Chapter - III
The Present Study
THE PRESENT STUDY

This chapter provides following information: rationale of the study, research questions, conceptual and operational definition of terms used, and Vignette study method.

RATIONALE

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Contrarily, mental disorder refers to a psychophysical and cognitive pattern that occurs in an individual and is usually associated with distress or disability that is not expected as part of normal development or cultural milieu (Sixty-Sixth World Health Assembly, 2013).

Though, the recognition and understanding of mental disorders have changed over time and definitions, assessments, and classifications vary to an extent, but guideline criterion listed in the manuals by WHO (ICD-10) and APA (DSM-IV TR) are widely accepted by mental health professionals world over. Categories of diagnoses in these schemes include anxiety and mood disorders, developmental and personality disorders, psychotic and substance related disorders and many other categories. In many cases there is no single accepted or consistent cause of mental disorders, although they are widely understood in terms of a diathesis stress model and bio psychosocial model.

These mental, neurological and behavioural disorders are common to all countries and cause immense suffering. They make a substantial contribution to the Global Burden of Diseases (Vos, et al., 2012) along with undefined and hidden burden. WHO (2012) estimates that about 450 million people worldwide currently suffer from some form of mental or behavioural disorder, approximately
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one in four people at some time in life. Prevalence varies between countries, but these conditions affect about 10% of the world’s population at any one time.

WHO (2013) further emphasizes that mental illnesses affect and are affected by chronic conditions such as cancer, heart and cardiovascular diseases, diabetes and HIV/AIDS. Mental illness also has a huge effect on general physical health, and thus on the need for physical healthcare. Broadly speaking, compared with other people of the same age, people who are mentally ill are 50% more likely to die (Mykletun, et al., 2009; Satin, Linden & Phillips, 2009). So, there are significant costs of mental illness, in terms of lost production and extra physical healthcare. Untreated, they bring about unhealthy behaviour, non-compliance with prescribed medical regimens, diminished immune functioning, and poor prognosis. It is estimated that the real contribution of mental disorders to the global burden of disease is even higher, amongst others due to complex interactions and co-morbidity of physical and mental illness (Saxena, Funk, & Chisholm, 2013).

Moreover, along with increased mortality, people with these disorders are often subjected to social isolation and poor quality of life and are the cause of significant economic and social costs (World Economic Forum, 2011). Most middle and low-income countries devote less than 1% of their health expenditure to mental health. Even in rich countries, less than a third of people who suffer from mental illness are in receipt of treatment and care; in lower-resource settings, the situation is considerably worse (World Happiness Report, 2013).

Kohn and others (2004) pointed out that a key contributing factor to the burden of mental disorders is the lack of appropriate care and treatment for those in need. This difference between identified need and actual service provision has been referred to as the “treatment gap.” Making use of community-based psychiatric epidemiology studies that included data on the
percentage of individuals receiving care, the median treatment gap for schizophrenia has been estimated at 32%, but for all other conditions, including bipolar disorder, depression, dysthymia, anxiety disorders and alcohol dependence, it well exceeded 50%.

Whatsoever, the effects of treatment are now highly predictable and relatively inexpensive and, if correctly applied, could enable most of those affected to become functioning members of society. Unfortunately, people do not opt or sincerely adhere to treatment regimen, which may be attributed to varied reasons. Barriers to effective treatment of mental illness include lack of recognition of the seriousness of illness, prevailing stigma, unscientific perceived causality and lack of understanding about the benefits of services. Thus, mental well-being can be put at risk by a wide range of factors that span not only the life course but also different spheres of life: cognition and behaviour at the individual level; living and working conditions at the social level; and, opportunities and rights at the environmental level.

Moreover, there is a long-standing and widely accepted proposition that happiness represents the ultimate goal in life and the truest measure of well-being (Layard, et al., 2013). It is hard if not impossible to flourish and feel fulfilled in life when individuals are beset by health problems such as depression, anxiety or schizophrenia. In this regard, World Happiness Report (2013) projects mental illness to be one of the main causes of unhappiness. It is further deliberated that people can be unhappy for many reasons from poverty to unemployment to family breakdown to physical illness. But in any particular society, chronic mental illness is a highly influential cause of misery, the single biggest determinant of misery.

More treatment of mental illness is therefore probably the single most reliably cost-effective action available for reducing misery. Treatments are now well-developed and their impact on recovery is well known. So a completely
different attitude to mental health is required worldwide, which could affect the availability of treatment, as well as major steps to prevent mental illness and to promote mental health. In this regard Commission on Social Determinants of Health (CSDH, 2008) highlighted the importance of building the evidence base for mental health promotion and the prevention of mental disorders, given current gaps and weaknesses in knowledge. Though, number of attempts have been made in recent past suggesting efficient interventional strategies, ruling out cost of scaling up mental healthcare and integrating health care to attain health equity (Buttorff, et al., 2012; Chisholm, Lund & Saxena, 2007; Chisholm, et al., 2000), still globally, it has been realized that individuals in particular, and societies and nations in general should enhance their capacity to combat stigma, reduce the burden of mental disorders and promote mental health.

Whatever, very recently, Gallup (2013) report indicated India's 111th ranking on happiness with a sub average value (4.772) on a 10-point rating scale. Available data from the Indian studies suggest that about 20% of the adult population in the community is affected with one or the other psychiatric disorder (Math & Srinivasaraju, 2010), where the overall prevalence rate is approximately 190-200/1000 population. Increase in invisible mental health problems such as suicidal attempts, aggression and violence, widespread use of tobacco, alcohol and other drugs, increasing marital discord and divorce rates emphasizes the need to prioritize and make a paradigm shift in the strategies to promote and provide appropriate mental health services countrywide. It is further argued that considering this as a modest estimation of the psychiatric prevalence in the Indian population, it is high time to stop the long-term debate about the prevalence rate of mental illness in India and move forward to actual actions that call for investing and improving the mental health services. The need of the hour is in addressing major challenges such as lack of mental health manpower, financial aid, poor mental health
literacy and stigma, which are the major threats to developing comprehensive psychiatric services in the community (Math & Srinivasaraju, 2010).

Thus, helping people avoid and overcome behavioural, emotional and mental problems in the wake of turmoil is one of the most important challenges for psychologists, psychiatrists and social scientists. Moreover, promoting healthy development is as important as preventing problems and serves the same end more effectively. More so, with the recent development of the Positive Psychology movement, happiness, wellbeing, optimism, altruism, resilience, forgiveness and above all mental health is being recognized as a positive human endeavour (Seligman, et al., 2005; Gangdev, 2009), and also being associated with counselling and psychotherapeutic interventions.

Above all, it is also unanimously realized that adolescence, in particular, is a time of challenge and turmoil during which numerous changes take place. While developing an independent sense of identity, learning about their personal strengths, weaknesses, beliefs and value systems, sometimes adolescents and youth adopt oppositional role in order to increase confidence in their capabilities and to develop problem-solving and coping skills. Along with the challenges inherent, outside threats may also occur that can encumber normal development. Issues such as poverty, abuse, neglect, or poor parenting impact the developmental process. Consequently, youth may respond others with hostility, aggression, and violence or may themselves become disordered.

Globally, it is found that 1 out of 5 in this age group experiences a mental, emotional or behavioral disorder that is severe enough to seriously affect their daily functioning at home, school, or within the community. Some of the common mental disorders affecting the adolescents and youth are Anxiety Disorders; Attention Deficit Hyperactive Disorder (ADHD); Autism Spectrum Disorder (ASD); Behaviour Disorders, including Oppositional Defiant Disorder (ODD), Conduct Disorder (CD); Mood Disorders, including
Depression, Bipolar Disorder; Eating Disorders; Schizophrenia; Substance Abuse; Tourette Syndrome, etc. (Murray & Lopez, 2002). Three out of the ten leading causes of disability in people between the ages of 15 and 44 are mental disorders, and the other causes are often associated with mental disorders. Both retrospective and prospective researches have shown that most adulthood mental disorders begin in childhood and adolescence (Kessler, et al., 2007). Suicide is the third leading cause of death among adolescents and that up to 50% of all adult mental disorders have their onset in adolescence. The disability burden is highest in adolescence and young adulthood (20% among 15-19 year olds), falling steadily to 10% by the age of 60-64 years (Ayuso-Mateos, et al., 2010).

With regards to India, the prevalence rate of psychiatric morbidity in adolescents and youth was found to be significantly high (ICMR, New Delhi, 2005; Srinath, et al., 2005; Bhola & Kapur, 2003; Ganguli, 2000; Math, Chandrashekar & Bhugra, 2007). Today, the youth in India form one of the most vulnerable group for social deviations and exploitations and consequently for mental illnesses. However, though a large proportion of adolescents and youth are not having any diagnosed illness, they are found to be lacking in communication and presentation skills, problem-solving capabilities and generic abilities, and an overall low level of confidence. It has been recently reported that a significant proportion of graduates, nearly 47%, were found not employable in any sector, given their English language and cognitive skills (National Employability Report-Graduates, 2013). Accordingly, in general educated Indian youth lack communication, analytical and problem solving skills and Domain knowledge. More so, India's more than 50% of population below the age of 25 and more than 65% below the age of 35 is an alarming situation in this connection.
Further, it may also be noticed that while extensive researches have explored the prevalence and incidence of mental illnesses, the holistic approach to relate the knowledge and belief about the mental illnesses with help seeking behaviour and recovery outcomes altogether is lacking. Fewer researchers have addressed the significance of mental health literacy awareness and its' relationship with curative and preventive strategies within the population in general and youth in particular.

Here, health literacy refers to the ability to gain access to, understand, and use information in ways which promote and maintain good health (Nutbeam, et al., 1993). Jorm, et al. (1997) introduced the term ‘mental health literacy’ and have defined it as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. Mental health literacy consists of several components, including: (a) the ability to recognise specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information.

Somehow, the importance of health literacy for physical health is widely acknowledged, the area of mental health literacy has been comparatively neglected, where as the need for the public to have greater mental health literacy is highlighted by the high lifetime prevalence of mental disorders (Kessler, et al., 1994), which means that virtually everyone will either develop a mental disorder or have close contact with someone who does. Poor mental health literacy may place a limit on the implementation of evidence-based mental health care, in the form of unwillingness to seek treatments or to adhere to clinicians' advice (Jorm, et al., 2000). A second consequence of poor mental health literacy is that the task of preventing and helping mental
disorders is largely confined to professionals. However, the high prevalence and the low workforce cannot help everyone affected and focus is on those with more severe and chronic problems. Thus, there is a strong need for a ‘mental health literate’ society in which basic knowledge and skills are more widely distributed. An increase in mental health literacy in the population may assist prevention, early intervention, effective self-help and support of others in the community.

Thus, in an effort to extend the knowledge base concerning the relevant issues concurrently, the present study aims at examining the relationship and causality of perceived stigma and causal attributions with beliefs about medicines, treatment adherence and recovery taken together amongst Indian youth.

**RESEARCH QUESTIONS**

The study attempts to answer mainly the questions regarding the public perceptions, mental health awareness and literacy amongst youth. Specifically, the questions guiding this research include:-

- Is there any difference between stigmatized attitudes towards various mental illnesses amongst youth?
- Which causes are in general attributed by the youth as responsible for mental illnesses?
- What are the beliefs of youth regarding the medicinal use and benefits of treatment adherence?
- Which kind of attitudes towards recovery from mental illnesses are held by youth?
- What is the relationship between public perception of stigmatized attitude and causal attributions with attitudes towards medicinal use, treatment adherence and recovery from mental illnesses in general?
The following are conceptual and theoretical definitions of the variables under study based on existing literature followed by the operational definition for each variable as it is used in the present study:

**Stigma**

Stigma of mental illness can be defined as the negative attitude (based on prejudice and misinformation) that is triggered by a marker of illness - e.g. odd behaviour or mention of psychiatric treatment in a person's curriculum vitae. The presence of stigma starts a vicious circle that leads to discrimination in all walks of life (Sartorius, 2007), decreasing self-esteem and self-confidence, a low treatment effect or high probability of relapse for those in remission, and thus to a reinforcement of the negative attitudes and discrimination (Sartorius & Schulze, 2005). According to Link, et al. (1989) perceived stigma is the belief that most people will devalue and discriminate against individuals who use mental health services and or have a mental illness. Thus, stigma is a social construction that devalues people as a result of a distinguishing characteristic or mark (Biernat & Dovidio, 2000).

Here, stigma is operationally defined as the **Stigmatized Attitude** denoted by the high negative scores on the Attitudes to Mental Illness Questionnaire (AMIQ) by Luty, et al.,(2006).

**Causal Attribution**

A causal attribution refers to the way a person thinks about plausible causes in relation to a given effect or how the attributor perceives the causes for an event. Most people have a set of schema that facilitate causal attributions. With regards to mental illnesses, biological causal explanations promote the belief that individuals with mental illness are not capable of controlling their behaviour, whereas environmental causal explanations promote the belief that individuals with mental illness are capable of controlling their behaviour;
thus, according to attribution theory, biological explanations can help reduce stigma (Link, et al., 2004).

Causal attributions represent cognitive processes which suggest that the person has control over the behaviour and subsequently could be “blamed” for the behaviour (Penn, et al., 1994). Cognitive and attitudinal biases with negative thinking are responsible for criticizing and blaming the patients of mental illness whereas medical and biological attributions such as genetic or brain disease are perceived as permanent and rests on the belief that an imbalance of certain substances in the brain is a cause of the patients problem (Phelan, 2002).

Causal Attributions are operationally defined as **Perceived Causes** in the form of high scores on Biological and Environmental Subscales of Causal Attribution Scale by Jorm and Griffiths (2008).

In addition to this, a Vignette based method suggested by Link, et al. (1999) was also used to gather perceptions of the studied sample about the likely causes of various mental illnesses.

**Treatment Adherence**

Adherence to treatment may be defined as the extent to which the patient's history of therapeutic drug-taking coincides with the prescribed treatment (Urquhart, 1996). The point that separates "adherence" from "non-adherence" would be defined as that in the natural history of the disease making the desired therapeutic outcome likely (adherence) or unlikely (non-adherence) to be achieved (Volmink & Garner, 2000). Thus, treatment adherence refers to compliance, a passive approach where the patient faithfully follows the advice and direction of the healthcare provider (Vermeire, et al., 2001). Another term concordance as patients’ considered choice indicates the extent to which patients' thoughts matches with the health caregiver.
Similarly, adherence proposed as an alternative to compliance reduces attribution of greater power to the doctor in the doctor-patient relationship. Adherence is a collaboration between the patient and healthcare provider regarding health-related decisions. Utilizing this terminology (adherence) with the patient assists in fostering ownership and the continuation of treatment decisions by the patient. The term adherence incorporates the broader notions of concordance, cooperation and partnership.

Adherence is known to be associated with beliefs about medicines. The observed stability in such beliefs could have implications for the design of interventions to improve adherence to prescribed medication regimes. General beliefs about medicines appear to remain stable over time, irrespective of changes in health status.

Operationally, Treatment Adherence refers to **Beliefs about Treatment/Medicines** and was assessed by The Beliefs about Medicines Questionnaire-General (Horne, Weinman & Hankins, 1999), where high scores denote the subscales-Overuse and Harm. Further, opinion towards **Benefits of Treatment Adherence** was also rated on a categorical scale, i.e. Yes and No.

**Recovery**

Recovery is generally taken to mean getting back to how the patients were before the illness started, being restored to former state and implies that one can do the same things that he/she could before illness and feel the same as before. This conception of recovery refers to a state of a person as the end state following a period of illness.

Recovery is a process and experience people share and face the challenge when they experience the crises of life, such as the death of a loved one, divorce, physical disabilities, and serious mental illnesses. Successful recovery does not change the fact that the experience has occurred, that the
effects are still present, and that one’s life has changed forever. Rather, successful recovery means that the person has changed, and that the meaning of these events to the person has also changed. They are no longer the primary focus of the person’s life (Anthony, 1993).

In present context, operationally recovery has referred to **Attitude towards Recovery** and is assessed as comprising of two attitudinal factors related to possibility and difficulty.

Further, 'Recovery is possible' and 'Recovery is difficult' are operationally defined as the high scores on the Recovery Attitudes Questionnaire (RAQ-7) by Borkin, et al. (1998).

**Vignette Study Method**

The Vignette is a method for collecting data by presenting hypothetical situations or stimulus and asking research participants a set of directed questions to reveal their values and perceptions. This methodology is often used when dealing with sensitive and difficult topics like mental disorders, substance abuse or sexuality. It allows the interviewee to distance himself from the situation so that he will be free to answer honestly without fear of being judged negatively (O'Connor, Davies, Heffernan, & Eijk, 2003). This method may also be used when research participants voice their opinion on topics which they may not have had personal experience. Vignettes consist of stimuli in the form of a picture, illustration, or depiction in words as written and spoken narratives, visual imagery, video, and sound presented to research participants. The purpose is to selectively portray aspects of reality to which participants are asked to respond. Like any research method, vignettes address clearly defined research questions and their form and application are directed by the research questions posed, the topics under study and the kinds of participant groups involved. The simplicity of scenarios can help to identify, clarify and disentangle the complexities of real-world processes.
Further, a vignette in psychological and sociological experiments presents a hypothetical situation, to which research participants respond thereby revealing their perceptions, values, social norms or impressions of events. Rossi & Berk (1985) developed a framework for creating vignettes by systematically combining predictor variables in order to dissect the effects of the variables on dependent variables. Vignettes in the form of sentences describing actions have been used extensively to estimate impression formation equations in research related to affect control theory. Vignettes enable controlled studies of mental processes that would be difficult or impossible to study through observation or classical experiments. However, an obvious disadvantage of this method is that reading a vignette is different from experiencing a stimulus or action in everyday life.

With regards to mental illnesses, this approach was first used by Star (1955) to study public attitudes towards mental illness. Later on, Philips (1963) ensured the future use of vignettes by integrating their use with the experimental method. Since then, number of researchers (Link, et al., 1999; Angermeyer & Matschinger, 1999; Jorm, et al., 1997) employed vignette based questions to cover DSM-IV and ICD criteria.

According to Link, et al. (2004) vignettes have enjoyed a very prominent position in research on the stigma of mental illness by allowing the researcher to present a more elaborate stimulus to respondents and by use of random assignment bring the power of the experimental method to hypothesis testing. Furthermore, because vignettes can be used in survey research to randomly selected general population samples, therein achieve better external validity that employ college students as subjects.

On similar lines, the present study is mainly a vignette based attitudinal research where to measure stigmatized attitudes towards mental illnesses short fictional vignettes were used depicting Injecting heroin, Depression, Drinking
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heavily, Convicted criminal, Diabetes, Schizophrenia and Practising Muslim. Further, to assess perceived causes vignettes about schizophrenia, Major depressive disorder, Alcohol dependence, Cocaine dependence and Troubled person were used. Further, stigmatized attitudes and perceived causes were related with beliefs about medicines, treatment adherence and attitudes towards recovery.