background, as well as other cultural phenomena" (SAMHSA, 2009, para. 1). One such variable is one's age group, as researchers have found that adolescents or younger adults tend to have more negative views towards mental illness or mental health treatment than members of older cohorts (Crisp, Gelder, Goddard, & Meltzer, 2005; Kobau, Dilorio, Chapman, & Delvecchio, 2010; Reavley, McCann, & Jorm, 2012; Siu, Chow, Lam, Chan, Tang, & Chui, 2012). Also, with respect to gender, data have shown that males tend to endorse more negative views towards mental illness or mental health treatment than females (Corrigan, Watson, & Miller, 2006; Crisp et al., 2005; Kobau et al., 2010). And with respect to the subject of this dissertation, Mohan (2010) recently found that, among U.S. Asian Indians, females were more open to mental health treatment than males.

Another significant demographic predictor of the stigmatization of mental illness is level of education. Perhaps not surprisingly, cross-sectional studies have shown that individuals who have more knowledge about mental illness are less likely to endorse stigmatized attitudes (Brockington, Hall, Levings, & Murphy, 1993). With a sample of African American college students, Gilbert and Romero (2005) found that the higher the level of education, the more confidence the college students were in the efficacy of mental health services. This study clearly indicates the significant impact of level of education on one's views towards mental illness, which underscores the effectiveness of educational interventions aimed at reducing stigma

(Ventieri, Clarke, & Hay, 2011).

Researchers have also examined whether the type of information learned about mental illness influences stigma. For example, some researchers demonstrated that providing people with information regarding the biological causes for mental illness decreased stigma (Boysen, 2011; Deacon & Baird, 2009; Lincoln, Arens, Berger, & Rief, 2008). Other researchers have obtained conflicting results: That is, being informed of the biology of mental illness actually increased stigma, because people then doubt the ability of PWMI to recover (Deacon & Baird, 2009; Lam & Salkovskis, 2007; Lincoln et al., 2008). Future research is needed to clarify this dichotomy.

Recently, Brown (2012) explored the psychosocial attributes of openness to experience with respect to views towards mental illness. Brown (2012) found that, among college students, greater openness to experience and greater agreeableness were both associated with a lower stigmatization of mental illness.

Similarly, research has shown that stigma towards mental illness is one of the few stigmas that is universal and prevalent in all cultures. To name just a few, evidence of mental illness stigma has been found in Germany (Angermeyer & Matchinger, 2003), Norway (Hamre, Dahl, & Malt, 1994), China (Li, Gao, Long, Bai, & Zhao, 2010), India (Raguram, Raghu, Vounatsou, & Weiss, 2004), Brazil (Piza Peluso, & Blay, 2011), and the U.S. (Kobau et al., 2010).

Nonetheless, views on mental illness do differ among various cultural groups, and what qualifies as socially deviant also varies among cultures (Hinshaw, 2007).

In a systematic review of mental illness stigma, Hinshaw (2007) pointed out that all cultures are driven to identify specific groups within their society who are stigmatized and oppressed. Rao, Feinglass, and Corrigan (2007) confirmed Hinshaw's assertion, stating, "Diagnoses of mental illness are given based on deviations from sociocultural, or behavioral, norms...."

Therefore, mental illness is a concept deeply tied to culture” (p. 1020).

In some cultures, negative views towards mental illness are founded upon religious beliefs or historical stigmas, such as the notion that mental illness is indicative of a weakness of character or deformity such as a scar or physical disfigurement (Pescosolido, Martin, Lang, & Olafsdottir, 2008). However, Sue (1999) asserted that it is important to note that although stigma towards mental illness has been looked at through the variables of race and ethnicity, those variables are demographic indicators. That is, they are not the direct cause of the stigma or the differences in views among groups. Rather, these variables are the closest indicator available for measuring cultural and contextual factors underlying group differences (APA, 2003).

In addition to the studies listed above showing differences in attitude based on country, other such studies are presented here, with various results. Angermeyer, Buyantugs, Kenzine, and Matschinger (2004) conducted a comparative study assessing the similarities and differences in mental illness views among respondents in Germany, Russia, and Mongolia. They gave the participants one of two vignettes of a psychiatric case history depicting a person with schizophrenia. One of the vignettes was explicitly labeled “schizophrenia,” while the other vignette was not labeled. The researchers then asked the respondents how they would describe the person in either the labeled or unlabeled vignette. Unlike the respondents in Mongolia, the respondents in both Germany and Russia tended to describe the individual in the labeled vignette as being more dependent on others. In Russia and in Mongolia, but not in Germany, the respondents attributed greater dangerousness to the individual in the labeled vignette. Angermeyer et al.’s results lend support to other studies that have demonstrated that the effects of labeling on mental illness are culture-specific.

In less culturally homogenous nations like the United States, researchers have studied how

views on mental illness differ among various racial or ethnic minority groups, looking specifically at African Americans, Asian Americans, Latino Americans, and Native Americans. Notably, in a large sample of U.S. respondents ($N = 1,468$), Whaley (1997) compared the attitudes among many of these ethnicities towards homeless persons and generally homeless persons who also suffered from a mental illness. Results showed that Asian American and Latino American populations perceived mentally ill homeless persons to be significantly more dangerous than did other groups.

In another study with a similar participant pool, Saetermoe, Scattone, and Him (2001) compared American students from African, Asian, Latino, and Caucasian backgrounds and measured the participants' desired social distance from persons with physical/mental disabilities compared to persons with mental illness. The results showed that the African American, Latino American, and Caucasian American students had a greater desire for social distance from mentally ill persons compared to physically/mentally disabled persons. In contrast, the Asian American students had the greatest desire for social distance from both physically/mentally disabled persons and mentally ill persons, indicating that Asian Americans did not discriminate between the two stigmatized groups.

In their study, Anglin, Link, and Phelan (2006) found that African American respondents viewed persons with mental illness to be more dangerous and more blameworthy for acts of violence than did Caucasian American respondents, even after controlling for variables such as age, income, education, political views, and religious beliefs. In a study conducted a year later, Rao et al. (2007) found that, among Americans, African American and Asian American respondents reported the most stigmatized attitudes towards mental illness, followed by Caucasian Americans, and lastly by Latino American respondents. Adding sexual identity to the

equation, Kobau et al. (2010) found that male respondents identifying as Latino or Hispanic or “Other” (not Latino, Caucasian, or African) reported more negative attitudes towards mental illness than did Caucasian Americans or African Americans. Perhaps most noteworthy in Kobau et al.’s study was the finding that compared to Caucasian Americans and Hispanic Americans, the African American respondents reported the most positive views about the benefits and expectations associated with the treatment of, and recovery from, mental illness.

Other studies have looked primarily at Asian Americans. Cheon and Chiao (2012) compared Asian American to Caucasian American respondents and found that Asian American respondents reported more stigmatized attitudes towards mental illness. Also, comparing Asian American college students—in this case South Asian Americans—to Caucasian American college students, Loya, Reddy, and Hinshaw (2010) found that South Asians harbored more negative attitudes towards psychotherapy counseling in general than did Caucasian Americans. In yet another study of college students, Miville and Constantine (2006) found that among Asian American female college students, greater Asian cultural values were associated with greater stigma towards counseling. Similarly, Cheng, Kwan, and Sevig (2013) found that the more robust the sense of ethnic identity among Asian Americans and Latino Americans (or the greater their awareness of cultural values and practices, cultural pride, and affective attachment to the culture), the greater their tendency to stigmatize mental illness. These studies suggest that members of U.S. ethnic minority groups tend to exhibit more stigmatized views and attitudes towards mental illness than members of the majority culture. Taken as a whole, despite variations in the degree of stigma ascribed to mental illness between different cultures, this stigma is evident and pervasive across the globe.

The mental illness diagnosis also factors into the degree of stigmatization. Luty, Fekadu,

Umoh, and Gallagher (2006) developed a valid and reliable measure known as the Attitudes Towards Mental Illness Questionnaire (AMIQ). Luty et al. randomly surveyed 879 people in the U.K., offering four separate vignettes depicting hypothetical persons with different diagnoses. The results showed that opiate dependence was ranked as most stigmatized, followed about equally by schizophrenia and alcohol abuse, and lastly by depression with self-harm. Other studies using the AMIQ have shown that a schizophrenia vignette elicits more stigmatization than an alcohol dependence vignette (Luty, Umoh, & Nuamah, 2009; Luty, Umoh, Sessay, & Sarkhel, 2007). Luty et al., (2009) explained the greater stigmatization of schizophrenia as compared to alcoholism by referring to the impact of the negative and often violent portrayal of schizophrenia in the media. Another explanation offered is the fact that people are more likely to have a personal experience of alcoholism than schizophrenia simply because alcoholism is known to be far more prevalent.

Rao et al. (2009) also employed the AMIQ in their survey of U.K. health professionals ($N = 108$). Rao et al. found that there was much greater stigmatization towards a hypothetical person diagnosed with schizophrenia than a person diagnosed with a brief psychotic episode. Moreover, respondents also stigmatized a hypothetical person admitted to a forensic psychiatric hospital to a greater degree than a non-committed person with schizophrenia. Finally, a hypothetical person with active opiate or active alcohol dependence was more stigmatized than a person who was abstaining from either opiates or alcohol and who had also found employment. Thus, we see that stigmatization towards mental illness is also influenced by diagnostic and contextual information.

The level of familiarity or actual contact a person has with mental illness has also been well researched, and researchers have found that this familiarity influences the degree to which a

person stigmatizes mental illness. Such familiarity ranges from one extreme—seeing an individual with mental illness portrayed in a movie—to the other—living with a person with mental illness (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999). In this regard, researchers found an inverse relationship between the level of familiarity or level of contact a person has with mental illness and the degree to which he or she stigmatizes it (Corrigan et al., 2003; Desforges et al., 1991; Penn et al., 1994). Corrigan, Edwards, Green, Diwan, and Penn (2001), commented, “Individuals who are relatively more familiar with mental illness, either through school learning or experience with peers and family members, are less likely to endorse prejudicial attitudes about this group” (p. 223).

In their studies, Corrigan, Green, Lundin, Kubiak, and Penn (2001) also demonstrated that respondents with greater familiarity or contact with mental illness were less likely to endorse the stereotype that all persons with mental illness tend to be dangerous. Similarly, they were also less likely to fear and socially avoid people with mental illness. In a similar study, Anagnostopoulos and Hantzi (2011) found that participants reporting more familiarity with mental illness tended to be less prejudiced and support greater social care for individual suffering from mental illness.

A number of recent studies have also shown that exposure to, or contact with, individuals with mental illness diagnoses reduce stigmatized views (i.e., Nguyen, Chen, and O’Reilly, 2012). Luty, Kumar, and Stagias (2010) noticed a stigma-reducing effect when participants in their study were exposed to treatment-seeking individuals diagnosed with opiate dependence. A large meta-analysis was conducted by Corrigan, Morris, Michaels, Rafacz, and Rüsçh (2012) that examined the effects of various stigma-reducing interventions using a participant pool of 38,364 adults from 14 countries. The researchers found that increasing participants’ contact (particularly

face-to-face contact as opposed to contact by video) was more effective in reducing stigma than providing education on mental illness.

Acculturation and mental health stigma. An association has been found between the level of acculturation among ethnic minorities and their views on mental illness. Specifically, lower levels of acculturation are associated with more negative views on mental illness and mental health treatment among various groups of U.S. ethnic minorities, including Asian Americans (Gim, Atkinson, & Whiteley, 1990; Kim & Omizo, 2010), Asian international students (Yakunina & Weigold, 2011), as well as Hispanic Americans (Pomales & Williams, 1989), including Mexican Americans (Miville & Constantine, 2006) and Puerto Rico and Cuban Americans (Rojas-Vilches, 2011).

Researchers have obtained mixed results with respect to Asian Indians in the U.S. and their attitudes towards mental illness. Sharma (1994) noted that the higher degree of acculturation to the American society and an awareness to the mental health issues lead to a positive attitude towards psychological help seeking behaviors. Similarly, Panganamala and Plummer (1998) found a correlation between lower levels of acculturation and more negative attitudes towards psychotherapy among Asian Indians. In their study, the researchers compared Asian Indians who had immigrated before age 10 and those who had immigrated after age 10. In contrast to these findings, Mohan (2010) found that, among U.S. Asian Indian parents and caregivers, mental health stigma or intentions to seek mental health services were not associated with levels of acculturation. In support of this finding, Atkinson and Gim (1989) found that in the general U.S. Asian population, more positive attitudes towards treatment were actually associated with lower levels of acculturation.

Asian Indians and mental illness. Asian Indians have long been aware of mental illness.

The ancient Vedic texts dating back to 1100 BC, and the Indian epics: the Ramayana and the Mahabharata, include references to disorganized thinking and psychotic states (Kumar & Nevid, 2010). However, also longstanding among Asian Indians is the stigma of mental illness, which is evident in the historical and religious discourse surrounding the meaning of mental illness. The deeply entrenched belief in reincarnation found in Hinduism and other religions of the Indian subcontinent lead some Asian Indians to view mental illness as a punishment resulting from sins or bad deeds from a previous life (Raguram et al., 2004). Other beliefs include the view that symptoms of psychosis are indicative that a person has been possessed by evil spirits or that a person has been influenced by certain planetary alignments (Padmavati, Thara, & Corin, 2005).

In modern-day India, the limited research on mental illness stigma indicates that it continues to be widely pervasive (Bell et al., 2010; Raguram et al., 2004; Thara & Srinivasan, 2000; Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001). Also, in India today, there appears to be limited knowledge and understanding of what constitutes mental illness. Disorders that present with more severe and overt symptoms, such schizophrenia and bipolar disorders, have been recognized as mental disorders, whereas depression and anxiety have not (Thara, Padmavati, & Srinivasan, 2004).

The stigma of mental illness among Asian Indians is deeply tied to shame: The general view is that a person with mental illness is responsible for his or her condition and hence to blame. Additionally, because mental illness is understood to be heritable, the presence of mental illness in one family member tends to “shame” the entire family and decrease the family’s social status (Ahmed & Lemkau, 2000). Sadly, mentally ill persons are usually avoided within their communities and deemed ineligible for marriage or for education (Raguram et al., 2004). Loganathan and Murthy (2011) found that males with schizophrenia in India “were ridiculed,

feared losing their job, and had concerns of being passed over for promotion” as a consequence of their condition (p. 580).

Given how the stigma and shame associated with mental illness permeate the entire family, it is not surprising that Asian Indians tend to be very private about mental illness. This need to maintain privacy and prestige is tied to the collectivistic (as opposed to individualistic) nature of the Asian Indian culture, which also emphasizes the importance of status. Das and Kemp (1997) theorized that the low rates of mental health treatment among South Asians may be due, in part, to the fact that the traditional goals of psychotherapy are individualistic (i.e., individual growth, self-expression, and self-determination), which stand in opposition to collectivistic cultural values. Padmavati et al. (2005) found that Asian Indians prefer to talk to close and extended family members, close friends, or religious figures and tend to believe that seeking mental health treatment—or even just discussing mental health issues with outsiders—would shame the family and endanger their societal prestige. Also, Asian Indian Americans’ interdependent cultural values leads them to prefer sharing mental health related issues within the family. Conversely, sharing outside the family elicits discomfort and a sense of awkwardness (Argo, 2009).

The stigma and shame of mental illness exerts its most harmful effects by inhibiting treatment-seeking behaviors. Interviews with caretakers of family members with schizophrenia in India showed that “stigma motivated an effort to contain the illness within the home. Families hoped the problems of the affected person would get better in time, and they chose to avoid the social disapproval anticipated from seeking help outside” (Raguram et al., 2004, p. 743). Similarly, Daley (2004) found that Asian Indian parents of children with autism exhibited delays in symptom recognition and treatment-seeking. In a study conducted in a U.S. psychiatric hospital, cultural stigmatization of mental illness served as a barrier to the early recognition of

symptoms and the early intervention for Asian Indian patients (Conrad & Pacquiao, 2005).

Another barrier to mental health treatment among Asian Indians is the cultural conceptualization of mental illness. In the Indian culture, there is less of a distinction between the mind and the body, and as such, there is less distinction between mental or emotional distress and physiological distress. The enmeshed perspective on the mind and body that is pervasive in many Asian Indian cultures renders Asian Indians with a greater potential to somaticize psychological distress in a variety of ways. In fact, Holmes (2007) found that, among Asian Indians seeking professional help, the most common presenting concerns included somatic complaints involving underlying anxious or depressive symptoms. Of note, because of this strong connection between mind and body, Asian Indians are more likely to seek mental health treatment from general physicians (Padmavati et al., 2005), religious healers (Abdullah & Brown, 2011; Padmavati et al., 2005), or from traditional modes of healing, such as Ayurvedic medicine (Durvasula & Mylvaganam, 1994), yoga, or meditation (Nieuwsma, 2009).

Asian Indians residing in the U.S. have retained many of their stigmatized views towards mental illness (Loya et al., 2010). U.S. professionals who provided counseling to Asian Indians have found that their clients exhibited negative attitudes due to the “the shame and stigma associated with counseling; the need to maintain a sense of pride, prestige, and privacy; and having limited knowledge about the field of counseling” (Khanna, McDowell, Perumbilly, & Titus, 2009, p. 62). Clearly, researchers do not yet fully understand Asian Indians’ attitudes towards mental illness and the underlying variables influencing these attitudes. As such, more research in this area is warranted.

Shame

Tangney, Wagner, Hill-Barlow, Marschall, and Gramzow (1996b) define shame as a particularly intense, negative emotion involving feelings of powerlessness, inferiority, self-consciousness, and a strong desire to conceal one's deficits. Similarly, based on interviews with 215 women, Brown (2006) developed a definition of shame as "the intensely powerful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (p. 45). Each of these definitions highlight a primary concern associated with the feeling of shame: a belief that one is defective (Greenberg & Goldman, 2008).

Shame consists of emotional, cognitive, and behavioral components. When experiencing feelings of shame, the object of scrutiny and negative evaluation is the entire self, and this experience often is accompanied by a sense of feeling exposed in front of a real or imagined audience, feeling small, and a desire to escape (Tangney, 1993; Wicker, Payne, & Morgan, 1983). Behaviors that typically occur when a person feels ashamed are withdrawal, avoidance of others, and hiding the self (Mills, 2005). Non-verbal signs of shame include hanging the head down, eyes cast downward, and letting hair cover one's eyes. One may also react defensively when ashamed which may include "frozen face" when the face is kept in tight control, head tilted back with chin jutted out, and one's lip forming the appearance of a sneer in contempt (Ekman, 1999).

Shame is considered a self-conscious emotion, which is an emotion that involves self-referential processes during which the self is evaluated against some standard (Tangney, 1995). Other self-conscious emotions include embarrassment, guilt, and pride (Mills, 2005). The study of self-conscious emotions is considered to be in its infancy, though shame, in particular, has been neglected in the literature of emotion (Gross & Hansen, 2000; Lewis, 2008; Mills 2005).

Shame deserves further study because it plays a central role in self and social development, and is considered unique from other self-conscious emotions in important ways.

Distinguishing between shame and guilt. The terms shame and guilt are frequently confused in the literature, which is likely because these emotions share a few important features. Both shame and guilt are considered self-conscious emotions because they involve a self-referential process. Additionally, shame and guilt are considered moral emotions because they are thought to have a role in regulating behavior, and both involve the experience of negative affect (Tangney, 1995).

Despite the presence of negative affect in both shame and guilt, the focus of attention in these emotional states is quite different, resulting in critical distinctions in the thoughts, feelings, and behavioral reactions associated with these emotions (Tangney, 1995; Tangney, Miller, Flicker, & Hill-Barlow, 1996a). Lewis (2008) offers a cognitive-attributional model to understand the differences between shame and guilt. According to this model, each of us develops beliefs about what is acceptable for others and ourselves with regard to our actions, thoughts, and feelings. When an event occurs, attributions about the cause of the event, such as whether the self is responsible (internal attribution) or not responsible (external attribution), must be determined. Once an internal attribution is made, the next step involves the evaluation of one's actions, thoughts, and feelings against one's personal standards; a person must determine whether they succeeded or failed in meeting their standards. If it is determined that the person's action met his or her standards, hubris or pride is experienced, but if a standard is violated, shame or guilt occurs (Lewis, 2008). In the final step of the cognitive-attributional model, a person makes either a global self-attribution (i.e., entire self) or specific self-attribution (e.g., specific attributes or behaviors).

Based on this model, shame involves an internal evaluation, in which a person fails to meet a standard, and attributes this failure to the whole self. In contrast, the evaluation involving guilt is failure and internal, but the attribution is specific (Lewis, 2008). Shame involves the negative, global evaluation of the self (e.g., I am a mistake), as compared to guilt in which the object of concern is some specific action or failure to act (e.g., I made a mistake; Tangney & Dearing, 2002a).

Despite negative affect experienced with both shame and guilt, the focus of the affect differs, resulting in differing phenomenological experiences. Lewis (1971) concluded that while feeling shame, the whole self, as opposed to some correctable behavior (as with guilt), is experienced as flawed and intolerable. This aspect of Lewis' conceptualization of shame has been supported empirically (e.g., Tangney et al., 1996a; Tangney et al., 1996b).

In line with this description of shame, a study examining guilt and shame narratives found that individuals consistently described shame as more emotionally painful than guilt (Tangney, 1992). More specifically, during feelings of shame, individuals felt their entire self being painfully scrutinized and negatively evaluated, which led to feelings of worthlessness and powerlessness. When individuals experienced guilt, they tended to feel tense and remorseful about the "bad thing" that was done (Tangney, 1992). The feelings associated with guilt and shame result in different behavioral motivations. For shame, a desire to hide or escape is typically present, whereas feelings of guilt tend to motivate people to want to apologize and repair (Lewis, 1971; Tangney & Dearing, 2002a).

The idea that shame and guilt are distinct emotional experiences is further supported by a number of studies utilizing a variety of different methodologies. Studies using quantitative ratings of shame and guilt experiences (Tangney et al., 1996a), content analyses of shame and

guilt narratives (Tangney, 1992), and qualitative case studies (Lewis, 1971) support this distinction. In addition, studies examining interpersonal problem solving abilities (Covert, Tangney, Maddux, & Heleno, 2003) and attachment styles (Akbag & Imamglu, 2010) offer support for the idea that shame and guilt are distinct emotional experiences.

Impact of shame. Kaufman (1989) described the negative impact of shame on the self, “shame” is acutely disturbing to the self. In fact, no other affect is more deeply disturbing. Like a wound made from the inside by an unseen hand, shame disrupts the natural functioning of the self” (p. 89). Research has demonstrated that chronic and intense levels of shame contribute to the development of numerous psychological disorders including anxiety (Harder, Cutler, & Rockert, 1992), depression (Cheung, Gilbert, & Irons, 2004), and self-injurious behavior (Gilbert et al., 2010). Additionally, data links shame to cortisol reactions and to immune activation, further supporting the view that shame is a significant psychological stressor, and suggesting that a high level of shame may be a physical health risk (Dickerson, Kemeny, Aziz, Kim, & Fahey, 2004). Given shame’s distressing nature and its potential role in mental and physical health, it is important to gain a clearer understanding of this complex emotion.

Shame as an interpersonal phenomenon. Experiences of shame typically occur within an interpersonal context when a relational bond is disrupted (Lewis, 1980; Nathanson, 1987; Scheff, 2003). Developmentally, small doses of shame contribute to the socialization process (Nathanson, 1987). When a person is alerted to actions or attributes that might elicit rejection, the person is able to engage in efforts to prevent possible rejection and maintain social connection. With repeated exposure to interpersonal rejection, however, a person is likely to experience shame at doses that may be detrimental to one’s psychological health.

Schore (1994; 1996) described the continual experience of misattunement and/or rejection by a caregiver as repeated experiences of unregulated shame. Caregivers have a major role in regulating a child's emotional state. In order for optimal alertness and positive affect to develop, the caregiver must be able to provide affective communication that is in line with the emotional state of the child (Schore, 1996). For example, if the child is experiencing a non-optimal hyper-aroused state, the caregiver must accurately reflect the child's experience while balancing the affect by modeling a more optimal response (Schore, 1994). Through this attunement, the child develops the expectation of shared positive affect with the caregiver.

Misattunement, an inaccurate reflection of emotion, violates the child's expectation of the shared positive affect, which can result in the sudden deflation in positive affect and rapid shift to a negative state, which is referred to as state shame (Schore, 1996). For example, a child might experience this sudden and painful shift in affective states when they are engaged in a pleasurable activity and look to their caregiver anticipating attuned positive mirroring, but instead their caregiver says "no" while displaying a facial expression such as disgust, anger, or fear. In response, the child experiences feelings of shame, and although the child wishes to resume connection with the caregiver, they are unable to regulate the debilitating distress associated with shame independently (Kaufman, 1989). The child needs the caregiver to help them re-establish a positive affective state.

These experiences of shame become mental representations of how to manage intense emotional reactions (Kaufman, 1989). The child's expectations of connectedness to others are shaped by how the caregiver responds to these emotional experiences. Responsive, attuned repair to the experience of shame helps the child develop representations that interactions are positive and reparable, others are reliable, and the self is effective in getting needs met (Schore, 1994). In

the repeated absence of this type of repair, the child learns that shame states are overwhelming and dysregulating, others are inconsistent and/or unavailable, and they are not able to get their affective needs met (Schoore, 1994). An overwhelming sense of defectiveness can arise from chronic misattunement during shame states and as a result, defensive strategies such as contempt, withdrawal, blaming, and denial may allow for the feeling of shame to be consciously avoided or bypassed (Kaufman, 1989; Lewis, 1971).

Implicit, “bypassed” shame. It has been argued that many shame states are not experienced in conscious awareness, but instead are unconscious. This phenomenon has been labeled “bypassed shame” (Lewis, 1971; M. Lewis, 1992; Scheff, 2003). Lewis (1971) conducted seminal work on shame by analyzing transcripts of numerous psychotherapy sessions. Lewis was surprised by the amount of shame she discovered that remained unacknowledged by both client and therapist in therapy sessions and coined the term “bypassed shame.” Bypassed shame involves some conscious thought about how one looks to others or that one is inferior, but all that is consciously available may be a “wince,” a “blow,” or a “jolt” (Lewis 1971, p. 197). There is no awareness of the shame affect. On the other hand, explicit shame involves a feeling of being ashamed (Mills, 2005). This awareness can be of one’s autonomic reactions (e.g., rapid heart rate, blushing, sweating) paired with a subjective feeling of feeling small, helpless, and/or unable to control the situation. The acknowledgement of shame may be more challenging for certain people because they consider the experience of shame and related behaviors to be a sign of weakness and/or vulnerability (Lewis, 1971; Scheff & Retzinger, 1991). Individuals who might be particularly prone to experience shame about shame are those who tend to defend against and avoid painful emotions (Sabag-Cohen, 2009).

Shame often is regulated by avoidance techniques. Feelings of shame frequently result in a desire to hide or escape (Tangney, 1993; Wicker et al., 1983). Moreover, shame often motivates actual withdrawal from a triggering situation (Covert et al., 2003; Tangney et al., 1996a). Individuals commonly repress or deny shame experiences while others may not recognize shame experiences as such (Harder & Lewis, 1987; Lewis, 1971). It is unclear whether individuals' reports of their own feelings of shame are accurate (Scheff, 2003). There may be a difference in what a person experiences compared to what they report, highlighting the need for the development of an indirect measure of shame. This measure could be utilized to overcome an individual's defenses and examine implicit shame levels.

Shame coping styles. In a review of the developmental literature on shame, Mills (2005) noted the importance of not only understanding trait and state shame, but also identifying ways in which individuals cope with and manage feelings of shame. Additionally, Elison, Pulos, and Lennon (2006b) argue that the experience of shame is not necessarily problematic, but instead it is how one copes with, or defends against shame that may lead to negative outcomes. The Compass of Shame (Nathanson, 1992) is a model of shame coping styles that was developed based on clinical observations. According to this model, constructive shame management occurs when a person attends to the source of shame and decides to address the source. Unfortunately, few people are able to consistently achieve this ideal, and the Compass of Shame model describes four shame coping styles (i.e., poles) people typically engage in to diminish, ignore, or magnify shame without addressing the source of the shame (Elison, Lenon, Pulos, 2006a; Nathanson, 1992). The poles of the Compass of Shame are: withdrawal, attack self, avoidance, and attack other. Each pole can be viewed on a continuum from mild to severe (Elison et al., 2006a).

At the withdrawal pole, the shame message is recognized and accepted as valid, and the person attempts leave the situation. The action associated with this pole is to escape or hide to limit feelings of shame (Nathanson, 1992). The attack self pole also involves the person recognizing and accepting the shame message as valid, but unlike withdrawal, the message is amplified by internalizing the feeling of shame (Elison et al., 2006b). Specifically, the person responds with contempt, harsh criticism, and anger directed at the self which intensifies the feelings of shame. The motivation behind this behavior is to engage in self-deprecation to elicit reassuring affirmations from others. A key difference between the withdrawal and attack self-poles is that individuals who utilize attack self may endure the feeling of shame to maintain a relationship, whereas individuals who withdraw may sacrifice the relationship by pulling away emotionally from others to reduce the discomfort with the shaming experience (Elison et al., 2006a). Ultimately, with attack self and withdrawal, the self is experienced as damaged or flawed suggesting that these coping styles might be more likely to be utilized by an individual who maintains a negative view of themselves.

At the attack other pole, the shame message may or may not be recognized, likely is not accepted, and to alleviate the potential emotional pain, attempts are made to make someone else feel worse (Nathanson, 1992). The emotion often experienced is anger and it is directed outward, at times at the source of the shaming event (Elison et al., 2006b). This often involves the person verbally or physically attacking someone or something else. The purpose of this response is to defend the vulnerable self against messages of worthlessness or inadequacy associated with the experience of shame, bolster one's self-image, and externalize the shame by projecting its impact onto others (e.g., demeaning or blaming others) (Elison et al., 2006a).

The avoidance pole also involves the person likely failing to recognize the shame message or not accepting the message, and attempts are made to distract, dissociate, or disconnect the self and others from the feeling of shame (Nathanson, 1992). The purpose of this reaction is to minimize awareness of the shame or to dismiss the shaming experience as unimportant. It is designed to prevent the conscious experience of shame and is believed to operate outside of a person's awareness (Elison et al., 2006b). Both attack other and avoidance involve the limited awareness of shame suggesting that they may be utilized more often by individuals who tend to inhibit emotions that are associated with feeling vulnerable, such as shame.

The four strategies identified in the Compass of Shame model are not necessarily used independent of each other. An individual might utilize features of multiple poles simultaneously (e.g., attack self and withdrawal) to defend against feelings of shame (Nathanson, 1992). It is important to note, however, that a common characteristic of each of these strategies is that they fail to promote successful processing of emotion. Specifically, when these strategies are used chronically, their use prevents an individual from resolving core issues and increases their difficulty developing positive, accurate perceptions of the self that might aid them in adaptively coping with shame (Elison et al., 2006b).

Difference between shame and guilt. The difference between shame and guilt puzzles most North Americans since the terms "shame" and "guilt" often have been used interchangeably, and theorists have disagreed about whether they are in fact distinct emotions (Hynie et al., 2006). In fact, experiences of shame and guilt are often intertwined (Harper & Hoopes, 1990). However, a growing body of research has demonstrated their unique qualities. Shame and guilt are distinct in both their phenomenology and their behavioral consequences (Roseman, Wiest, & Swartz, 1994; Tangney, 1999; Tangney & Dearing, 2002; Tangney, Miller, Flicker, & Barlow, 1996).

Helen Block Lewis (1971) was perhaps the first to state that the difference between shame and guilt focuses on the different roles and functions of the self. Guilt is behavior-focused, pertaining to how one's behavior would be evaluated (Tangney et al., 1996; Tangney & Dearing, 2002). Guilt is a negative feeling of responsibility or remorse for having done something (Hoffman, 1998). It has been proposed that guilt is primarily a private experience in which the feelings of guilt do not generally need an audience (Qian & Qi, 2002); we experience guilt when our conscience, our inner voice, speaks to us. Guilt involves self-criticism for a specific action (Lewis, 1971). Research in U. S. contexts suggest that experiencing guilt leads to higher self-esteem and increases in empathy and perspective taking, and is associated with variables that relate to maintaining strong interpersonal bonds (Leith & Baumeister, 1998; Tangney, 1998). Guilt is generally a less painful or devastating experience than shame although people experiencing guilt often think of the wrongdoing over and over, wishing they had behaved differently or could somehow undo the deed (Kubany & Watson, 2003; Tangney, 1998).

In contrast, shame is more self-focused than guilt and pertains to a belief that one would be evaluated negatively by others in response to a transgression (Tangney et al., 1996; Tangney & Dearing, 2002). It involves strong self-deprecating evaluations of the entire self that are associated with a feeling of helplessness, worthlessness, and powerlessness (Anolli & Pascucci, 2005; Fischer & Tangney, 1995; Tangney, 1994). Personal inadequacy is an example of a shame related self-evaluation. A shamed individual responds to negative events by saying such things as "I feel like a failure." or "I am a bad person." (Kubany & Watson, 2003); shame is therefore a highly painful state (Tangney, 1995).

Shame and guilt typically lead to very different motivations in interpersonal contexts. Guilt motivates individuals to redress the violation and repair relationships. Feelings of guilt are

actually fairly optimistic and adaptive because of their involvement with empathetic concern (Tangney, 1994). This other-oriented empathy may motivate individuals towards actions that repair or redeem the violation, strengthen interpersonal relationships, and undo harm through actions like confessing or apologizing (Tangney, 1994). For some people, guilt might be maladaptive if it is excessive or inappropriate, as with clinical depression (American Psychiatric Association, 2000). However, guilt is often related to healthier social and emotional functioning in Western cultures (Tangney, 1998; Tangney & Dearing, 2002).

People's reactions to shame are more intense than to guilt. They feel lonely and angry with themselves (Xie & Qian, 2000) and fear being humiliated, ridiculed or laughed at (Li, Wang, & Fischer, 2004). The person experiencing shame feels exposed, which leads them to desire to escape, to hide or to sink into the floor and disappear (Tangney, 1998). Shame is accompanied by a sense of shrinking or of being small, and a sense of passivity in correcting the perceived mistakes (Hoffman, 1998; Tangney & Dearing, 2002). Shame therefore motivates an individual to withdraw from contact with others (Frijda, 1987; Tangney, 1995). Experiences of shame in Western cultures are related to many negative psychological symptoms including depression, somatization, pessimism, suicide attempts, drug use in both adolescents and adults, maladaptive and non-constructive responses to anger, negative cognitions about oneself, social anxiety and social avoidance (Anolli & Pascucci, 2005; Lutwak & Ferrari, 1996; Tangney, 1994; Tangney & Dearing, 2002).

Shame and guilt also differ in the range of conditions which can elicit them. It has been argued that there are many more situations that lead to shame than to guilt. Research suggests that guilt arises primarily in relation to events that involve a violation of moral order (Lindsay-Hartz, 1984). However, shame can arise from both moral transgressions as well as non-moral

situations. One can feel ashamed of not only one's thoughts and actions (e.g., invasions of personal privacy), but also of one's body (e.g., lack of attractiveness), incompetence (e.g., not trying one's best; a failure to live up one's ego ideal), one's humble condition in life (Li, Wang, & Fischer, 2004), feelings of inferiority (Ferguson & Stegge, 1995), disappointment, social snubs, sexual rebuffs, and socially inappropriate behavior (Taylor, 1985). However, others note that it is very difficult to identify situations that elicit only one of these emotions, because the distinctions between shame and guilt may be subtle (Sabini & Silver, 2005), and shame and guilt often are experienced simultaneously (Hynie & MacDonald, 2001; Tangney et al., 1996).

Cultural differences in shame and guilt. Most of the above considerations of shame and guilt are related to a Western cultural perspective. However, although shame and guilt are believed to be universal emotions, some research suggests that there may be cultural differences in how shame and guilt are experienced and expressed (Bedford, 1994), because cultural beliefs and values shape emotional experiences.

Historically, some scholars who studied cultural differences in shame and guilt argued that cultural differences in these two affects exist between Western and Eastern countries (Benedict, 1946; Kluckhohn, 1960). They argued that societal order depends on two punishing strengths (Benedict, 1946; Mead, 1937). One is internal punishment, which is the feeling of guilt; the other is external punishment, which is the feeling of shame. According to these scholars, different cultures tend to rely more on one form of societal control than the other. Western countries are typically described as guilt cultures. These cultures advocate individualism, not bending to power, continuously seeking self-control, and self-supervision. Freedom is the most important component for these cultures, and Western individualism is premised on the concept of personal rights, rather than personal duties or social goals. The dominant values are concepts like: you are

responsible for yourself; follow your own conscience; and meet your own needs (Triandis, Bontempo, Villareal, Asai & Lucca, 1988). Therefore, individuals are expected to internalize a sense of proper behavior in congruence with social norms. Guilt, by focusing on internal standards and control, is naturally associated with these values.

On the other hand, Asian and other non-Western cultures are typically described as shame cultures. These cultures emphasize collectivism, which pays much more attention to the relationships among people, and emphasizes hierarchical organization. Interpersonal harmony is more important than freedom in a collectivistic culture (Tinsley & Weldon, 2003). Non-Western cultures emphasize concepts like bringing honor to your group; being loyal to your family, nation, and company; showing respect to elders and seniors; and not criticizing others publicly (Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Shame, with its focus on others' negative evaluation, is hypothesized to be more consistent with these collectivist values. Thus, it is proposed that cultures differ in the extent to which people in them experience guilt as opposed to shame.

Other research suggests that there may be different triggers for guilt and shame, in Eastern cultures and Western cultures. For instance, empirical research found that Japanese patterns of guilt are related to failure of responsibility and failures to achieve positive goals (De Vos, 1974; Lebra, 1988) or particular capabilities that Westerners do not recognize (Bedford, 1994). Similarly, in Chinese culture, guilt may be elicited by a lack of capability, because the Chinese experience a strong sense of duty and obligation to family and group, which is not typically observed to be a cause of guilt in Western culture (Bedford & Hwang, 2003). Thus, there is reason to believe that guilt and shame may play a broader role in Eastern than Western cultures.

Shame in South Asian community. The use of shame, *sharam*, and honor, *izzat*, was pervasive in traditional South Asian culture. These feelings were deep rooted in the South Asian identity; their impact felt intensely in all aspects of their lives (Gilbert et al., 2004; Kay, 2012). In their qualitative study exploring the impact of izzat, shame, and subordination on the mental health service use of South Asian women in the United Kingdom, Gilbert et al. (2004) found these feelings were a measure of respect and as ways to leverage control in order to maintain respect. Gilbert et al. (2004) found that shame was experienced both internally, through negative self-perceptions and feelings, and externally, through negative perceptions of how others think and feel about the self. Izzat, described as reflected shame and honor, was brought to others by one's own behavior, which in turn led to feelings of individual personal shame (Gilbert et al., 2004). Shame, honor, and respect, which are measured and maintained at the individual, familial, and community levels, are built and destroyed by the actions of the self, the family, and the community (Gilbert et al., 2004). A similar study by Kay (2012) exploring moral reasoning revealed the deep and pervasive nature of such internalized forms of stigmatization.

Kay (2012) explored the reasoning of personal and family honor among 128 first- and second-generation Indians in the United States. The qualitative study revealed that 91% of first- and 68% of second-generation participants believed extra-marital sex would harm their family and group honor. Additionally, 87% of first- and 52% of second- generation participants believed marrying someone of another religion would damage their honor. A failure to conform to traditional cultural values and the loss of honor was as a personal moral failing. Furthermore, Kay (2012) found that judgments about moral failing were harsher when the protagonists were female. These findings provided an insight into how devastating the implications may be for South Asian queer women trying to challenge a far more sensitive and taboo subject such as

sexual identity, whilst also negotiating their own deep-rooted socialized interdependence.

LGBT literature widely supports the notion that while sexual minorities experienced societal discrimination in the form of homophobia, many also experienced internalized homophobia as they dealt with their own ingrained socialized values that reject their queer sexual orientation (Choudhury et al., 2009; Sandil et al., 2014; Rusi, 2014). The latter can significantly complicate acceptance of self, irrespective of other factors, and their ability to embrace a healthy lived identity. For South Asian queer women, these internalized feelings of shame, honor, and respect may act in a very similar way as they negotiate such strong cultural opposition in the process of both embracing their sexual identity and obtaining social acceptance for an openly lived identity (Choudhury et al., 2009; Sandil et al., 2014; Rusi, 2014).

The burden of maintaining familial and community respect lay disproportionately on the woman, inflating power dynamics in an already highly gendered society (Brar, 2012; Gilbert et al., 2004; Kay, 2012; Raval, 2009; Srinivasan, 2001). These power differentials were leveraged against women through community policing; women were watched, monitored, and judged against cultural and community expectations (Brar, 2012; Gilbert et al., 2004; Srinivasan, 2001). There is an expectation for South Asian women to be gentle, submissive, moral, chaste, self-sacrificing, devoted to family, and pure because of their gendered roles as keepers of family tradition and culture (Deepak, 2005; Durham, 2004; Gilbert et al., 2004). Failure to meet these expectations resulted in punishment in the form of social exclusion and/or limitations of freedoms (Brar, 2012; Gilbert et al., 2004; Srinivasan, 2001). As a result, South Asian women have become victims of socialized oppression through the control of their sexuality and bodies, which must always reflect appropriate familial and community respect (Brar, 2012; Gilbert et al., 2004; Srinivasan, 2001). Izzat, then, was also associated with fulfilling stereotypical role

expectations, and a failure to do so would bring shame to oneself and the family (Brar, 2012; Gilbert et al., 2004).

Stigma and Shame Associated with Mental Health in Asian Indian Community

Asian Indians have long been aware of mental illness. The ancient Vedic texts dating back to 1100 BC, and the Indian epics: the Ramayana and the Mahabharata, include references to disorganized thinking and psychotic states (Kumar & Nevid, 2010). However, also longstanding among Asian Indians is the stigma of mental illness, which is evident in the historical and religious discourse surrounding the meaning of mental illness. The deeply entrenched belief in reincarnation found in Hinduism and other religions of the Indian subcontinent leads some Asian Indians to view mental illness as a punishment resulting from sins or bad deeds from a previous life (Raguram, Raghu, Vounatsou, & Weiss, 2004). Other beliefs include the view that symptoms of psychosis are indicative that a person has been possessed by evil spirits or that a person has been influenced by certain planetary alignments (Padmavati, Thara, & Corin, 2005).

In modern-day India, the limited research on mental illness stigma indicates that it continues to be widely pervasive (Bell, Aatonen, Airaksinen, Volmer, Gharat, Muceniece, & Chen, 2010; Raguram et al., 2004; Thara & Srinivasan, 2000; Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001). Even though awareness about mental illness has been present in India for a long time, in the present it appears that there is limited knowledge and understanding of what constitutes mental illness (Maulik et al., 2017; Bhattacharya, 2002). Disorders that present with more severe and overt symptoms, such as schizophrenia and bipolar disorders, have been recognized as mental disorders, whereas depression and anxiety have not (Thara, Padmavati, & Srinivasan, 2004).

The stigma of mental illness among Asian Indians is deeply tied to shame: The general view

is that a person with mental illness is responsible for his or her condition and hence to blame. Additionally, because mental illness is understood to be heritable, the presence of mental illness in one family member tends to “shame” the entire family and decrease the family’s social status (Ahmed & Lemkau, 2000). Sadly, mentally ill persons are usually avoided within their communities and deemed ineligible for marriage or for education (Raguram et al., 2004). Loganathan and Murthy (2011) found that males with schizophrenia in India “were ridiculed, feared losing their job, and had concerns of being passed over for promotion” as a consequence of their condition (p. 580).

Given how the stigma and shame associated with mental illness permeates the entire family, it is not surprising that Asian Indians tend to be very private about mental illness. This need to maintain privacy and prestige is tied to the collectivistic (as opposed to individualistic) nature of the Asian Indian culture, which also emphasizes the importance of status. Das and Kemp (1997) theorized that the low rates of mental health treatment among South Asians may be due, in part, to the fact that the traditional goals of psychotherapy are individualistic (i.e., individual growth, self-expression, and self-determination), which stand in opposition to collectivistic cultural values. Padmavati, Thara, & Corin (2005) found that Asian Indians prefer to talk to close and extended family members, close friends, or religious figures and tend to believe that seeking mental health treatment—or even just discussing mental health issues with outsiders—would shame the family and endanger their societal prestige. Also, Asian Indian Americans’ interdependent cultural values lead them to prefer sharing mental health related issues within the family. Conversely, sharing outside the family elicits discomfort and a sense of awkwardness (Argo, 2009).

Stigma and shame related to mental illness have an adverse impact on the prognosis of an individual's disorder as they inhibit the family and individual in seeking treatment early. Interviews with caretakers of family members with schizophrenia in India showed that stigma motivated an effort to contain the illness within the home. Also, the families hoped the problems of the affected person would get better in time, and they chose to avoid the social disapproval anticipated from seeking help outside (Raguram et al., 2004, p. 743). Similarly, Daley (2004) found that Asian Indian parents of children with autism exhibited delays in symptom recognition and treatment-seeking. In a study conducted in a U.S. psychiatric hospital, cultural stigmatization of mental illness served as a barrier to the early recognition of symptoms and the early intervention for Asian Indian patients (Conrad & Pacquiao, 2005). Likewise, Mackenzie (2006) found that among South Asian caregivers for dementia patients in the U.K., shame was linked to concealment of the family member's illness.

Additionally, in the Indian culture, there is less of a distinction between the mind and the body compared to Western medicine, and as such, there is less distinction between mental or emotional distress and physiological distress. This also relates to Asian Indians having a greater potential to somaticize psychological distress in a variety of ways, which in a way takes away the shame and stigma associated with having a psychological distress. In fact, Holmes (2007) found that, among Asian Indians seeking professional help, the most common presenting concerns included somatic complaints involving underlying anxious or depressive symptoms. Of note, because of this strong connection between mind and body, Asian Indians are more likely to seek mental health treatment from general physicians (Padmavati et al., 2005), religious healers (Abdullah & Brown, 2011; Padmavati et al., 2005), or from traditional modes of healing, such as Ayurvedic medicine (Durvasula & Mylvaganam, 1994), yoga, or meditation (Nieuwsma, 2009).

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