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Research Paper

Attitudes towards Depression in India: Lower Socio-Economic-Status Groups May Demonstrate Higher Tolerance

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ABSTRACT

By any measure, depression is a severe problem in India. Adding to the suffering associated with the condition itself are judgmental and stigmatizing attitudes that are nearly ubiquitous in all strata of Indian society. Such social disapproval prevents millions of people from seeking appropriate medical attention which in-turn leads to added distress and increased burdens for affected individuals and their families. A more granular understanding the social attitudes towards depressed individuals may help in policy-makers devise campaigns to reduce depression-related stigmatization – and is therefore an important health priority. At first glance, levels of stigma and misinformation with respect to people suffering from depression are uniformly high and oppressively negative. However, when responding to a vignette, individuals from low socio-economic-status (SES) backgrounds unexpectedly tended to be more accepting (i.e. showed less social distance) towards people described as having symptoms of depression compared to individuals from higher SES backgrounds (Study 1). However, this difference in SES-based levels of stigma disappeared when depression was labelled as a mental disorder in a questionnaire (Study 2). This finding is relevant in designing interventions to combat the stigma attached to depression.

Keywords: *Depression, Attitude, Socio-Economic-Status (SES), India, Social Distance*

According to the Global Burden of Disease Study conducted by the World Health Organization (WHO), an estimated 300 million people in the world suffered from depression in 2016. An analysis of these data suggests that at least 50 million people are suffering from depression in India in 2019 (for a related discussion see Shidhaye, Gangale, & Patel, 2016). A methodologically rigorous, large sample study (Poongothai, Pradeepa, Ganesan, & Mohan, 2009) estimated a prevalence rate as high as 15.1% in South India. Indian youth are particularly afflicted by depression and have attempted suicide rates that are several times the global average (McLoughlin, Gould, & Malone, 2015).

Staggering as these numbers are, they are exacerbated even further by prevailing attitudes towards depression and depressed individuals. Stigma against depression is pervasive in India (Raguram et al., 1996), and such stigma has been strongly associated with preventing depressed individuals from seeking treatment for their condition (Amanzar et al, 2014). This

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lack of treatment places added stressors on those suffering from depression and their families (Moos, 1990).

Therefore, there is a critical need for interventions seeking to improve social attitudes towards depression. One pre-requisite for the development of such interventions is that there is a clear understanding of the up-stream drivers that contribute towards negative attitudes towards depression. In the present work, we sought to analyze the impact of socio-economic status (SES) on attitudes towards depression.

SES has been shown to exert a powerful influence on people's personal and social identities (Manstead, 2018). It has been shown to influence both the way people think and how they feel about their social environment and key aspects of their social behavior and attitudes. Given the strong existence of class structure and strong and deepening SES disparities in India (Dirks, 2011), it appeared possible that variables related to social and economic class had the potential to offer new insights into the attitudes towards people afflicted with depression.

There are two competing hypotheses that suggest different impacts of SES on attitudes towards depression. On the one hand, it is possible that lower literacy rates, more homogenous and smaller social circles, and chronic monetary pressures will cause lower SES individuals to have more negative attitudes towards depression compared to higher SES individuals. On the other hand, it is at least possible lower SES individuals will display *greater* empathy and understanding towards the people afflicted with the difficulties inherent in depression. This latter hypothesis has some support in research that suggests that lower SES individuals favor explanations of personal outcomes that are oriented to features of the external environment rather than dispositional or internal factors (Argyle, 1994). To the extent that they take in more contextual information when judging other people's conditions, lower SES individuals may exhibit greater empathy towards depressed individuals than their higher SES counterparts (Kraus, Côté, & Keltner, 2010).

The aim of the present work was to investigate these competing hypotheses. This required the selection of scales to measure SES in way that is appropriate for India, and for the selection of scales to appropriately measure attitudes towards individuals with depression. I next describe each of these measures.

Measuring SES

Many researchers have relied on a handful of scales to measure SES. These include the four-factor Hollingshead scale, Nakao and Treas scale, and the Blishen, Carroll, and Moore scale (Cirino et al., 2002). These scales were developed in the U.S. and Canada, and while they did emphasize measures related to income, wealth and education, they do not feature questions related to caste and were not customized to social participations and/or material possessions relevant to India.

SES scales that have been developed for India often tend to ask direct questions about income and wealth. These include the Kuppuswamy scale, and the B.G. Prasad socio-economic scale (Singh, Sharma, & Nagesh, 2017). In my experience it is difficult to get accurate responses related to economic measures. Respondents are often unwilling to discuss matters related to their wealth, or they provide inflated estimates of their household income and savings. The Udai Pareek scale does not collect information on income or savings (rather it asks about

material possessions more generally), so the data collected with the scale may be more valid for present purposes. This scale was revised for 2017 by Singh, Sharma, and Nagesh (2017) and was used – with modifications to include urban and semi-urban residents – in the present study. The items associated with this modified scale were as follows (the points for each item are shown in parenthesis):

Caste: Schedule caste (1), Lower caste (2), Artisan caste (3), Agriculture caste (4), Prestige caste (5), Dominant caste (6).

Occupation: None (0)**,** Laborer (1)**,** Caste occupation (2), Business (3)**,** Independent profession (4), Cultivation (5)**,** Service or Professional (6).

Education: Illiterate (0)**,** Can read only (1), Can read and write (2), Primary (3)**,** Middle (4),High school (5), Graduate (6),And above (7).

Social participation: None (0), Member of one organization (1), Member of more than one organization (2), Office holder in such an organization (3),Leadership position (4).

House: No house (0), Hut (1), Kutcha house (2)**,** Mixed house (3), Pucca house (4)**,** Mansion (5).

Material possessions: None (0)**,** Bullock cart (1), Cycle (2), Radio (3)**,** Chairs (4)**,** Mobile phone (5), Television (6), Refrigerators (7), Car (8).

An individual's SES Score was simply the sum of the points he/she received which spanned from 1 (lowest) to 36 (highest).

Measuring Attitudes towards Depression

There are at least two approaches to measuring depression: The first consists of presenting a vignette concerning a person suffering from depression and asking participants to indicate their attitude towards the person described in that disorder. This approach does not require the labeling of a particular mental disorder. The second approach identifies a mental disorder, labels it as 'depression', and proceeds to query participants on their attitudes towards depression – if and only if they are previously familiar with it. In this work, I used the first approach for Study 1 and the second approach for Study 2.

Following prior studies (Kermode et al., 2009), Study 1 used a case vignette describing a person who met DSM-V diagnostic criteria for major depressive disorder with the symptoms of depressive mood, markedly diminished interest, decrease in appetite, weight loss, insomnia and fatigue, feelings of worthlessness and guilt, diminished ability to concentrate, and recurrent suicidal ideation (American Psychiatric Association,2013). The vignette, adapted from Kermode et al. (2009), was as follows:

Meena is 30 years old, a married mother of two children. She was fine until 6 months ago, but then something changed. She started to feel tired all the time. She became disinterested in food and lost a lot of weight. She was frequently sad and would cry repeatedly. She often stayed awake at night, and was tired during the day. It became difficult for her to cook, clean, and take care of housework. Even her children did not make her happy. She told her sister that her life was worthless, as she had brought a lot of trouble to her family. She sometimes thought that it might be better to just end her life.

To measure attitudes towards depression, participants responded to a list of items measuring their social distance from the person depicted in the vignette. These included the following items (scored positively for affirmatives):

1. Having Meena as a neighbour would not irritate me

2. Provided her family paid on time, I would rent my house to Meena
3. I can imagine socializing with Meena
4. I can imagine being friends with Meena
5. I can imagine a person like Meena marrying into my family

A second set of questions invited study participants to make causal attributions underlying the condition described in the vignette. These were as follows:

1. Meena's problems are a sign of personal weakness and she is to blame
2. Meena's problems are a sign of mental illness and/or bad luck and she is not to blame.

Importantly, these sets of questions did not seek to label the specific condition of depression. Rather their focus was to concretely describe the symptoms often associated with depression. It is known that the labeling of a disorder can powerfully contribute to stigma. Link and Phelan (2001) describe this process as follows:

In our conceptualization, stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. Thus we apply the term stigma when elements of labeling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold (Link & Phelan, 2001, p. 367).

By avoiding labeling in Study 1 below, I sought to measure how people from different SES backgrounds are likely to respond to the symptoms of depression, rather than to its association as a mental disorder. In Study 2, I explicitly labeled the symptoms of depression as a mental disorder and collected mental attitudes towards the disorder from people – across SES groups – who were previously familiar with the mental disorder known as depression.

Study 1: Responses to Depression Vignette from Different SES groups

The purpose of Study 1 was to determine whether differences in SES were associated with differences in attitudes towards the person described in the depression-related vignette above.

Participants: This study was carried out with a representative sample of Inter-State bus terminuses in Delhi, UP and Haryana. Bus terminuses afford the opportunity to recruit participants from rural as well as urban backgrounds that often span the SES spectrum. The inclusion criteria for Study 1 were being over 18 years old and having physical and mental competence to answer the questions. Surveys were administered by trained male and female research associates who each approached perspective participants of the same gender. Participants were paid INR 20 for their time. The final sample consisted of 225 individuals (102 females).

Procedure: Selected participants were first presented with a vignette (shown above) that described person experiencing symptoms potentially attributable to major depressive disorder as defined in DSM 5. Questions related the vignettes invited responses on a 1-5 scale that

ranged from 'Strongly Disagree', 'Disagree', 'Neither Disagree Nor Agree', 'Agree', and 'Strongly Agree'. The first set of questions featured items measuring social distance towards the person depicted in the vignette. The second set of questions involved two items querying whether the circumstances depicted in the vignette were the result of personal weakness (coded as '1') or the result of mental illness and/or bad luck (coded as '0'). After these vignette related questions, the modified Udai Pareek SES scale was administered.

The vignette, questions and response categories were translated into Hindi with support from a Hindi-speaking psychologist, and were back-translated to ensure equivalence of the items. The questionnaire was pilot-tested prior to its administration. Interviews were connected in Hindi and lasted approximately 10 minutes each.

Results: We recruited 225 individuals, 102 of whom were females. Their mean age was 27 (SD 9.4 years) with a range of 18 – 55 and an approximately normal distribution around the mean. The variation across genders was not statistically different. 85% of the sample was married, and 88% of the sample had an educational level equivalent to high school or below. Further SES details are shown in Table-1 below:

Table -1: Social Distance Measures in Study 1

	Mean	**95% CI**	**Range**
Caste: Schedule caste (1), Lower caste (2), Artisan caste (3), Agriculture caste (4), Prestige caste (5), Dominant caste (6).	3.2	±0.8	1-6
Occupation: None (0)**,** Laborer (1)**,** Caste occupation (2), Business (3)**,** Independent profession (4), Cultivation (5)**,** Service or Professional (6).	3.7	±1.4	1-6
Education: Illiterate (0)**,** Can read only (1), Can read and write (2), Primary (3)**,** Middle (4),High school (5), Graduate (6),And above (7).	4.2	±1.6	0-7
Social participation: None (0), Member of one organization (1), Member of more than one organization (2), Office holder in such an organization (3), Leadership position (4).	1.2	±0.9	0-4
House: No house (0), Hut (1), Kutcha house (2)**,** Mixed house (3), Pucca house (4)**,** Mansion (5).	3.8	±1.7	1-4
Material possessions: None (0)**,** Bullock cart (1), Cycle (2), Radio (3)**,** Chairs (4)**,** Mobile phone (5), Television (6), Refrigerators (7), Car (8).	4.8	±1.8	2-8

The overall SES composite average was 20.9. The SES survey was presented *after* responses related to the vignette (described above) had been collected (it is presented prior in this section to illuminate the demographics of the participants in Study 1.

Social distance measures for the entire group across all SES conditions are shown in Table 2 (the 'agree' category includes the 'strongly agree' and the 'agree' responses from the questionnaire, and 'disagree' category includes the 'strongly disagree' and the 'agree' responses from the questionnaire). The differences from 100% in Table 2 indicate the number of people who indicated that they neither agreed with, not disagreed with the item in question.

Table -2: Social Distance Agree/Disagree Percentages in Study 1 (all respondents)

	Agree (%)	**Disagree(%)**
Having Meena as a neighbour would not irritate me	77.2%	16.2%
Provided her family paid on time, I would rent my house to Meena	69.1%	24.1%
I can imagine socializing with Meena	66.7%	22.4%
I can imagine being close friends with Meena	44.1%	25.7%
I can imagine a person like Meena marrying into my family	22.7%	51.0%

Importantly, there was an unmistakable correlation ($r = 0.28$, $p<0.01$) between SES scores (high scores corresponding to high status) and social distance (less affirmative scores in Table 2 correspond to higher social distance – and lower affiliation). Overall, higher SES people had higher social distance – and potentially felt higher levels of stigma for the person depicted in the vignette. On the other hand, lower SES people had less social distance – and potentially felt higher levels of affiliation with the person depicted in the vignette.

In addition, more people considered that the symptoms described in the vignette were a result of personal weakness (52.0% ± 19.1%), rather than mental illness or bad luck (44.8%± 11.4%). Here too lower SES individuals tended to agree with causal attributions of bad luck/and or mental illness, whereas higher SES individuals tended to favor causal attributions related to personal weakness ($r = 0.19$, $p<0.01$).

Study 2: Responses to Depression Questionnaire from Different SES groups

In Study 2 we sought to determine whether higher tolerance levels from low SES individuals would persist in situations when depression was labeled as a mental illness and was presented via abstract survey items rather than vignettes.

The recruitment process was similar to that used in Study 1. A total of 205 people (78 females) participated in Study 2 (mean age 29.3 years, SD 9.5 years). Unlike Study 1, participants were not paid for their involvement in Study 2, because the team's experience in Study 1 suggested that people waiting for their transportation at the inter-state bus terminus would participate in the study without requiring payment.

In Study 2, potential candidates were first asked whether they were familiar with a mental condition (not illness) called depression. People responding in the affirmative were invited to participate in the study. They first (verbally) responded to a questionnaire administered by an interviewer that measured their attitudes towards depression (i.e. the illness) and depressed people. They then completed the SES survey used in Study 1.

Results: The SES average composite score was 23.4 (compared to 20.9 in Study 1) suggesting that filtering for people previously familiar with depression resulted in a higher SES demographic. Participants' attitudes towards depression and depressed people was generally quite negative and is shown in Table 3. Each survey item was scored on three dimensions: 'Agree', 'Neither Agree nor Disagree' and 'Disagree' (the first and third dimensions are shown in Table 3, the remainder from 100% fell into the second dimension). The last 5 items on the depression attitude survey were generalized versions of the questions

asked with respect to the vignette. Notably the answers to these items appeared to be consistently more negative than those observed in Study 1.

Table - 3: Attitudes towards Depression and Depressed People in Study 2

	Agree % (±95%CI)	**Disagree % (± 95%CI)**
People with depression should snap out of it	38.2±11.1	44.9±10.2
Depression is just personal weakness	81.9±18.3	15.5±8.6
Depression is a punishment from God	78.3±11.4	9.3±3.2
Depression is not a real illness	90.9±8.8	4.1±0.9
People with depression are dangerous	32.4±9.2	61.8±12.3
People with depression should be avoided	47.1±9.8	50.8±9.3
People with depression are unreliable	77.2±13.3	11.2±7.3
Having a depressed person as a neighbour would not irritate me	65.7±11.9	27.8±7.7
Provided timely payment, I would rent my house to a depressed person	40.0±7.1	52.1±8.9
I can imagine socializing with a depressed person	18.3±5.7	50.9±9.7
I can imagine being close friends with a depressed person	8.3±3.1	52.2±11.4
I can imagine a depressed person marrying into my family	~1%	92.6±4.1

The last 5 items on the depression attitude survey were generalized versions of the questions asked with respect to the vignette. Notably the answers to these items appeared to be consistently more negative than those observed in Study 1.

We coded the responses to the survey such that higher scores reflected greater social distance and stigma towards depression and depressed people. We then correlated scores with SES scores of all participants in Study 2. While a positive correlation was seen in Study 1, no such meaningful correlation was observed in Study 2 (r=0.03).

General Discussion

Depression in India is a problem of staggering proportions. One of the overarching findings of Study 1 (vignette based) and Study 2 (survey based) in the present work is that people in India have negative views of depression and depressed people. For example, in Study 1, over half of the participants believed that the depression related symptoms described in a vignette were the result of personal weakness not mental illness. In Study 2, when people were explicitly asked about their attitudes towards depression, large majorities (80-90%) expressed the view that depression was not a real illness and that people suffering from depression had no one but themselves to blame. It is not difficult to imagine that such ubiquitous social disapproval prevents millions of people from seeking appropriate medical attention which in-turn leads to added distress and increased burdens for affected individuals and their families. It is therefore critical for policy makers to develop a more granular understanding the social attitudes towards depressed individuals so that it is possible for them to design interventions that reduce negative attitudes towards depression.

One step towards developing such granular understanding may be illuminated by the present work which revealed that when responding to a vignette, individuals from low socio-economic-status (SES) backgrounds unexpectedly tended to be more accepting (i.e. showed less social distance) towards people described as having symptoms of depression than individuals from higher SES backgrounds (Study 1). However, this difference in SES-based

levels of stigma disappeared when depression was labelled as a mental disorder in a questionnaire (Study 2)

There are at least three possible (mutually non-exclusive) reasons that could explain the presence SES/Depression Attitude link in Study 1, and its absence in Study 2. First, in Study 2, I only recruited those participants who had previously heard of the mental illness known as depression. This participant pool was different from the participant pool in Study 1 in that Study 2 participants possibly had prior stigmas against depression which were absent for a sub-group of participants in Study 1. Second, the average SES scores of participants in Study 2 was higher than SES scores in Study 1. It is possible – and Study 1 provides some confirmatory evidence – that lower SES groups are more tolerant of depression and depressed people. Finally, Study 2 named depression as an abstract construct (unlike Study 1which used a vignette about a specific person). Such labeling is known to affect attitudes towards mental illness (Rosenfield, 1997).

It is not immediately clear *why* lower SES individuals had more tolerant views towards the plight of an unfortunate person depicted as struggling with depression. One hint may be provided by the work of Piff and colleagues who showed that lower class individuals orient to the welfare of others as a means to adapt to their more hostile environments and that this orientation gives rise to greater pro social behavior (Piff et al., 2007). Across several studies these researchers demonstrated that lower SES individuals proved to be more generous, charitable, trusting, and helpful compared with their upper-class counterparts. They argued that lower SES individuals acted in a more pro social fashion because of a greater commitment to egalitarian values and feelings of compassion (Piff & Moskowiz, 2017).

One intriguing possibility suggested by the present data is that interventions related to removing stigmas related to depression should aim to describe the stories and situations of people (for a discussion on media depictions of mental health, see Smith, 2007). These findings also have implications in the teaching of psychopathology. I propose, consistent with prior views (e.g. Mann & Himelein, 2008), that person-centric teaching is the best way to minimize stigma in our teaching institutions.

REFERENCES

Almanzar, S., Shah, N., Vithalani, S., Shah, S., Squires, J., Appasani, R., & Katz, C. L. (2014). Knowledge of and attitudes toward clinical depression among health providers in Gujarat, India. *Annals of Global Health, 80*, 89-95.

Argyle, M. (1994). *The psychology of social class*. Psychology Press.

Blaney, P. H. (2013). Stress and Depression ln Adults: A Critical Review. *Stress and coping*, 263.

Cirino, P. T., Chin, C. E., Sevcik, R. A., Wolf, M., Lovett, M., & Morris, R. D. (2002). Measuring socioeconomic status: reliability and preliminary validity for different approaches. *Assessment, 9*, 145-155.

Dirks, N. B. (2011). Castes of mind: Colonialism and the making of modern India. *Princeton University Press*.

Kermode, M., Bowen, K., Arole, S., Pathare, S., &Jorm, A. F. (2009). Attitudes to people with mental disorders: a mental health literacy survey in a rural area of Maharashtra, India. *Social Psychiatry and Psychiatric Epidemiology, 44*, 1087-1096.

Kraus, M. W., Côté, S., & Keltner, D. (2010). Social class, contextualism, and empathic accuracy. *Psychological Science, 21*, 1716-1723.

Link, B.G., Phelan, J.C., 2001. Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385.

Mann, C. E., &Himelein, M. J. (2008). Putting the person back into psychopathology: an intervention to reduce mental illness stigma in the classroom. *Social Psychiatry and Psychiatric Epidemiology*, *43*, 545-551.

Manstead, A. S. (2018). The psychology of social class: How socioeconomic status impacts thought, feelings, and behaviour. *British Journal of Social Psychology, 57*, 267-291.

McLoughlin, A. B., Gould, M. S., & Malone, K. M. (2015). Global trends in teenage suicide: 2003–2014. QJM: *An International Journal of Medicine*, *108*, 765-780.

Moos, R. H. (1990). Depressed outpatients' life contexts, amount of treatment, and treatment outcome. *Journal of Nervous and Mental Disease*, *178*, 105-112.

Piff, P. K., & Moskowitz, J. P. (2017). The Class–Compassion Gap: How Socioeconomic Factors Influence. *The Oxford handbook of Compassion Science*, 317-331.

Piff, P. K., Kraus, M. W., Côté, S., Cheng, B. H., & Keltner, D. (2010). Having less, giving more: the influence of social class on prosocial behavior. *Journal of Personality and Social psychology*, *99*, 771-784.

Poongothai, S., Pradeepa, R., Ganesan, A., & Mohan, V. (2009). Prevalence of depression in a large urban South Indian population—The Chennai Urban Rural Epidemiology study (CURES–70). *PLoS One*, *4*, e7185.

Raguram, R. D. P. M., Weiss, M. G., Channabasavanna, S. M., &Devins, G. M. (1996). Stigma, depression, and somatization in South India. *American Journal of Psychiatry, 153*, 1043-1049.

Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review*, 660-672.

Shidhaye, R., Gangale, S., & Patel, V. (2016). Prevalence and treatment coverage for depression: a population-based survey in Vidarbha, India. *Social Psychiatry and Psychiatric Epidemiology*, *51*, 993-1003.

Singh, T., Sharma, S., & Nagesh, S. (2017). Socio-economic status scales updated for 2017. International Journal of Research in Medical Sciences, 5, 3264-3267.

Smith, R. (2007). Media depictions of health topics: Challenge and stigma formats. *Journal of Health Communication, 12*, 233-249.

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Conflict of Interest

The authors carefully declare this paper to bear not conflict of interests

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