Title: Fear of relational impact mediates differences in treatment-seeking for depression between women in the UK and India

Submitted by Jessica Elizabeth Joseph, to the University of Exeter as a dissertation for the degree of Master's by Research in Psychology, January 2024

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Abstract

Fear of relational impact upon diagnosis of depression refers to an apprehension that an individual may experience regarding how their mental health condition could affect their relationships with others. It holds a significant influence over an individual's treatment-seeking intentions for mental illness. The current thesis explores the fear of relational impact through the lens of cultural differences among British and Indian women who are diagnosed with depression. The paper explores the impact of stigma linked to depression on societal norms and how these norms influence attitudes toward depression. The mixed-methods research was conducted in two sequential stages, commencing with a qualitative study. In Study 1 (N= 16), self-reported clinically diagnosed women with depression from the UK and India were approached to take part in a semi-structured interview about their experiences. Study 2 (N= 341), which was a quantitative study, was conducted to investigate the differences reported between the two groups. . The second study included two questionnaires, the first assessed treatment-seeking behaviour (using the Attitudes Toward Seeking Professional Psychological Help-Short Form) while the second questionnaire was developed by the researchers to assess relational concerns, based on the insights from Study 1 data. The results of these studies collectively suggest that fear of relational impact is negatively associated with treatment-seeking intentions and how this varies across cultural contexts. Participants from India reported more fear of relational impact than the UK participants and hence they reported lower treatment-seeking intentions. Furthermore, fear of relational impact in regard to diagnosis of depression was found to be a significant mediator that facilitates the influence of cultural background and treatment-seeking behaviour. We conclude that treatment-seeking for depression is associated with stigma-related fears of its negative relational impact, with variations across cultural context.

The number of people living with depression worldwide is estimated to be 322 million, that is 4.4% of the global population (Friedrich, 2017). However, only a minority of people seek treatment for depression (Moussavi et al., 2007). There are increased levels of awareness across the globe for depression treatments, but substantial barriers exist that hinder treatment-seeking behaviour (Thornicroft et al., 2017). For example, the reluctance toward seeking help even in nations with high mental health awareness, such as the UK, suggests low treatment rate may be due in part to societal perceptions of mental illness (Salaheddin & Mason, 2016). Similarly, in other nations with lower mental health awareness, such as India, social stigma toward depression is deeply engrained within society, thus there is a widespread tendency to avoid seeking help for mental illnesses (Furnham & Malik, 1994). Consequently, this reluctance to seek timely treatment for depression can exacerbate the progression of symptoms, potentially leading to the worsening of the individual's condition. One challenge of encouraging people to seek treatment could be that a depressed patient might be reluctant due to the stigma that exists in the society (Goldman et al., 1999) which in addition to affecting them personally, they think might also negatively affect their social and personal relationships. This concern regarding their relationships can be termed as a fear of relational impact. The emotional phenomenon of fear of relational impact encompasses concerns about the potential negative consequences or strain, that depression might introduce into their interactions with family members, romantic partners, friends, or colleagues. Furthermore, population-based studies show more women than men are diagnosed with depression in both the UK and India (Furnham & Malik, 1994). One reason for this gap may be that women tend to be affected by public and self-stigma more than men (Furnham & Malik, 1994). According to the World Economics, India's Gini Coefficient of inequality is 57.1% and the UK is 32.6% in 2019. This prompts consideration of higher economic inequalities in India as compared to the UK might contribute to mental health disparities, particularly among women. This might potentially impact access to resources and support systems for women facing mental health challenges in either of these countries. Therefore, to lessen disparities and support efforts to improve mental healthcare services, it is vital to investigate potential differences in treatment-seeking among women in these two countries, as well as examine the role of fear of relational impact.

Gaps in Prevalence of Depression and Treatment-Seeking

Lifetime rates of clinical depression in Western countries are reported to be 4-10 times greater than in Eastern countries (De Vaus et al., 2018). In Japan, the 12-month prevalence rate for mood disorders is 2.5% (Kawakami et al., 2008) in China, it is lower than 2% (Huang et al., 2008; Lee et al., 2009). In contrast to this, the US exhibited a significantly higher prevalence rate of 20.8% (Kessler et al., 2008). Similarly, Simon et al. (2002) reported the difference between the prevalence of depression in the UK and India among patients who have undergone a diagnostic assessment by the hospital. They found the prevalence of major depressive disorder in the UK (participants from Manchester) was comparatively higher (17.1%) as compared to India (participants from Bangalore, 8.6%). Their results suggested that in higher or lower prevalence countries, the rate of depression onset may be dependent on the actual prevalence difference or differences in the diagnostic threshold. This might also suggest that the difference between the reported rates could be because depression is more likely to be diagnosed in the UK than in India. One of the reasons for underreporting or misdiagnosing of depression could be that Indians might perceive it as more potentially stigmatising (Simon et al., 2002).

The prevalence of diagnosed cases and help-seeking behaviour is notably low (1 in 27 people) in low/low-middle-income countries as compared to high-income countries, where 1 in 5 people receive adequate treatment for depression (Thornicroft et al., 2017). For example, Jani et al., (2021) reported that across India there exists a treatment-seeking gap of 75-85%, with heterogeneity across multiple dimensions. This could be attributed to the understanding of the illness and the difference in the display of symptoms across countries. For instance, in an example of a cultural comparison of western and non-western country, Waza and his colleagues investigated the difference in symptom display in the US and Japan (1999). They found that Japanese patients were more likely to somaticize depression symptoms whereas Americans were more likely to share psychological distress as a cause of depression (Waza et al., 1999). Hence, one could say that self-reporting somatic symptoms in place of psychological distress leads to instances of misdiagnosis or absence of reported cases of depression, consequently resulting in fewer cases of treatment-seeking for depression. Research evidence for somatic manifestation of depression suggests that somatising cognitive distress is a result of the influence of sociocultural or childhood experiences (Katon et al. 1982; Waza et al., 1999). The impact of external factors such as stigma associated with depression, points toward the necessity to delve deeper into the underlying reasons that might cause reluctance in seeking treatment among women.

Depression symptoms and consequences have been investigated in relation to a wide range of demographic characteristics such as gender (Salk et al., 2017), personality (Ho et al., 2022) and ageing (Bedaso & Han, 2021). For example, recent evidence has shown that the prevalence of depression is higher among women in the general population than among men (Halbreich & Kahn, 2007). A study on COVID-19 noted that older women were approximately twice as likely as older men to report depression (Reppas-Rindlisbacher et al., 2022). Additionally, Mackenzie et al., (2008) reported in his research that women (*N*= 3310) were more likely to seek treatment than men (*N*= 2382). Hence, we assumed that the age factor and gender association with depression can significantly influence the experiences of depression and interplay with the psychological and social aspects of the individual's life.

In addition to gender and age, loss of social connections has been identified as a significant predictor of depression along with a range of other cultural factors that impact one's experience of being diagnosed with depression (Djernes, 2006). There are different mechanisms that contribute to the cultural phenomenon of social distancing from diagnosed individuals, such as reduced family support or encountering stigmatising attitudes from friends and colleagues (Spence et al., 2014). Preconceived notions regarding the potential impact of a diagnosis on social relationships might turn into fear of damaging or straining these relationships. In turn, such worries over social relationships might impact people's mindset to approach treatments for mental illnesses.

Furthermore, stigma and perceptions of illnesses and treatment-seeking approaches have historically varied cross-culturally, with individuals from Western countries favouring an individualistic approach whereas those from Eastern countries tend to have a collectivistic approach (Tafarodi & Smith, 2001). The attributes that individualism rewards include personal goals that have priority over in-group goals (Tafarodi & Smith, 2001). In this approach, there is a stronger tolerance for deviation from societal expectations and people are less dependent on each other (Triandis, 1995). On the other hand, people from more collectivistic cultures tend to be clearer or stricter about what the society wants and expects. Women from collectivist societies are required to be interdependent with their families, and familial relationships are a high priority in society (Carpenter, 2000). Thus, in such cultures where conformity to societal expectations is highly valued and surveillance is high, individuals with mental illnesses are easily rejected or stigmatised (Ahmed et al., 2020). In addition, the prevalence of depression particularly is increasing in low- and middle-income countries such as India (Kessler & Bromet, 2013). Therefore, to understand the behaviour of depressed women, particularly in India, we decided to investigate a cross-cultural influence on treatment-seeking behaviour.

Culture and Stigma of Depression

Building on conceptual and empirical work, stigma is referred to as "a social identity that is devalued in a particular context" (Crocker et al., 1998). The stigmatisation of depression has been observed in places like the USA, the UK, and India and such stigmatisation has persisted for decades now (Furnham & Malik, 1994). Over time, studies have identified that mental illnesses are strongly stigmatised human characteristics that affect social relationships (Link & Phelan, 2001; Wright et al., 2000). Due to the stigma people perceive the diagnosis of depression as a label that elicits negative stereotypes such as being unpredictable, worthless, and ignorant (Olmsted & Durham, 1976; Phelan & Link, 2004). In studies by Birtel and Mitchell (2021) and Jobanputra and Furnham, (2005) greater levels of stigma are noted among people belonging from collectivist cultures than among those living in individualist cultures. Both studies have shown that Indian immigrants in the UK are more likely to display stigmatising behaviour towards health and illnesses as compared to British Caucasian individuals. These stereotypes can contribute to producing adverse reactions from others towards those who are diagnosed, and most importantly, labelled (Link et al., 1989).

Cultural perceptions and stereotypical beliefs shapes stigma in important ways (Kleinman, 1977). For instance, those in Western countries often understand that the aetiology of depression could be a mixture of genetic predisposition, biological factors, and environmental stressors (Dein & Bhui, 2013). Reports have shown that in Western societies, depression is regarded as a medical problem, unlike in Eastern societies, where there are tendencies to view it as a personal weakness or lack of mental strength, instead of a legitimate medical condition (Krendl & Pescosolido, 2020; Link et al., 1999). In Asian cultures, as psychological distress is also reported as physical symptoms, people in general dismiss the emotional symptoms of depression (Kramer et al., 2002). The difference could be due to the collectivist and tight culture that non-western countries like India showcases (Gelfand et al., 2011). Due to the expected communal living of individuals in non-western countries, gendered stereotypes for women are more strongly emphasized compared to women in western countries (Avasthi, 2010). Avasthi (2010) notes that when women deviate from expected behaviour such as being unsuccessful in fulfilling social roles like child rearing, they are often victims of stigma. Similarly, being diagnosed with a mental health disorder is viewed as deviating from their social roles which are controlled and regulated by family or societal norms (Bhaskaran, 1970). On being diagnosed with depression, women are presumed to not be able to take care of their family or children, which is basically deviating from what they have been taught and expected to do. Hence, due to social role expectations reportedly higher in India, it could lead to more stigmatising behaviour in India than in the UK (Furnham & Malik, 1994).

Furthermore, among Asian cultures there is a widespread belief that depression is linked with supernatural causes (Lauber & Rössler, 2007). One such example is a study on Indonesian cultural understandings of depression, which revealed that people are more likely to believe that depression is an outcome of spiritual punishment, possessions by spirits or demons, and consecutive wraths of Gods and Ancestors (Subu et al., 2022). In general, in other Asian cultures developing depression is also viewed as a problem that must have been affected by the actions or aftermath of the previous life (Raguram et al., 2004). Similarly, ancestral inheritance of misconduct is frequently seen as a cause of mental disorders in the East (Botros et al., 2006). Krendl and Pescosolido (2020) explain that prejudice-related behaviour in the East can be due to the moral attributions of the illness, like spiritual implications, linking the condition to an individual's past deeds. As a result, social judgments may more strongly impact other areas of life, such as close relationships. Birtel and Mitchell (2022) suggest that fear of losing close relationships exists among people who belong to more stigmatising societies, which are common in Eastern nations. Due to apprehension regarding adverse effects on relationships, individuals in the East may tend to refrain from seeking help or hesitate to disclose their problems to close ones. Hence, due to the labels that exist in society, in order to maintain a "respectable" social image and protect social relationships, individuals might avoid getting diagnosed or seeking professional help.

Negative stereotyping or false perceptions, also lead to negative treatment in social interactions. Sibicky and Dovidio (1986) discuss that when patients undertake psychological therapy for mental illnesses, other individuals have a preconceived notion that affects their social interactions with the patient. The participants of their experiment were randomly divided into two groups, targets and perceivers. The perceivers were told that their conversational partners that is, the targets, were either just psychology students or were recruited based on students seeking psychological therapy. The perceivers who thought their conversational partners (targets) were seeking therapy, rated them as less favourable when they interacted. The findings on social reactions to seeking treatment suggest that the stereotypes associated with depression can and do in fact influence social relationships (Sibicky & Dovidio, 1986).

Furthermore, women's susceptibility to depression can be linked to relational stressors, as discussed by Vlassoff (1994), who underscores the impact of familial dynamics, and Parry (2000), who addresses post-partum depression. These studies emphasize the significance of relational stressors in increasing the risk of depression among women. Das et al. (2018) indicates that women facing increased susceptibility to depression face different challenges in seeking assistance, possibly due to societal or personal barriers which might come from familial relationships.

Relational Consequences of Treatment-Seeking

Depression often leads to range of behaviours which can significantly impact individuals' abilities to meet societal expectations and sustain relationships. The symptoms of depression, such as apathy (Lanctot et al., 2023), lethargy (Targum & Fava, 2011), mood swings (Bowen et al., 2017), or even heightened aggression (Sahu et al., 2014), can disrupt established relational and societal norms. Depression can affect families of the patients as well. For instance, as reported by Ringoot et al. (2015) parents that are diagnosed with depression might struggle to bond with their children. Similarly, children diagnosed with depression can cause distress for parents due to worrying about their health and school performances. In order to maintain healthy relationships while diagnosed with depression, it is vital to create a treatment plan which is supported by the people the patient surrounds themselves with.

Within a Family Context

In order to tackle depression, Trivedi and Jilani (2011) suggest that there needs to be effective social support (e.g., from family) for diagnosed individuals. If women are displaying “too much” emotion or if they are seen to be rebellious or arrogant, it is largely criticized by family and friends (Trivedi & Jilani, 2011). Hence, the symptoms of depression are oftentimes not approached with care. Specifically, in many Asian cultures, it is mandated that a woman’s behaviour emphasises emotional self-control (Murata et al., 2013). This means that women are often encouraged or expected to display control over their emotions as well as a sense of calmness and self-control in their interactions and expressions. Asian women in general are expected to maintain a composed and restrained demeanour even when they are emotionally feeling low; they are expected to refrain from burdening others with their personal problems (Link & Phelan, 2001) which can impact private and professional lives.

In familial relationships, women with mental disorders may be unable to fulfil their prescribed social roles, which might lead to resentment or frustration within relationships (Schuster et al., 1990). Gender roles or prescriptions assign socially desirable traits to women, such as a good mother, daughter, sister, or child-carer (Lindsey, 2020). Thus, people react negatively to counter-stereotypical behaviour (Phelan & Rudman, 2010), which is portraying symptoms of a mental disorder. This is because of the expectations of the society which are explained by the social structural approach (as discussed by Prentice & Carranza, 2002) which suggests that as long as men are dependent on women for domestic and child-care responsibilities, the prescriptive gender stereotype of women cannot change. Hence, people expect women to live up to these social expectations created by society, which we think would also encourage reluctance to being diagnosed with any mental disorders.

Being diagnosed with depression can create strained relationships. It can be said that the factors that cause this stress on a relationship stem from a lack of understanding of the illness and the challenge of providing sufficient support (Hamedani et al., 2023). When the illness is largely stigmatised, these challenges only become worse and it has an adverse effect on the well-being of the individual (Raj et al., 2022). In countries like India, past research showed that support for depression was provided by traditional methods (Trivedi & Jilani, 2011), such as taking the depressed person to traditional healers (Trivedi & Sethi, 1979). Thus, family support that the person required was limited in developing countries like India. It is also possible that limited resources could lead to a substantial burden on family members and strained relationships as people would not receive appropriate treatment. However, with growing awareness limited urban populations, Raj and his colleagues (2022) note that the number of initial contacts with traditional or native healers in India has decreased among urban populations and a significant proportion of patients seek help from psychiatric care providers.

Within a Spouse Relational Context

A diagnosis of depression can also lead to significant distress within a marital relationship, evoking feelings of anxiety, guilt, and even resentment (Antoine et al., 2018). This was noted due to the consequences of increasing emotional shifts and lifestyle patterns when the individual is married. Not only the depressed person but the individual living with the depressed person, like a romantic partner, is also linked with developing psychological distress which can lead to marital strain (Rosand et al., 2012). The spousal relationship alters for both the partners, even when partners report high levels of commitment, they also describe high levels of loneliness and personal unrest which leads to marital instability (Lawn & McMahon, 2014; Checton et al., 2015). Communal societies like India tend to approach depression in a marriage by providing support from extended family (Avasthi, 2010). Therefore, it can be said that relationship satisfaction takes a toll on both individuals and leads to difficulties beyond the individual couple and within the wider social network.

Marital adjustment and degree of satisfaction with the spouse in the marriage are also linked to depression among women (Shek, 1995); that is, lower satisfaction and marital adjustment increase risk for the development of depression. Bernard’s theory (1976) and Fowers’ (1991) study show that marriages are more favourable to men than women. This might be due to economic disparities, where men are paid more than women or according to traditional gender norms, men are dominating women in the decision-making process of the household and women take on larger share of responsibilities which affects her overall well-being. Glenn (1975) reports that men indicate more happiness and satisfaction than women in marriage. Due to lower satisfaction, women are also more likely to report mood disorders than men (Glenn, 1975). Furthermore, the gap in mood disorders, such as depression, between men and women can be attributed in part to gender roles of married women in different cultures. Fowers (1991) found that Chinese married women are more likely to be depressed as compared to married men. This could be due to the traditional female role in marital relationships in China, which is more stressful and disadvantaging for women than men (Fowers, 1991), as women are expected to take care of the household and prioritise other family members over themselves, which might also lead to ignoring medical assistance when needed (Shek, 1995). Married women in many Western countries are more autonomous as compared to women in Eastern countries, which gives them more power to prioritise themselves over other members of the family (Shek, 1995).

Within a Colleague Relational Context

In the workplace, employees may encounter a range of issues at work, including high demands, challenging relationships, bullying, harassment, and a hostile work environment, over which they have little control and receive low support for coping (Tennant, 2001). The way people interact at work is strongly patterned by these social characteristics. Within an organization, interactions occur not only amongst individuals but also collectively, where close-knit group formation and isolation of others are a common phenomenon (Colligan & Higgins, 2006). Such social patterns can be difficult to navigate for a person with depression. Apprehension about how discussing depression at work might impact one's professional image or career advancement due to the stigma associated with mental illnesses that exists in the workplace is common (Phelan & Rudman, 2010). Being diagnosed with depression might imply decreased energy, motivation, and concentration, all of which are needed for productivity at work (Colligan & Higgins, 2006). Therefore, people who are diagnosed are likely to be afraid to discuss their depression treatment at work because they are afraid to be dismissed from their jobs or that they would not be taken seriously by others at work (Farina & Felner, 1973; Phelan & Link, 2004). Results from Manning and White (1995) suggested that 54% of employers were unwilling to hire a person with a diagnosis of a mental illness. The fear of being perceived negatively or being treated differently by colleagues, which can affect work relationships, can contribute to lower intentions of treatment-seeking for depression.

The Present Research

The aim of the present research was to compare how the fear of relational impact between British and Indian women who were born and are currently living in the UK or India affects treatment-seeking for depression. The first study used a semi-structured interview methodology to answer the question, how does the fear of the relational impact of diagnosis with depression look among women from India and the UK and how does it impact treatment-seeking behaviour? The second study took this further to quantitatively test a novel model to explain different rates of treatment seeking in the UK and India by linking fear of relational consequences to treatment seeking in the two countries (See Figure 1).

Figure 1

Conceptual model tested in Study 2

Positionality

I am a married Indian cisgender woman. Regarding my supervisors, DD is a gay cisgender man from the United States and MB identifies as a Portuguese cisgender woman. Both DD and MB lived and worked in the UK for several years at the time of this research. Members of the team have lived experience with depression, as well as with depression in their family members. In terms of research experience, both DD and MB have conducted qualitative and quantitative research on the social experiences, relationships, and identities involving members of marginalized social groups. These identities place us in a specific position in relation to the research question and the data, which we acknowledge might influence our interpretations.

Method

Design

The current study explored different responses to depression and treatment-seeking stemming from an individual's relationship experiences and aimed to elucidate perceptions of societal and relational norms that might have influenced treatment-seeking among women in the UK and India.

Participants

We recruited a total of 16 participants, of which 10 participants were from the UK and 6 were from India. The inclusion criteria were that participants, had to be born and be living as a resident either in the UK or in India, be 18 years of age or above, and had to be receiving treatment for depression. The inclusion criteria were provided through the research advertisement, which was used for recruiting the participants. All participants completed demographics forms online, where they indicated their age, current city of residence, country of birth, history of mental health prevalence, type of treatment-seeking, contact of mental health service provider, education level, Socio-Economic Status (SES), relationship, and employment status (refer to full wording of all demographic questions in Appendix C). The participant's age range was from 22 to 32 years of age (see Table 1 for detailed characteristics of the sample). Following the completion of the interview, participants were rewarded with a £12 Amazon voucher for their participation.

Table 1

Demographics of the Indian and British participants for study 1

Participant No.	Age	Treatment type	SES	Education level	Relationship Status	Employment Status
			UK participants			
1.	23	Medication + Therapy	Medium	Higher	Single	Employed
2.	22	Therapy	Medium	Higher	Married	Student
3.	23	Therapy	Medium	Higher	Dating	Employed
4.	27	Therapy	Low	Further	Single	Employed
5.	26	Medication + Therapy	Medium	Higher	Dating	Employed
6.	26	Medication + Therapy	Medium	Further	Single	Unemployed
7.	27	Therapy	Medium	Higher	Dating	Employed
8.	27	Therapy	Medium	Higher	Single	Employed
9.	30	Therapy	Medium	Higher	Married	Employed
10.	27	Therapy	Medium	Higher	Single	Employed
			Indian participants			
11.	22	Therapy	High	Higher	Single	Student

12.	25	Medication + Therapy	High	Higher	Single	Unemployed
13.	30	Therapy	Medium	Further	Married	Unemployed
14.	32	Therapy	High	Higher	Married	Unemployed
15.	25	Therapy	Low	Higher	Single	Student
16.	29	Therapy	High	Further	Married	Unemployed

Note. The table indicates the responses as self-reported by participants. Refer to Appendix C for full wording of demographic questions and answer option.

Procedure

All procedures used in this research were reviewed and approved by the Psychology Research Ethics Committee at the University of Exeter (Ethics Application Reference no. 517021). The research advertisement (Appendix A) was circulated to support groups (Meet up), mental health organisations (Women's Wellbeing Club and Mind in the UK, EHSAAS Centre for Psychiatric Care and Tejas Shah's Healing Studio in India) and on social media (Twitter, Instagram, and Facebook) in order to recruit women who were currently being treated for depression. Participants who were interested in the study sent an email to the researcher sharing their interest in participation. The researcher then arranged a time for the online interview and sent the participant a link for the scheduled time by email. Interviews were scheduled with all women who expressed interest in participating and met the inclusion criteria—no additional screening for depression was used. This was followed by an information and consent sheet (Appendix B) which was signed by the participants prior to the interview. The information sheet also stated the inclusion criteria. The demographic form was rechecked by the researcher before starting the interview to check eligibility and the presence of an emergency contact in case the individual disclosed any intentions to harm themselves or others. The interview was conducted online, and it was an audio call on either of these platforms, Microsoft Teams or Facetime or Zoom.

Before starting to record the interview, the researcher reconfirmed the participant fulfilled the inclusion criteria and took a verbal consent from the participant of the study. The topics and the questions asked to the participant were designed to elicit their perceptions of their relationship with others before and during the treatment of depression. For example, to elicit their experiences of how they felt before seeking treatment, they were asked, *"Did you have any concerns as to how people would react to you seeking treatment?"* Participants who indicated having concerns were further asked questions about what the concerns were. To understand the relationship changes they may have experienced, participants were asked, *"How was it for your partner to know that you have been diagnosed and you are willing to start with treatment?"* Additionally, they were asked the type of symptoms they were experiencing and the kind of help or the type of treatment they sought (for e.g., *"Did you seek any formal type of treatment for depression, and can you tell me about that?*"). The complete question set can be found in Appendix C.

Data Analysis

Based on limited previous research on the relationship of stigma associated with mental illnesses and treatment-seeking attitudes (Sheikh & Furnham, 2000; Cauce et al., 2002; Picco et al., 2016), an inductive thematic analysis approach was chosen for the current study. This is a widely used method to identify, describe, and report patterns within a qualitative data set (Braun & Clarke, 2006). First, all transcripts were transferred to the NVivo software. Familiarization with the transcripts consisted of reading transcripts and making preliminary notes. The initial codes were highlighted and organised in NVivo, by researcher JJ. Codes stored information about patient's depression symptoms and type of treatment they were undergoing. Moving forward, codes were given descriptives of participant's experiences or what the researcher inferred from the statements made by the participants. Initially, codes were grouped into broader categories based on similarities or patterns observed within and across the data from the UK and India. The data was analysed comparatively between the two countries. JJ compared similarities and differences in the broader themes and highlighted any evident contrasting experiences shared by women from each country. The supervisors, DD and MB, read part of the transcripts and the initial classification, and provided feedback to JJ to improve the identified themes. A sub-theme analysis within each country and across country was done where we examined differences and similarities based on demographic factors (such as, age, socioeconomic, employment and marital status). JJ generated examples for each theme, which were discussed among the research team and in a presentation to the supervisors' wider research group. The members of this group provided some feedback and input on categorisation and explanation of each theme for each code. The codes and themes were iteratively reviewed by the research supervisors (DD and MB) multiple times.

Study 1

In this qualitative study, our primary objective was to explore and delineate the multiple factors and aspects of fear of relational impact experienced by women diagnosed with depression, particularly researching the question of what specific facets of such fear exist within different cultures and how they impact treatment-seeking intentions.

Results

We identified five overarching themes in the data: 1) Stigmatizing Views of Depression; 2) Lack of Understanding of Causes and Treatment Options; 3) Ambivalence in Familial Responses to Diagnosis; 4) Impact of Diagnosis and Treatment on Extended Family; and 5) Social Detachment as a Result of Being Treated Differently. The fear of relational impact and how people react to seeking treatment for depression were observed across all themes (Table 2).

Table 2

Themes and descriptions

Identified themes	**Description**
Stigmatizing Views of Depression	Women who are diagnosed with depression may worry about stigmatization, which might affect their identity. Women who disclose their illness to others may also experience judgmental reactions and straining relationships because of social stigma.
Lack of Understanding of Causes and Treatment Options	People frequently have misconceptions regarding the nature of depression, with some incorrectly equating it with momentary sadness or lack of willpower while ignoring its complex and multilayered nature.
Ambivalence in Familial Responses to Diagnosis	The conflict between providing support and ingrained cultural beliefs, which can be stigmatizing, reflects the ambivalence with which people in the social network view depression and how to support others.
Impact of Diagnosis and Treatment on Extended Family	Individuals may sense a lack of empathy from family and friends upon diagnosis, potentially leading to gossip within networks. New acquaintances might be reluctant to forge new relationships

	and experience guilt and shame regarding relationships that already exist.
Social Detachment as a Result of Being Treated Differently	The diagnosis creates societal stigma and negative perceptions within other people of the society, which in turn cause the person with depression to fear exclusion from social gatherings.

Stigmatizing Views of Depression

Participants from both countries expressed feeling social pressure regarding their diagnosis and shared their thoughts and experiences when discussing their condition with others. While both groups expressed some discomfort in discussing their diagnosis, Indian participants were relatively more hesitant than British participants to talk about their diagnosis and treatment with others. British participants showed somewhat lower concerns about the societal acceptance of depression compared to their Indian counterparts. Nevertheless, participants from both cultures to some extent discussed their experiences of being labelled, stereotyped, and distanced from because of their diagnosis.

Mostly individuals from India reported that they felt frustrated with their family's reactions to the diagnosis. One participant from India stated: *"She [mother] is thinking it is an attention seeking problem"* (participant 14). This statement reflects the imposition of a dismissive and invalidating label, which might impact the participant's wellbeing and relationship to the person imposing the label. A similar observation was made among British participants, for example, participant 1 explained:

> *You know when someone would be like, okay so, when you are like trying to talk about it, so you are like, you were depressed a while ago, did you see a shrink, you know like that. I think I was more afraid of that tag. I did not want it to come up in conversations with people. You know, when friends are talking, and it comes up in conversations. (P 1)*

Here we can see that a British participant could also fear a biased response from their community which might stop them from sharing information with others. Therefore, participants in both countries mentioned how people's responses to their disclosure of depression involved labels.

Alongside labels, participants from both countries discussed the judgements that they received from people when they shared their diagnosis and treatments. One British participant (5) felt that *"[I] have that fear that they would not understand, which is horrible because they might reason more things, but it is that idea that it might be seen as a weakness [in me]"*. This participant is therefore highlighting the fear that a judgement might be made of her character (as weak) and hence, she might not want to disclose her diagnosis to others. Other British participants also mentioned the fear that others would judge them as incompetent and specifically reflected on the impact this might have at work. For example, participant 5 (British) reported, "*I never would want my workplace to know. I wouldn't want my manager to know or co-workers like that."* The fear of being renounced from their work duties can also be the reason for which depressed people might hide their diagnosis from people. Participants from India who were either students or unemployed, tend to refer less to competence and more to how the judgement from others commonly revolved around woman's abilities to fulfil traditional gender roles, such as their eligibility for marriage or their capacity to take care of other members in the family. For example, participant 14 (Indian), felt that *"she told me that, don't go to a therapist. And before my marriage, also, I had this problem once, so that time also my mother told me, don't tell anybody as there will be some problem with getting married."* Here the participant suggests that the people around the depressed person might stop them from seeking treatment as they would not like to tarnish their societal image, especially before the girl is married.

Moreover, judgmental attitudes have contributed to the development of various negative stereotypes (sometimes internalized) that are associated with individuals experiencing mental illness. For example, participant 16 (India) reported that people say psychiatric treatment of depression is something that does not exist for those who are within a "normal" range of functioning:

> *It is a common thing that people say that- a psychologist or a psychiatrist is someone that only mad people go to. So that was the thing, even if I talk or want to talk about it, they just*

> *say, "no no there is nothing like this or nothing like this exists". That is what I am told. (P 16)*

A similar statement was made by participant 14 (Indian) who discussed, *"They [family] are judgmental and maybe they will think she [the woman who is depressed] is mental".* The judgmental statements that others make for depressed individual suggest a stigmatising view of depression within a community. This reflects a common theme of external and internal attributions in the face of dealing with judgemental attitudes of people.

Additionally, participants also discussed how people perceived the causes of their depression. Some British and Indian participants reported that others perceived the cause of their illness to be related to their family, whilst others reported perceptions that the cause was linked to the self. For instance, participant 10 (British) reported:

> *Most people [at work] are quite judgemental. Most people are like, the reason why you are depressed [death of a sibling] is not even worth it. Most persons see it as petty; I don't know, in general, I felt everyone's going to be, or some persons are going to be judgemental. (P 10)*

Upon asking in what ways participant 10 thought people were going to judge her, she said "*she's [the participant] supposed to get over it [death of a sibling] and what's there to dwell, it's not that serious after all. Those people [at work] ... people say, people go through worse than that, so why is she different."* In the participant's narrative, there lies an underlying sentiment of people dismissing the reason for depression due to the prevailing stigma in the society. The overarching message of this statement is that the prevailing attitude of others suggested that the circumstances of depression were not deemed serious enough to warrant such emotional distress.

It is also important to note that even though there were stigmatising views of others noted by participant 10, she also reported that her family was supportive. This suggests that the societal labels can cause distress, but the support from family also helps sought treatment effectively.

> *I was actually hoping that whatever effect that comes with therapy sessions should be positive, so I didn't think there would be any negative effect… I felt like after a few of my therapy sessions I just got better and everyone in the family was really supportive. And they didn't treat me in some kind of different way, I was really treated the same way and I felt really well. (P 10)*

Participants also discussed their own opinions on what they thought could be the cause of their depression. For instance, participant 13 (Indian), discussed how internal issues with the family must have caused depression for her, saying:

> *So, I think I got married and everything was okay like the family is nice and everything, but I have always lived in a small family, so you know the expectation that comes with a big family so that was a little troubling and then my husband was having some money issues also, so I have never faced that so maybe because of that. So yeah, this is it. (P 13)*

The findings suggest that there is a tendency to identify mental health struggles as something that is unacceptable or seen as undesirable, especially within the close-knit family environment where conformity to traditional values is highly regarded. This perception can create pressure for individuals to withhold or hide their mental health challenges, fearing that it might not align with the assumed norms within their family context. One such example is where Indian participant 13 talked about how she did not want to inform the rest of the family of her seeking therapy by herself, instead doing so through her husband. Participant 13 said:

> *I don't know how they [family] would react, no? because now like my husband sat and told everybody and they understand, but I cannot sit and talk to everybody about this is normal and this is nothing. This, I don't want to take that stress, not now. (P 13)*

Due to the nature of the illness and the stigma around it, the husband tried to explain to them the nature of the illness. Whilst British participant 8 stated that, *"They [family] didn't react much because they knew what I was going through. I just felt like most of them would've wanted me to get well. Get better."* Here we see that participant 8 experienced a better attitude from her family towards her getting treatment for the illness and this was probably due to better understanding of the illness (in the UK). In addition to this, she also reported that she wanted to get better for them. Whereas participant 13 (India) had reported that she wanted to feel better for herself, and she said, *"for me I just want to be happy in my life. I want to be mentally strong so that I can live peacefully maybe. If that can happen, then I think I will be successful."* Hence, the way depression is perceived by the participant herself also differed across participants residing in other countries.

Furthermore, in many instances Indian women would mention fear of blame from their mothers due to the lack of understanding of the illness. For instance, participant 16 said, "*In fact, today also if I tell my mother, that I take therapy sessions, she will say it is all a waste and there is nothing like this. Just divert your mind*." The statement quoted portrays a belief that depression can be easily overcome by diverting one's attention rather than seeking professional help. The response highlights the prevalence of stigma and misconceptions surrounding depression. Hence, it is the deep-rooted cultural attitude that lacks recognition of valid treatments for depression and undermines health care overall. A similar statement was recorded by British participant 5, where she said, "*I was really worried that my current partner would think that 'oh you are doing this only for attention', or like 'you are trying to this to manipulate me.*" The fear of misinterpretation in this quote, like the previous quote by Indian participant 16 shows that the participant's=worry to address depression might be misunderstood and might exacerbate their mental health struggles and strain close relationships.

Lack of Understanding of Causes and Treatment Options

An extension of fear of judgement (stigma) encompassed concerns regarding the misconceptions surrounding the causes and treatment procedures associated with depression. From previous research, it was suggested that the misunderstanding is usually the result of stereotypes and the lack of knowledge of mental illnesses among people. Both groups of participants discussed how people offered well-intentioned but misguided suggestions regarding dealing with depression. Thus, limited knowledge of depression made participants from India and the UK feel the repercussions of stigma in their everyday life.

Some participants from both groups stated that '*others would not understand what they are going through.*' This sentiment expressed by the participants highlights a common theme observed within both cultures, which is the fear of being misunderstood. This suggests a perception of lack of empathy from external individuals or group of people towards the depressed person. This could indicate that the depressed individual feels a sense of isolation or disconnect as they perceive that those around them may not understand the depth of their experiences of undergoing depression. For example, upon asking participant 15 (Indian) how people reacted to her diagnosis, she reported:

> *My friends have sometime suggested that one can just listen to music if they think that they are feeling sad and my mother, because she thought I was doing it to gain attention from boys, so she would just tell me to read religious books. (P 15)*

Here we see the narrative by participant 15 suggests that without adequate knowledge of the nuances of depression, the depressed person might take a misinformed decision for treatment. Listening to music can be a good activity to do if the person is depressed, but here the participant's statement has a negative undertone which suggests that the individual perceives a lack of awareness around her and interprets that people are not able to fathom the depth of the individual's emotional experience. The suggestion to read religious books can be seen as an alternative that may suggest a mother's attempt to redirect the participant's focus from depression to something else. This also indicates a cultural influence in the understanding of depression as it is commonly noted in previous literature that Easterners tend to link traditional alternatives to mental illnesses. British participants also reported that people around them misperceived depression and its symptoms. For instance, participant 6 said, *"Other people thought I have sick[ness] of attention, others thought I am mentally broken. Like I am not fit to make decisions and I am not [fit]… to a point [they were] criticizing my judgements* *[decisions]."* Thus, participants in both countries noted a misunderstanding of depression, albeit in slightly different ways. Whilst Indian participants referred to dismissal of symptoms, British participants referred more often to how depression was seen to taint their individual capacities.

Ambivalence in Familial Responses to Diagnosis

The perceptions of depression reported by participants from both countries showcased a spectrum of reactions from immediate family (such as, parents, siblings, and spouses), covering both positive and negative elements. Participants sharing their experience of diagnosis varied depending on the sort of relational partner (e.g., mother, husband, or boyfriend). From what the participants reported, different relational partners exhibited diverse responses (such as, hope, fear, guilt, frustration) towards them that either fostered a reassuring environment or contributed to a further challenging situation. The differences between the responses evoked by various sorts of relationships are highlighted in this section. Some participants reported that they were uncomfortable to share their experiences with their family, and some participants were happy that they could share their experiences of being diagnosed with depression and sharing their intentions of treatment-seeking with family. In this study, participants who could not openly talk about depression with other members of the family were desperate to feel better and were afraid to lose their relationships in this battle of feeling better. Therefore, it can be said that within non-supportive systems, getting diagnosed with a mental illness can often lead to a sense of fear of relational break down. One such example is the following: participant 15 (Indian) reported her experience of conflicting responses when she wanted to talk to her family about her treatment:

> *But they [family] would never respond to it [her experience of therapy sessions], they still don't respond to it, in a positive manner. So, when I try to sit with them and talk about it, they would just change the topic and turn on the television and just keep looking into the television instead of listening to me. (P15)*

The statement by participant 15 shows the family's consistent lack of positive response despite the participant's attempt to draw attention to their conversation. On one hand there is an avoidance of the topic by the family members by changing the subject, on the other hand, the depressed person's persistent effort to talk about her experiences of depression. This reflects a desire for understanding and support from the family by the participant, but the avoidance response of the family contradicts familial support by disengaging and not providing emotional support to the depressed individual. This dynamic represents the ambivalence in familial responses that oscillates between avoidance and the desire for effective communication during the period of undergoing therapy sessions. Another example following familial support was, participant 11 (Indian), described her internal conflict of seeking therapy. Participant 11 reported:

> *I did want support and I did want people to understand. And by people, I mean I mean people close to me. So, I wanted my loved ones to understand how I felt so I did want their support and I felt like it might not be there, so I did refrain from considering proper therapy as an option for a very long time. (P 11)*

Here we see that the desire for emotional support from family but as there was uncertainty regarding whether the participant would be offered the level of understanding and assistance, she sought help after a period. The ambivalence lies in the conflict between the desire for family support and the realisation of the lack of support over a period. Hence, this influenced the individual's decision-making process of seeking support.

There are individuals with depression who are developing a positive outlook when their close relationships are open to communication and understanding. This is noted through the British participant who also reported that they were glad that their partners knew that they had been diagnosed with depression; it had improved their conversation styles and the treatment had worked in improving their relationship. As participant 7 (British) stated:

> *I feel very comfortable and grateful at some point because I think he [partner] is the only person that fully understands what I was going through at that time. My therapist understands me but also it is her [therapist] job to do that. Well, he [partner] showed more concern and affection so that has really helped me. (P 7)*

In this narrative, the participant shows contrasting perspectives, that is, while the therapist also assists the individual to overcome depression, the partner's support is received with a sense of comfort and gratitude. Hence, the emotional support and empathy from the partner regardless of therapy plays a significant role in the well-being of the depressed person.

Furthermore, very few Indian participants reported that the treatment had any positive relational effects. Instead, they highlighted potential negative effects on their relationships. An example of this finding is that participant 16 (Indian) reported that she was first hesitant to tell her family that she was undergoing treatment, but when she finally told them, the family did not take it well, as quoted by the participant "*I told them I am going for therapy and everything. They were taken aback. They were like why are you wasting money? There is no need of it. These things are just myths."* It can be said that the reactions of other people around her, particularly of family members, may have created a direct negative effect within her social relationships. Such reactions are observed as a common reason for diagnosed individuals to refrain from communicating their emotional struggles.

Impact of Diagnosis and Treatment on Extended Family

This theme primarily relates to the wider effects of a diagnosis and treatment on the individual's extended family unit. It digs deeper into how a diagnosis affects not only the immediate family but also the relatives and close friends. The topics discussed in this theme look at the potential societal stigma and consequences associated with disclosing their diagnosis to their extended family. For instance, participant 16 (Indian) said,

> "*If my extended family gets to know then I think I will not be invited to any family event. I don't think people would want me in their house. Plus, other thing is, in our culture how marriage is so important and if people get to know this then I don't think anybody would want to marry me. Let alone me, people would not want to get associated with the family because that's what I have heard from my parents, and it will just make like difficult for me and my entire family. So why put my cousins and everybody at risk of shame from the society". (P 15)*

This narrative reflects the societal pressure and importance placed on marriage. It also suggests the fear of shame that might attach to the family that plays a significant role in the participant's decision to seek treatment. This interpretation also highlights the deep-rooted concern of social backlash associated with mental health conditions within the Indian culture. Therefore, to avoid outcomes where participants could be held accountable for embarrassing the family, they worry over their diagnosis and might want to avoid treatment as it could negatively impact their extended familial ties.

Additionally, sharing the news of diagnosis with extended family can seem to invade privacy and autonomy regarding personal feelings. Participant 11 (Indian) distinguishes between the close relationships and her extended family, reported as:

> *"I would probably need to justify myself and my actions, every single time. And I guess I just don't want that assumptions when it comes to anything that I do, especially from extended family and friends because they are not going to be around all the time and they are not going to understand my feelings as nicely as people who are close to me because I wouldn't be able to communicate it with them all the time or I might not wish to do so I just don't want them to be aware that I am depressed because I think it is very personal to my feelings." (P 11)*

This desire for privacy as mentioned by participant 11 stems from various factors, one being the need to protect her emotional well-being and avoid judgments from acquaintances. The individual implies through her statement, "*they are not going to understand my feelings as nicely as people who are close to me"* that people who are close to her will have a deeper understanding of the illness. From the narrative by participant 11 we can infer that the closeness allows the depressed individuals to openly communicate personal emotions. It can be assumed that the depth of understanding of the individual's feelings are due to the nature of the relationship and limited interactions with the extended family. Similarly, participant 7 (British) hints the emotional burden of explaining her circumstances of depression to her extended family. Participant 7 stated:

> *"I would say most of them will not understand what I am going through. They will not understand how that affected your life and affected my family. So going through the process of explaining my thing to my [extended] family it's a bit annoying." (P 7)*

The statement reflects an annoyance which suggests a desire that the extended family of the participant to acknowledge the impact of diagnosis without the need for the participant to get into extensive explanation. Through the feelings of emotional burden suggested by the participant, we can infer that there might be potential disconnection within relationships of the depressed person and extended family after diagnosis of depression.

Furthermore, some participants reported concerns about burdening their family or partner because of their illness. For instance, participant 3 (British) expressed her concern of not wanting her partner to worry too much about her, "*He has to constantly check up on you to make sure you are alright, so I just feel like a burden even if he doesn't feel that way*." Indian participants also reported similar sentiments to participant 3 about being a burden on others. Participant 13 (Indian) said, *"there is no extra burden on me, or I don't put that burden on my husband or anybody in the family anymore…"*. When an individual faces stigma, it is observed that they begin to feel like a burden and therefore either internalise these struggles or seek therapy. That is, professional help was sought by participant 13 to shield their family relationships from the negative perception associated with the diagnosis. In addition to feeling burdened, another Indian participant reported feeling disheartened when she sought treatment. Participant 16 (Indian) reported that not telling the partner was an extremely upsetting feeling, as she said, "*I feel horrible, it's very… it feels bad because the one person you expect to be with you, isn't there and it just feels bad."* Unlike the quote by participant 3, here we see treatment-seeking did not work for the betterment of participant 16's relationship. Hence, we can see that in some instances women noted concerns that seeking treatment might negatively impact their close relationships.

However, regardless of self-perception and public perception of the diagnosis and treatment-seeking, there were also positive effects of treatment-seeking that were extensively discussed by all participants, especially by the British participants. All British participants, apart from one, reported that they were glad that they were diagnosed as this gave them more clarity on their own situation. Most of the British participants reported that their family was aware of them undertaking treatment for depression, which was a positive experience for the individual. For example, participant 5 (British) was happy that she was able to seek help as that had a positive effect on her relationship, saying:

> *Having spoken to my partner about it, it did definitely bring us closer together and actually right now he has been on anti-depressants as well and that is only because we have had those discussions and we talked about it, and he could see how they were affecting me. (P 5)*

This statement emphasizes the positive impact of communication and support within a relationship whilst undergoing treatment. The mutual support reported here shows the importance of addressing mental health concerns which can contribute positively to the relationship dynamics and potentially reduce barriers to seeking professional help within a family unit.

Moreover, participants who already had a diagnosis of depression in their family were open to the idea of sharing their experiences with extended family and did not report any signs of hesitation to seek treatment. Therapy was thus seen as a good thing. Referring to her relative's prior diagnosis, participant 12 (Indian) said, "*If anything it just made us a family that was more open in terms of conversations."* The statement suggests a positive outcome in terms of increased open communication within their family. Due to the awareness of depression within the family facilitated a positive experience of seeking treatment and contributing to a supportive environment for the depressed individual. Similarly, upon asking participant 8 (British) whether she felt supported by her extended family, she responded saying, *"I am actually very happy as it saves me a lot of stress and I feel accepted."* The statement implies happiness and relief of not having to hide it from their extended family. This goes to suggest that when families are informed and accepting of the illness, it allows open communication which contributes to reduced stress and feelings of acceptance when the individual is undergoing treatment.

Social Detachment as a Result of Being Treated Differently

People diagnosed with depression often feel treated differently from others who are not diagnosed, a phenomenon that can easily lead to social detachment. The findings show different factors beyond stigma that could also be related to feeling socially detached, such as loss of interest, negative thought patterns, lack of energy, and difficulty in communication. In addition, the convictions held by others in society can often impact patient's perception of their own illness, particularly being on the receiving end of societal distancing. The findings of the study suggest that negative feedback from family, friends or co-workers creates a sense of worry in participants from both countries in terms of their social lives.

Participants from Britain and India discussed the behaviour patterns of people when they hear about the diagnosis. For instance, participant 13 (Indian) felt that if friends knew about her illness, they would tell others, which eventually would become a topic of gossip. She said, *"it is like sometime if I tell my friend and they understand but if they will meet so many people and they try to tell that 'She has some problem' so I am not comfortable telling people yet."* Here this statement suggests that, to refrain from being a topic of gossip, it is better to not share your experiences with others. Hence, the participant chooses to have fewer social interactions or desires a certain level of social detachment. On the other hand, although British participants reported feelings of distrust of telling others, they did not report any concerns regarding being a topic of gossip.

Furthermore, for most participants the concerns of social detachment were accompanied by the fear of being treated differently. Indian and British participants expressed concerns about not wanting to be treated differently due to their diagnosis. For instance, participant 15 (Indian) conveyed reservations and distrust in seeking a diagnosis because of the apprehension that disclosing her condition might result in a lack of support from others. She said, *"If I talk to my friends, some try to understand but some try to make fun of it and I don't know if this is a dismissal tactic or they really don't understand but people don't really want to talk about it."* This fear of disclosure, rooted in the anticipation of becoming a subject of gossip, often leads to a desire to maintain distance from those aware of the diagnosis, leading to a sense of social detachment from others. However, British participants mentioned the same emotion in a different context; it was mostly less about how their family treats them, but it was more about how they wouldn't want people at work to know as they could treat them differently. For instance, participant 5 reported:

> *I never would want my workplace to know. I wouldn't my manager to know or co-workers like that… Yeah, definitely I would only tell a selected few, like close friends, my partner, and a medical professional or like yourself for this research study. (P 5)*

The narrative here suggests that the reluctance to share mental health information with colleagues might be due to the fear of potential negative relationships with them. In order to avoid social detachment and increase inclusivity, the participant demonstrated this feeling through the intentional separation of diagnosis of depression from the professional life. The boundary-setting within workplace can be seen as a method to maintain a perceived sense of social protection from being isolated. These findings suggest that women from Britain might be more likely to be worried about professional setbacks even when their mental health is at stake. On the other hand, the results suggest that Indian women might worry about their close relationships and how others might have an opinion about life choices.

British participants also described a concern for social gatherings, with participant 5 (British) saying: *"Also, with friends I didn't want to show the typical kind of depression signs and, you don't want to become like a burden, like a thing. I didn't want to talk about it either."* Another participant (9, British) talked about how her friends are staying away from her: *"well, they were saying things like, she was going crazy, she's overreacting and other stuff."* Because of these judgements, the participant thinks she would not be invited for social events: *"They would not invite me in any way because they would think that I am crazy."* This thematic element of wanting to be included in social gatherings suggest that other people in the society might display stigmatised behaviour towards a depressed person. Hence, the sense of isolation might be suggested as a concern for depressed persons.

Discussion

This study explored the concerns of women living in the UK and in India have about been diagnosed with depression, including, specifically, its relational impact. Women in both countries expressed concerns about strained relationships, social stigma leading to social withdrawal, and potential role changes within familial or partner relationships. The results showed that fear also leads to worries about poor communication within relationships, dependency concerns, and trust issues, emphasizing the complex ways in which a depression diagnosis might affect various relationships in both cultural contexts. Additionally, reports on other people's reactions to the participant's diagnosis sheds valuable insights on the factors that either supported or discouraged their pursuit of treatment. Both sets of participants mostly reported that treatment motivation was found within themselves but also with the help of family support. Where family support was lacking, the participant reported challenges such as participants struggled with communicating their emotions with family members of undertaking therapy.

The stigma associated with depression significantly influenced the experiences of individuals undergoing treatment. Specifically, Indian participants predominantly faced stigma from their families, while British participants also experienced it from colleagues. Notably, all Indian participants were either unemployed or students, whereas some employed British participants articulated concerns regarding their interactions with colleagues. Relationships such as with friends and mothers played a significant role in affirming and bolstering treatment-seeking behaviour among both sets of participants. Such supportive relationships as noted in this study were comparable to the study conducted by Lindsey, Joe and Nebbitt (2010). Their research discussed the stigma of depression among African American adolescent boys. They reported that social support served as a shielding factor against depressive symptoms, but particularly family support emerged as a key factor in making treatment-seeking experiences more positive than negative. These were similar to our findings, as family support surpassed professional and peer support in terms of support needed for seeking treatment. Thus, it highlights the importance of family involvement to enhance the early detection of depression and decrease barriers to healthcare entry.

Despite concerns of being stigmatised, women from Britain who were motivated to seek treatment were less likely to worry about people treating them differently. Those who sought treatment based on external indications of mental health such as having prior knowledge of depression by coming across mental health news on social media exhibited a positive attitude towards treatment-seeking. Therefore, they acknowledged the fact that stigma exists in society, and they did not succumb to that pressure. Instead, they were less likely to feel worried that a diagnosis would affect their relationships with others, or that they might be treated differently in society.

We also observed that stigmatising behaviour associated with depression directly affected the openness and comfort of the patient in terms of sharing and talking about their illness with others. In our study, Indian participants reported hesitating to talk about depression to others more than British participants. This may be due to the existence of greater stigmatising behaviour towards depression among Easterners compared to Westerners (Lauber & Rössler, 2007). Our current finding is in line with Ahmed et al., (2020). This study revealed that South Asians targeted greater prejudice and stereotypes to people with psychosis than did White British people (Ahmed et al., 2020). In this study, public stigma towards mental illness was demonstrated in both cultures but endorsed more strongly in the Eastern group as compared to the Western group (Ahmed et al., 2020). Hence, this could explain why in our study Indian participants showed more hesitation in talking about their illness in comparison to British participants.

Next, our findings shed light on concerns people had with being labelled as mentally sick or mentally unstable because of their diagnosis. Participants discussed this as a concern associated with their social identity and self-image in front of others. They reported that they do not wish to be labelled as ‘attention seekers’ or ‘weak’ because they are diagnosed with depression. Prior work (Crocker et al., 1998; Goffman, 1963), has suggested that stigma discredits and devalues a person’s identity and this finding is in line with the experiences of participants in our study. Similarly, Furnham and Malik (1994), described the cross-cultural beliefs of Indian women living in Britain as more likely to have problems in discussing their diagnosis with friends as they worry about the judgement that can tarnish their reputation within that social circle. Hence, it can be said that labels might directly affect people’s relationships with others.

Apart from public stigma reported by participants, they also anticipated stigma from close relationships towards their illness. Both groups of participants reported that their families would not talk to them if they sought treatment, and sometimes they perceived that they would be shunned by the family due to such judgments. A similar finding was reported by Brown et al. (2010). Brown and his colleagues (2010) reported that when people expect discrimination, they refrain from talking about their diagnosis and stop themselves from seeking treatment.

Furthermore, the findings of the current study also show that how people approach treatment might be influenced by cultural beliefs and attitudes of that society. The cultural beliefs among Indian participants were reflected in statements that suggested remedies for depression that were offered by others, such as diverting your mind by listening to music. Hence, mental health awareness needs to grow in some societies. This was notably more prominent among Indian participants. The findings of our study are similar to the study by Birtel and Mitchell (2022) who examined the casual attributions and stigma associated towards people with depression among Britons and South Asians living in the UK. They found British participants to endorse more biological beliefs whilst South Asians associated depression more with supernatural, moral, and psychosocial causes. Cauce et al. (2002) discuss that help-seeking behaviour is broadly undertaken when one is less stigmatised and less vulnerable to the judgments surrounding depression. Though evidence is scant, participants from East Asian cultures report that seeking help for depression can result in ‘loss of face’, that is, Indian participants reported their struggles to have initial conversations with family regarding their treatment because of the unwillingness of the people around them to understand depression as an illness that needs professional help. Moreover, approaching a mental health service provider in India can be seen to bring shame upon the family, or it is seen as allowing an individual to shirk their responsibilities (Corrigan et al., 2003; Corrigan & Miller, 2004). Thus, we can say that cultural and contextual beliefs influenced the understanding of depression.

The marital status of women in India was also a vital factor noted in the investigation of fear and treatment-seeking behaviour in our study, with married women perceiving treatment-seeking as a failure of womanhood and unmarried women perceiving treatment-seeking as a barrier to be an eligible relational partner (e.g., getting married). Women who were married in India were also experiencing fear of ruining their image as a good daughter-in-law. Women who were single in India, however, worried that people would consider them less qualified to be suitable for marriage. Marriageability was not discussed by any British participant. Instead, they discussed consequences of diagnosis in terms of their capabilities at the workplace. Therefore, this suggests that the social consequences of stigma for close personal relationships is more perceivable among Indian women as compared to British women. Overall, in our study the fear of relational impact was discussed in different situations by Indian and British participants, but the main impact was the same, which was the fear of not risking their ties with their respective families.

In sum, this study supports previous literature on the stigmatisation of depression and additionally suggests that fear of relational impact among depressed women might be an important factor influencing their treatment-seeking approach. In addition, the findings also highlight factors that might influence people in sharing their experiences of depression or the journey of diagnosis with members of the family or colleagues at work. This study emphasizes the critical importance of prioritizing healthcare for women in India, particularly regarding mental health and depression. It highlights the pressing need to raise awareness and empower women to openly communicate about their symptoms and seek help when experiencing signs of depression. Taking proactive steps to prioritize women's healthcare and promoting open dialogue can significantly contribute to improving the overall well-being and quality of life for women in India and the UK.

Study 2

This study is a quantitative study that is built on the qualitative findings from Study 1. The aim of the study is to investigate the differences in as well as correlations between fear of relational impact and treatment-seeking behaviour among women from different cultural backgrounds (i.e., India and the UK). By investigating relationship dynamics in study 1, study 2 is able to expand upon the themes (Stigmatizing Views of Depression, Lack of Understanding of Causes and Treatment Options, Ambivalence in Familial Responses to Diagnosis, Impact of Treatment and Diagnosis on Extended Family; and Social Detachment as a Result of Being Treated Differently), suggesting a better understanding of how sociocultural factors and various demographics might be associated with the fear of relational impact and subsequent treatment-seeking behaviour among women facing depression. Furthermore, this study directly tests the conceptual model outlined in Figure 1. We tested the following hypotheses in study 2:

H1: fear of relational impact is likely to be negatively associated with treatment-seeking intentions.

H2: women living in India are more likely to report fear of relational impact than women living in the UK.

H3: women living in the UK are more likely to report treatment-seeking intentions than women living in India.

H4: fear of relational impact is likely to mediate the relationship between country of residence and treatment-seeking intentions.

Method

Participants

The study included a total of 341 female participants, divided into two distinct groups. The first group consisted of 144 women who were born, and residing in, Britain, and the second group comprised 197 women who were born, and residing in, India. The age range among participants spanned 18-76 years.

A power analysis was conducted using G-Power version 3.1.9.7 (Faul et al., 2007). For sample size estimation, the effect size was based on data from Birtel and Mitchell (2022; N = 137), which compared cross-cultural differences in depression between White British and South Asians. In their study, stigma by association was measured on 3 dimensions (affective, cognitive, behavioural), with affective stigma by association measured with a common question stem, ‘How do/would you feel about having a family member who has depression?’. Affective stigma was selected because it is similar to the questions asked in our Study 1. To calculate Cohen’s d, we used the means of White British and South Asian participants on this measure, $d = 0.64$. This was done online using an effect size calculator. Further, with a significance criterion of $\alpha = .05$ and power ($1 - \beta$ err prob) = .80, the minimum sample size needed with this effect size was N = 80 for a t-test for difference between two independent means. Furthermore, we also determined that to test the measure of relational concerns developed for this study, with 10 participants per item of the relational concerns scale (Boateng et al., 2018) we would need 280 participants. Thus, the obtained sample size of N = 341 is adequate to test the study hypotheses.

Recruitment was conducted through Prolific and Clickworker, and participants received £2 for participation. British participants were recruited from Prolific and Indian participants were recruited from Clickworker. This was done because Prolific did not include enough Indian women who were born and residing in India, whereas, Clickworker's screen do not include a 'birth place' screen, which did not allow us to exclude the participation of participants based in the UK but born in India. We recruited UK participants from Prolific because this platform allowed us to screen for people who were both born and residing in the UK, which was important given that the UK hosts a large number of migrants from India and including these would have obscured the comparison we aimed to make. As such, there was one screening question for Clickworker participants which consisted of the place of current residence, whereas there were two screening questions for Prolific participants, that is, place of current residence and country of birth. We did not exclude participants of Indian ancestry living in the UK. Inclusion criteria necessitated that participants self-identify as women and British or Indian nationals who were born and residing in these countries as well as be over 18 years of age. No participant was excluded based on diagnosis of depression. All participants provided informed consent prior to participation, and the study received ethical approval (Ethics Application Reference no. 1246661) from the University of Exeter in accordance with ethical guidelines.

The demographic information collected from participants included age, employment status, marital status, highest degree received, country of residence, number of children, ethnic group, and self-perceived socioeconomic status. The question to evaluate perceived social status was based on the MacArthur ladder (Adler et al., 2000). On this scale, participants indicate where they think stand in the society where they currently live, relative to other people in that society, on a scale from 1 (low, were the people who have least money, least education and least respected jobs or no jobs) to 10 (high, were the people who have the most money, most education, and most respected jobs). This, higher values on this scale correspond to the perception that one's social status is high relative to those who live in the same country.

Measures

Participants completed two scales[1] (Treatment-seeking and Fear of Relational Impact) in two versions, depending on whether they reported being currently or previously diagnosed with depression or not.

Treatment-seeking behaviour. The treatment-seeking behaviour questionnaire was the ATSPPH short form (-SF) scale (Picco et al., 2016) which is adapted from Fisher and Turner's (1970) original 29 item scale. This survey has been used for both Eastern and Western populations, hence it is a good tool to compare cross-cultural data (Fischer & Farina, 1995; Razali & Najib, 2000; Sheikh & Furnham, 2000; Nam et al., 2010). This scale was presented to all participants regardless of their diagnosis. However, the introduction of the questionnaire differed for people with diagnosis and those without (Appendix D). People who self-reported diagnosis read: *Please complete each question by selecting the answer that most closely corresponds to how you thought/felt before you were diagnosed with depression.* People who self-reported as non-diagnosed read: *Please complete each question by selecting the answer that most closely corresponds to how you imagine yourself to be feeling right now if you were to be diagnosed with depression.* Items *2, 4, 8, 9* and *10* were reverse coded. The items were measured using a 4-point Likert-type scale (0= disagree, 1= somewhat disagree, 2= somewhat agree, 3= agree). These items formed a reasonably reliable scale for the complete sample (α= .66), although this reliability estimate was higher for the UK subsample (α= .77) and not satisfactory for the Indian subsample (α= .54). Scores were then summed together, and higher scores of the participants indicated more positive attitudes toward seeking treatment.

Fear of Relational Impact. The questionnaire on fear of relational impact was formulated by the researchers, based on the results of Study 1. In total, the questionnaire consisted of twenty-eight items.

Questions derived to assess stigma (theme 1 from study 1) consisted of seven items (version for non-diagnosed participants): *If I were to be diagnosed with depression, I am*

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[1] The Beck's Depression Inventory (BDI) and Somatic Symptom Scale-8 (SSS-8) were also administered to allow us to identify participants most at more risk relational impacts as a function of severity and symptoms. However, this was not the primary focus of the thesis, and due to time constraints, it was not included in the data analysis of this thesis.

concerned that most people would see me as a risk; If I were to be diagnosed with depression, I am afraid that others would stare at me; If I were to be diagnosed with depression, I am afraid that people would see it as a sign of personal weakness; I am afraid that others would judge the decisions I make in life if I were to be diagnosed with depression; If I were to be diagnosed with depression, I am concerned that others would see me as an "attention-seeker"; I am afraid that my partner might leave me if I were to be diagnosed with depression; I am scared that I would be less sexually attractive if I were to be diagnosed.

Lack of understanding (theme 2, from study 1) was measured with five items: (version for non-diagnosed participants): *I am afraid that people would ridicule me if I were to be diagnosed with depression; If I were to be diagnosed with depression, I am concerned I would feel guilty about my mental health; If I were to be diagnosed with depression, I am concerned that others would think that I am not fit to be a mother; I am worried that others would think of me as inferior if I were to be diagnosed with depression; If I were to be diagnosed with depression, I am afraid that I might be passed over for difficult tasks.*

Ambivalence (theme 3 from study 1) was measured with five items (version for non-diagnosed participants): *If I were to be diagnosed with depression, I am afraid that I would not want to tell people that I am undergoing treatment for it; I am afraid that my family might not support me if I were to be diagnosed with depression; If I were to be diagnosed with depression, I am afraid that most people would not trust me; I am afraid that I would not be able to fulfil the social role of a wife if I were to be diagnosed with depression; I am afraid that my family would give me a hard time if I were to be diagnosed with depression.*

Extended Impact (theme 4 of study 1) was measured with six items (version for non-diagnosed participants): *If I were to be diagnosed with depression, I am concerned that I would become dependent upon others (such as my family); I am scared to face negative emotional responses from my family if I were to be diagnosed with depression; I am worried that I would not be able to fulfil the social role of a mother if I were to be diagnosed with depression; I am afraid that I would not be able to fulfil my responsibilities at work if I were to be diagnosed with depression; I am afraid that I would not be a desirable marital partner if I were to be diagnosed with depression; I am afraid that my children might not want to be with me if I were to be diagnosed with depression.*

Social distancing (theme 5 from study 1) was measured with five items: (version for non-diagnosed participants): *I am afraid that I might not be given the same responsibilities at work if I were to be diagnosed with depression; If I were to be diagnosed with depression, I am afraid that I would not be invited to as many social events; I am afraid that I would have a harder time finding a job if I were to be diagnosed with depression; If I were to be diagnosed with depression, I am concerned that others would find it hard to talk to me; If I were to be diagnosed with depression, I am scared that others would feel that they could not make jokes around me because I might take it personally.*

All measures were scored on a Likert-type scale from 1 (*Strongly disagree*) to 5 (*Strongly agree*). The questions were separately formulated for depressed and non-depressed participants. An example of this, a question for a non-diagnosed participant was: *"I am afraid that people would ridicule me if I were to be diagnosed with depression."* For the diagnosed participant, this same question was: *"Before my diagnosis with depression, I was worried that people would ridicule me."*

Factor Analysis

I conducted principal axis factoring on the twenty-eight items used to assess Fear of Relational Impact, to determine whether these items loaded on one or more factors. The analysis revealed that five factors had eigen values above 1 (see Table 3). However, on closer examination it is clear that the data is best captured by one factor (see also the Scree plot, Figure 2), which has an eigen value of 12.38 and explains 44.20% of variance. Indeed, the eigen value drops significantly for the second factor, to 1.75.

Table 3

Total Variance Explained by each Factor (N = 341).

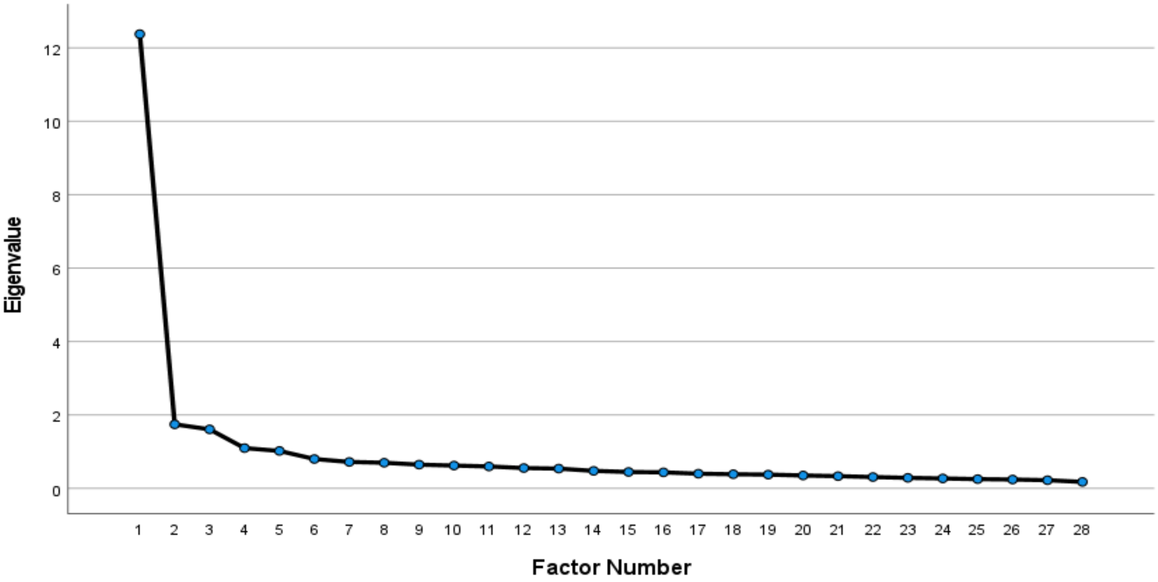
Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %

1	12.38	44.20	44.20	11.94	42.65	42.65
2	1.75	6.23	50.43	1.33	4.74	47.39
3	1.61	5.75	56.18	1.16	4.16	51.55
4	1.10	3.92	60.10	.72	2.56	54.11
5	1.02	3.65	63.74	.59	2.11	56.22

Figure 2

Scree plot for the scale items.



Based on this result, we checked whether a scale averaging across all items was reliable. The total twenty-eight items formed a reliable scale for the complete sample (α= .97), as well as for the Indian subsample (α= .98) and for the UK subsample (α= .97). We therefore proceeded by averaging across all items for further analyses using this scale.

Procedure

The online survey was created on Qualtrics. A pilot study of the questionnaire was first conducted among 20 participants (10 from each country) on Prolific and Clickworker. The pilot study served as a preliminary investigation to test procedures, tools, and methods. Participants in the pilot study were first asked to report if they were previously diagnosed with depression. They then saw the remaining questions in the version that corresponded to their diagnosis history. Initial observations of the results on Prolific and Clickworker indicated consistency in answering all the questions by both participants in UK and India which is important in order to increase the reliability of the results. No adjustments to the questionnaire were considered necessary for the main study.

Analytical Strategy

The data were analysed using the software Statistical Package for Social Science (SPSS) version 28. A Pearson correlation was conducted to examine hypothesis one, which is investigating the association between fear of relational impact and treatment-seeking behaviour. In addition, an independent samples t-test was employed to assess the mean differences in fear of relational impact between Indian and British participants (hypothesis two). For investigating hypothesis 3, a similar independent samples t-test was employed to assess the mean differences in treatment-seeking behaviour between Indian and British participants. Lastly, a mediation analysis was conducted to assess the direct and indirect effects of fear of relational impact on treatment-seeking behaviour based on participant's cultural background. A *p*-value level of less than 0.05 was considered significant.

Results

Table 4 summarizes the demographic characteristics of the overall sample (left column) as well as of each subsample. Subsample demographics were compared using a series of chi-square tests (for education, marital status, and employment) and independent samples t-tests (for age, number of children, and SES). As shown in Table 4, participants from the UK and India differed in age, with UK participants being, on average, older (*M* =40.87, *SD* = 12.73) than Indian participants (*M* = 31.16, *SD* = 8.72). There were also differences in socioeconomic status (SES) between the two groups, with Indian participants having higher SES (*M* = 6.14, *SD* =2.09) compared to UK participants (*M* = 5.22, *SD* = 1.35). The number of children did not significantly differ between the groups (UK: *M* = 1.16, *SD* = 1.19; India: *M* = .92, *SD* = .92). The variables, age, SES and number of children were adjusted while conducting the mediation analysis.

Table 4

Demographic Characteristics of Participants for study 2

Demographics	**Total**		**UK**			**India**		
	M	*SD*	*n (%)*	*M*	*SD*	*n (%)*	*M*	*SD*
Age	35.27	11.62		40.87*	12.73		31.16	8.72
SES	5.75	1.87		5.22	1.35		6.14	2.10
No. of children				1.16	1.19		.92	.92
Ethnicity								
Not specified			1 (0.7)			14 (7.1)		
Asian			6 (4.2)			181 (91.9)		
Black Caribbean			1 (0.7)			0 (0)		
British Asian Indian			1 (0.7)			0 (0)		
Mixed White Black African			1 (0.7)			0 (0)		
White Asian British			1 (0.7)			0 (0)		
White British			132 (91.7)			2 (1)		
White Mixed Other			1 (0.7)			0 (0)		
Education								
No schooling completed			1 (0.7)			5 (2.6)		
High School Graduate, diploma or equivalent			32 (22.2)			17 (8.7)		
Trade/technical/vocational training			21 (14.6)			3 (1.5)		

Bachelor’s degree	72 (50)	103 (52.6)
Master’s degree	14 (9.7)	53 (27)
Professional Degree	4 (2.8)	15 (7.7)
Marital status		
Single	25 (17.4)	59 (30.3)
In a relationship but not married	45 (31.3)	9 (4.6)
Married	64 (44.4)	118 (60.5)
Separated but not divorced	3 (2.1)	3 (1.5)
Divorced	5 (3.5)	0
Widowed	2 (1.4)	6 (3.1)
Employment		
Working full-time	74 (51.4)	67 (34)
Working part-time	41 (28.5)	59 (29.9)
Unemployed and looking for work	4 (2.8)	12 (6.1)
A homemaker or stay-at-home parent	8 (5.6)	32 (16.2)
Student	1 (0.7)	24 (12.2)
Retired	11 (7.6)	1 (0.5)
Other	5 (3.5)	2 (1)

*Note- *p <.05,*

H1: Fear of relational impact is likely to be negatively associated with treatment-seeking intentions.

A Pearson correlation was conducted to examine the association between fear of relational impact and treatment-seeking intentions for the overall sample. The results revealed a statistically significant negative correlation between the two variables ($r = -0.22$, $p < .001$), which supports H1.

H2: Women living in India are more likely to report fear of relational impact than women living in the UK.

An independent samples t-test was conducted to examine whether there was a significant difference in fear of relational impact of a depression diagnosis between the participants living in the UK (*M*= 86.67, *SD*= 22.89) and the participants living in India (*M*= 95.61, *SD*= 23.50). The results indicated a significant difference in fear of relational impact between the two groups, *t* (320) = -3.42, *p* <.001, *d* = -.36, with women living in the UK expressing less fear than women living in India. This supports H2.

H3: Women living in the UK are more likely to report treatment-seeking intentions than women living in India.

An independent samples t-test was conducted to examine whether there was a significant difference in treatment-seeking intentions between the UK women (*M*= 19.60, *SD*= 4.79) and the Indian women (*M* = 16.89, *SD* = 4.43). The results indicated a significant difference in treatment-seeking intentions between the two groups, *t* (334) = 5.35, *p* <.001, *d* = .59, with women in the UK reporting more treatment-seeking intentions than women in India. This supports H3.

We additionally examined possible differences between diagnosed and non-diagnosed women living in the UK and in India. The correlation between fear of relational impact and treatment-seeking for non-diagnosed participants was significant (*r*= -.17, *p*= .010). However, for diagnosed participants it was only marginally significant (*r*= -.20, *p*=.056), though it was of a similar (slightly larger) magnitude, and we can assume this is due to the small sample size (See Table 5) of the diagnosed participants (n = 90).

Table 5

Group statistics for participants for each scale.

	Diagnosed (*n*=)	**Non-diagnosed (*n*=)**	**Total**
	Fear of Relational Impact Scale		
UK	25	115	140
India	65	117	182
Total	90	232	322

ATSPPH-SF			
UK	26	117	143
India	71	122	193
Total	97	239	336

An independent samples t-test was conducted to examine whether there was a significant difference in fear of relational impact between the UK non-diagnosed women (*M*= 86.75, *SD*= 23.15) and Indian non-diagnosed women (*M*= 90.87, *SD*= 23.36). Although the means suggest that this fear is greater among Indian women, the results indicated a non-significant difference in treatment-seeking between the two non-diagnosed groups, *t* (230) = -1.35, *p* = .178, *d* = -.18. Similarly, an independent samples t-test was conducted to examine whether there was a significant difference in fear of relational impact between the UK diagnosed women (*M*= 86.32, *SD*= 22.15) and Indian diagnosed women (*M*= 104.14, *SD*= 21.39). The results indicated a significant difference in treatment-seeking between the two groups, *t* (88) = -3.51, *p* <.001, *d* = -.83, with Indian women expressing more fear than British women.

For treatment-seeking scores and non-diagnosed participants, an independent samples t-test was conducted to examine the difference between the UK non-diagnosed women (*M*= 19.81, *SD*= 4.90) and Indian non-diagnosed women (*M*= 18.02, *SD*= 4.45). The results indicated a significant difference in treatment-seeking between the two groups, *t* (237) = 2.95, *p* = .003, *d* = .38, with women in the UK more likely to seek treatment. Similarly, an independent t-test was conducted to examine whether there was a significant difference in treatment-seeking between the UK diagnosed women (*M*= 18.65, *SD*= 4.21) and Indian diagnosed women (*M*=14.94, *SD*= 3.68). The results indicated a significant difference in treatment-seeking between the two groups, *t* (95) = 4.23, *p* <.001, *d* = .97, with women in the UK more likely to seek treatment.

H4: Fear of relational impact is likely to mediate the relationship between country of residence and treatment-seeking intentions.

Mediation analysis was conducted using PROCESS macro, model 4 (Hayes, 2013) to examine the total, direct and indirect effects of the predictor variable (country, UK coded as 1 and India coded as 2) on the outcome variable (treatment-seeking) through the mediator (fear of relational impact; see Figure 3).

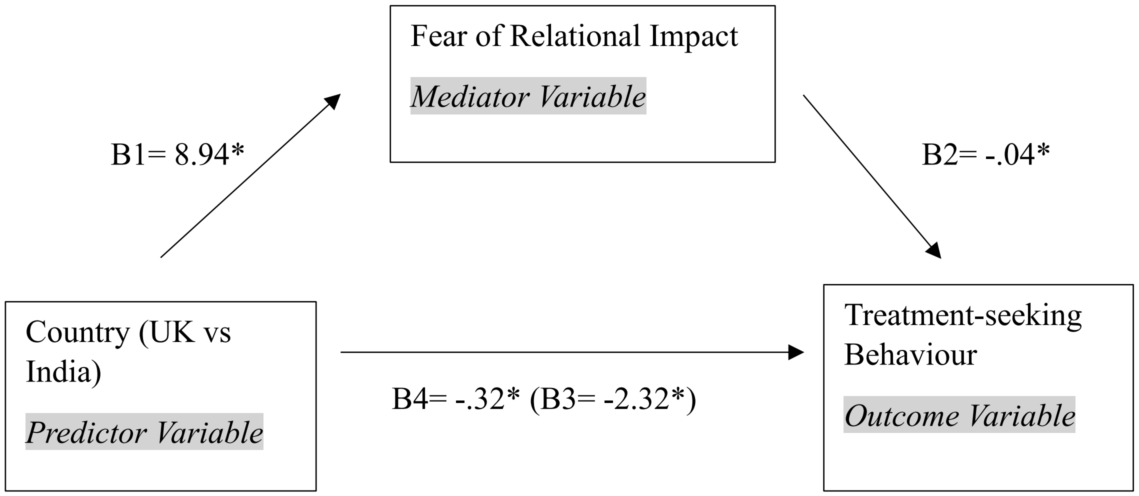
The effect of country on the mediator was statistically significant, *b*= 8.94, *SE* = 2.61, *t* = 3.42, *p* < .001, indicating country was significantly and positively associated with fear of relational impact. The effect of the mediator on treatment-seeking was also statistically significant, *b*= -.04, *SE*= .01, *t* = -3.27, *p* = .001, showing that fear of relational impact is significantly and negatively associated with treatment-seeking behaviour.

The indirect effect of the country on treatment-seeking through the mediator was statistically significant *b* = -.32, 95% CI [-.61, -.09], *p* <.05. This indicates that country affects treatment-seeking at least in part through its effect on fear of relational impact.

The direct effect of country on treatment-seeking behaviour after controlling for the mediator remained statistically significant (*b* = -2.32, *SE* = .52, *t* = -4.44, *p* = .001). This suggests that there is both a direct effect of the country on treatment-seeking intentions and an indirect effect through fear of relational impact.

Figure 3

Standardised regression coefficients for the relationship between country and treatment-seeking of depression as mediated by fear of relational impact.



Note: *p <.05

Additional Analyses

Controlling for Age, SES and Number of children. The variables age, SES, and number of children were different across the two groups. Therefore, an ANCOVA was conducted to examine the effects of country on fear of relational impact while controlling for the covariates. This analysis showed significant effects of age and number of children. Age was negatively associated with fear, $b = -.45$, $SE = .14$, $t = -3.30$, $p = .001$, hence older participants expressed less fear of relational consequences. Number of children was positively associated with fear, $b = 3.35$, $SE = 1.43$, $t = 2.35$, $p = .019$, hence the participants who had more children, reported more fear. However, no association with SES was observed, $b = .26$, $SE = .72$, $t = .36$, $p = .717$. In addition, once the effects of these covariates were controlled for, the effect of country on fear of relational impact was only marginally significant $b = 5.12$, $SE = 2.96$, $t = 1.73$, $p = .084$.

Similarly, a series of ANCOVA tests were conducted to examine the effects of country on treatment-seeking scores while controlling for covariates. Age was negatively associated with treatment-seeking, $b = -.01$, $SE = .03$, $t = -.19$, $p = .848$, hence older participants expressed less treatment-seeking intentions. However, no associations were found with number of children, $b = -.41$, $SE = .29$, $t = -1.42$, $p = .157$ or SES, $b = .18$, $SE = .15$, $t = 1.25$, $p = .213$. When controlling for covariates there was still a significant effect of country on treatment-seeking, $b = -2.63$, $SE = .60$, $t = -4.38$, $p < .001$.

Mediation analyses using the PROCESS macro (Hayes, 2013), model 4, with 5000 bootstrap samples, confirmed that country had a significant direct effect on treatment, but no significant indirect effect through fear of relational impact, when the effect of the covariates was controlled, $b= -.19$, 95% CI [-.49, .03].

Discussion

In this study, we examined whether fear of relational impact influences treatment-seeking for depression among British and Indian women. The findings of the study suggest that fear of a negative relational impact is higher among Indian participants than UK participants and it is inversely related to treatment-seeking intentions. Indian diagnosed participants reveal a lower propensity to seek treatment for depression than British diagnosed participants. This can be due to the stigma associated with depression that is higher in India as compared to the UK (Birtel &

Mitchell, 2022). Additionally, the unadjusted mediation analysis revealed that fear of relational impact among the participants acted as a significant mediator of the effect of country on treatment-seeking behaviour. To address this further, the analyses of the diagnosed participants and non-diagnosed participants yielded similar results in cultural comparison. Overall, Indian participants, diagnosed and non-diagnosed, reported a higher score on fear of relational impact and a lower score on treatment-seeking compared to British participants. This is helpful for researchers to understand the impacts of potential diagnosis on relationship dynamics. The study also suggests why people from different cultural backgrounds and different mindsets differ in their approach to seeking treatment for various mental disorders.

The effect size for the difference between the two groups in fear of relational impact suggests a substantial and practically meaningful difference. The negative effect is consistent with our hypothesis that the fear of relational impact is more likely to be reported by Indian participants than by UK participants. Although the two countries differ in a range of ways, one possibility is that this country difference is due to differences in fear of relational impact in collectivistic compared to individualistic culture (Papadopoulos et al., 2013). Hence, this finding can be useful to future researchers as it provides them with an understanding of the factors that can influence help-seeking behaviours and introduce new measures to motivate individuals to seek help when needed. Future researchers might also want to study further on the acculturation process that could be an influence on people's treatment-seeking behaviour in the two countries.

Furthermore, if the relational fear aspect of depression is approached correctly, there could be reduced symptoms and improved coping methods that could lead to healthier interactions with family members, friends, and romantic partners. For instance, a study by Barbato et al., (2018) noted that people who approached couple therapy as compared to individual psychotherapy appeared more effective in reducing distress levels at the end of the treatment. In addition to this, their results also suggest that therapy interventions can help people feel less dependent on external factors such as anti-depressant medicines and traditional methods for support (Barbato et al., 2018). Consequently, the therapy reduced the burden on close relationships as people also showed decreased dysfunctional behaviour and elicited more emotion-based behaviour, which made people more resilient and better partners or family members (Barbato et al., 2018). Hence, it can be said that the fear of negative relational impact can be controlled by improving coping methods and reducing stigma associated with approaching treatments for depression.

The measures used in the current study have a few key strengths. The ATSPPH-SF questionnaire was derived from the longer version, which had already established content validity, including in the UK and in India (Picco et al., 2016). The items in this questionnaire were selected to demonstrate key aspects of attitudes towards seeking psychological help. However, in our study the reliability coefficients for each sample differed, being lower for the Indian sample than for the UK sample. These observed differences could be due to the cultural differences, language barriers and educational backgrounds of participants. Specifically, the attitudes towards mental health treatment may have been less sensitive or relevant to the treatment seeking attitudes of Indian participants than the UK participants. Hence, there is a need for future research to include additional validation studies for this measure in cultural contexts, such as India.

Furthermore, the Fear of Relational Impact questionnaire measures the intended psychological construct. Before deploying the study, we conducted pilot testing which helped us gain insight into the clarity and relevance of the questionnaires. During the pilot testing, all participants completed the questionnaire easily, which meant that it was comprehensible. The questionnaire construct validity has been established through factor analysis, demonstrating that it accurately measures fear of a negative impact on relationships among women upon diagnosis of depression. Hence, the questionnaire can be used for other research purposes, and possibly examining fear of relational impact for other conditions or disorders. While factor analysis can establish the internal validity of the Fear of Relational Impact questionnaire, other limitations of the questionnaire might include a few topics. It is important to acknowledge that the questionnaire was developed and validated in Indian and British society, by only women, making it not necessarily reflective of the experiences of people from other cultural backgrounds. Furthermore, due to the limited number of participants in Study 1, the questionnaire formulated in Study 2 might not cover all the potential facets of fear of relational impact related to depression, which may leave certain aspects unexplored for future researchers to investigate.

General Discussion

In conclusion, we can say that the fear of relational impact is a psychological phenomenon that might influence a person's approach when seeking treatment for depression. The interplay between societal expectations and individual perceptions of relationships can shape the help-seeking behaviour of women in different countries. This research paper explored Indian and British women concerning their fear of relational impact and its influence on treatment-seeking behaviour when diagnosed with depression. The results yielded by both studies suggest that fear of relational impact can be more pronounced in India rather than in the UK. This might be due to the increased stigmatisation that is associated with depression in India as compared to the UK. While our study exclusively recruited women, it is important to recognise that gender can play a significant role in defining experiences and treatment-seeking behaviour. Thus, the findings of our study may not be directly generalisable to other genders. The societal and cultural diversity that exists in the UK and India makes this study a good cross-cultural example of the topic.

Studies have indeed indicated that the stigma associated with depression is higher among Easterners as compared to Westerners (Rüsch et al., 2014; Mohammadifirouzeh et al., 2023). This is in part due to the understanding of the aetiologies of depression, which varies culturally, resulting in some people refraining from sharing their experiences of treatment-seeking with others (Trivedi & Jilani, 2011). Hence, the findings of our study align with the previous studies where Indian participants reported lower treatment-seeking as compared to the UK participants (Jobanputra & Furnham, 2005). Many Indian societies still hold traditional beliefs of depression, such as depression is an attention-seeking behaviour or it affects marriage eligibility and the implications for the family group rather than just self, hence making it harder for depressed individuals to reach out for professional help (Raghavan et al., 2023). Psychiatric healthcare services for depression are more widely accessible in the UK than in India, which might further make diagnosis and the process of recovery easier for British women compared to Indian women (Jobanputra & Furnham, 2005).

In context of health discourse, the results of the study suggested the fear of social repercussions within family and friend group dynamics. Indian participants were concerned with how others such as family members disliked them if they discussed too much about their illness therefore, they hid it. This could be a result of the less awareness of mental health among Indian societies (Furnham & Malik, 1994). This phenomenon has lately been discussed by Altweck et al., (2015). In their study, they report low levels of Mental health literacy rate among non-westerners as compared to westerners. Low literacy rates suggest that people have peculiar ways of reacting to a diagnosis of mental illnesses such as they see patients with mental disorders as different or inferior, dangerous, or violent and this was commonly noted among non-westerners. The professional help-seeking beliefs model discussed by Altweck et al., (2015) suggests that in their Indian sample, people reported that professional help for mental disorders would not be as effective as traditional help. This could be due to less availability of mental health services in India. As previous studies have mentioned there is a mismatch between mental health care provision and the accessibility of it in India (Khandelwal et al., 2004; Mathias et al., 2015). On the other hand, British participants were hiding their illness as they were scared people around them would react to their diagnosis as a demotivation on the job front. Based on that, the findings of this study suggest that regardless of accessibility people are fundamentally afraid of the fear of being stigmatised which deters their willingness to approach a mental health professional.

Help-seeking for depression among British participants in the first study reported that non-family members such as colleagues would look down on them and in study 2, upon asking job-related questions, people agreed more with the opinion that a diagnosis can make finding a job more difficult. From this we can infer that fear might reside within people in relation to being diagnosed with depression, that is people are afraid of changes in the dynamics of the relationships outside of family, whilst also impacting their status and position at the work front.

In addition to this, the Indian sample in study 1 also suggested that people around them suggested traditional ways of approaching depression such as not listening to music, some participants reported the dismissal of the diagnosis by family members due to not knowing what depression really means. Participants reported that misguided solutions were given to the patients because of the lack of knowledge and beliefs about depression that the society already had. For instance, Razili, Khan, & Hasanah (1996) showed in their study that non-westerners who believed that depression is caused by supernatural reasons, were likely to go to a traditional healer such as witchcraft, or holy water which were preferred over professional help for mental illnesses. Hence, it could be said that diagnosed individuals might be reluctant on disclosing their treatments in fear of being criticised.

A major strength of the study is that the data was collected from a diverse population of India and the UK. This meant that the study criteria did not focus particularly in either of the rural, semi-urban, or urban populations in both countries. The individuals recruited for the study are a very limited number for the population size hence the data collected was not broad for a major generalisation. On the other hand, this allowed the researchers to dig deeper during the data analysis of the interview answers. However, there are some methodological limitations such as the experiences reported by participants might risk recall bias and cultural factors. Moreover, the online interviews were conducted on an audio call, which limits access to non-verbal cues, such as facial expressions. However, there was an advantage that there was less research bias towards the analysis of the data material. Future research can enhance these findings by examining the longitudinal impact of diagnosis on individuals, allowing for a more comprehensive understanding of the various types of fear impacting treatment-seeking attitudes. By studying participants over an extended period, researchers can capture the evolving dynamics and changes in these aspects, providing deeper insights into the long-term effects of diagnosis on individuals' psychological well-being and behaviours. This longitudinal approach offers a more nuanced perspective and can contribute to the development of more effective interventions and support systems for individuals with similar diagnoses.

Moreover, our study suggests that fear of seeking professional help for mental illness can be fundamentally related to interpersonal conflict. The nature of the fear reported in this study might suggest that a treatment-seeking attitude is connected with opinions of family and friends. Firstly, the findings of this study suggest that familial relationships can be a significant reason for less treatment seeking in India than the UK. The scores of participants on items that were directed to the participant’s relationship experiences with the family upon diagnosis captured a better understanding of the underlying reasons for the need for social support for a depressed patient. The misconceptions of society such as mental illness diagnoses are people with a weak personality or other depression labels can have a bad effect on the family’s reputation and this can be the fundamental reason for hesitation in seeking treatment at the right time (Jani et al., 2021). Jani and his colleagues discuss that in India, care-seeking behaviour is influenced by the role of stigma, religious, and supernatural interpretations of mental illness by individuals and families (2021). Therefore, it can be said that the social support offered by family might significantly influence individual’s concern regarding the potential negative effect on relationships before or during treatments for depression.

Furthermore, the result of this study suggests that in a negative association of fear of relational impact and treatment seeking, it was not only that fear of relational impact is higher in people who are diagnosed with depression, but it was also reported higher among non-diagnosed participants. That said, from the findings of the study we could suggest that women in India regardless of their diagnosis, might have a persistent prejudice against depression. British women who were diagnosed reported more fear as compared to the non-diagnosed, which could suggest that people tend to understand stigma only when they are diagnosed with a mental illness. Past research has highlighted that due to the widespread knowledge of mental health, the importance and understanding is present largely among British people than Indian people (Furnham & Malik, 1994).

In additional analyses of the variables in study 2, we found that age could also be a variable in understanding the impact of fear of negative relationships on treatment-seeking behaviour. This was similar in study 1, where participants of who were older reported fewer stigmatising outcomes of diagnosis as compared to the younger participants in both countries. Older aged participants feared less of the relational impact as they might have more emotional resilience, which is similar to the findings of the study by Uchino and Rook (2020). We think it could be because they have a more stable network of close-knit relationships which causes reduced fear of negative consequences. Moreover, older adults might have a cultural and generational difference from the younger generation in context to the way they have been raised with different social norms and expectations, thus making them respond to relational challenges differently (Luong et al., 2011). More investigation and qualitative analysis may be required to fully grasp the elements influencing older people's fear of relationship effect in order to have a more precise understanding.

Nonetheless, it is essential to acknowledge that cultural and societal influences are not static. India and the UK are constantly undergoing social and cultural transformations which can impact attitudes toward depression and treatment-seeking. As these attitudes are evolving, the fear of relational impact may be diminishing in certain circumstances. Today's youth or younger generations might display different patterns of treatment-seeking behaviour (MacDonald et al., 2018). Hence, future research should consider these changes to better address the needs of women of different ages from different cultures. It is vital to understand these dynamics as it can be crucial for healthcare professionals and policymakers to support and improve healthcare accessibility in parts of the world where it is needed.

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Appendix A

Research advertisement

UNIVERSITY OF EXETER

DEPRESSION & SOCIAL EXPERIENCES

RESEARCH PARTICIPANTS NEEDED

Earn an amazon voucher for your time!

We are conducting a study on diagnosis of depression and social experiences of women. You will be asked to sit down with the researcher and discuss a few questions based on your experience after diagnosis of depression.

Are you eligible to participate?

You must be

1. A female aged 18 years or above.
2. Previously or currently diagnosed of depression and undergoing treatment.

How long would the study last?

Approximately 30 minutes.

Where will you be called for the study?

We will conduct the study on zoom.

How will your data be used?

Your data will be confidential.

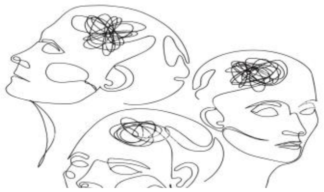
Interested???

For further information please contact

- **Jessica Joseph jj499@exeter.ac.uk**

SCAN ME

This study has been approved by the ethics committee of the University of Exeter. (Ref. 517021)



Appendix B

Information and Consent Sheet

INFORMATION SHEET

Before you decide whether to take part in the interview of this research, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Title of Project: Study about experiences of after being diagnosed with depression.

Purpose of the research:

This study is part of a broader project that aims to understand the factors that affect well-being of an individual who is diagnosed with depression.

Who is doing this research?

The lead researchers of this study are master's candidate Jessica Joseph, Dr David Doyle and Prof Manuela Barreto at the Department of Psychology, University of Exeter.

Why have I been approached to do this study?

This study is looking for female participants, who have been diagnosed with depression and is undergoing treatment for it.

What will you need to do?

If you agree to take part, you will be asked some questions about yourself and about your experiences in day-to-day life after being diagnosed with depression. The whole study will take approximately 30 minutes on a Zoom audio call.

Benefits and risks of taking part

There is unlikely to be any direct or personal benefit to you in taking part. There may be some benefit to science and society; but this cannot be assured at the start of the research project.

Although we do not expect this to be distressing, it is possible that the interview might upset some people a little bit. If you feel affected or distressed by the interview, you will be signposted to mental health services in your area.

If you consent to participate, the reimbursement for this study is 12 pounds (or Indian Rupees 1200) by voucher or bank transfer at completion with interview.

Voluntary participation and your right to withdraw.

Your participation in the study is voluntary. You are free to withdraw whenever during the experiment without prejudice. You do not have to give a reason and your data which has been collected until that point will be destroyed. You will be compensated if you withdraw from the study.

In addition, you can also choose to withdraw the data after you finish the experiment within one week. For this, you need to tell us and provide your participant ID number for us to recognise your data file. In this case, you will be still compensated with the participation money.

Anonymity and confidentiality

All the information you provide in the study is completely confidential.

The data collected (audio recordings) will be saved using your participant ID number but will be immediately deleted once the recordings are transcribed. Your personal information such as your email address/ bank details will not be associated with any recordings or research findings. The interviewer will be asking your location and GP details prior to the interview. Although, we do not expect this to happen, but if there is any significant risk identified during the interview, the interviewer will have to breach your confidentiality and contact emergency services in your area.

How will my data be kept confidential?

The audio recordings and the transcripts of this research will be first stored on the secure university server (OneDrive). The audio recordings will be transcribed by the researcher using the university laptop and recordings will be permanently deleted once it is transcribed. This will leave no trace of any personal data of the participants. The transcripts will be stored in the server with access to only the research team. This document will be stored here indefinitely and shared with other researchers only when the research team will have knowledge to their detailed intentions of accessing the data and how they will handle the data. This can promote greater openness in scientific research and to allow, as well as encourage, other researchers to perform full replications of published studies. Your personal data will not be identified in any report or publication.

Your contact details (email address and bank details) will be stored on the secure server-OneDrive and kept separate from the interview data. This will be only accessible to the researcher and the supervisors. The email address will be collected on a different form, and it will be permanently deleted after the experiment is completed and submitted by September 2023. Your bank details (for financial compensation of your time) will be collected on a different sheet, and your details will be permanently deleted from the server by September 2023.

What will happen to the results of this study?

The results of the study will only be used for academic purpose. This study will be used in a master's thesis for and potentially for publication in an academic journal and/or presentation at an academic conference. No individuals will be identified in the presentation of results.

Ethical review of this Research

This study has been reviewed by the Psychology Research Ethics Committee at the University of Exeter and received a favourable review. If you have questions or comments about the ethical aspects of this study, feel free to contact the Chair of the Psychology Ethics Committee, Dr Nick Moberly, at n.j.moberly@exeter.ac.uk.

Contact details

If you have any questions or concerns about the ethics underlying this research, please feel free to contact the researcher Jessica Joseph at jj499@exeter.ac.uk or the supervisor Dr David Doyle at d.doyle@exeter.ac.uk.

CONSENT SHEET

Please click on the boxes below to indicate your consent. ☒**- This indicates YES, you have given your consent to take part in the study.**

1. I confirm that I have read the information provided above. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the experiment without giving any reason and without my legal rights being affected. I understand I can withdraw the data only within one week after the transcripts (if asked from the researcher) are sent to me. ☐
3. I understand that relevant sections of the data collected during the study will be looked at by members of the research team. I give permission for these individuals to have access to my records. ☐
4. I understand that taking part involves anonymous data to be used for the purposes of:
    a. Inclusion on the University of Exeter's encrypted server (OneDrive)
    b. Registered and archived at Open Science Framework for data sharing purposes with other professionals and researchers.
    c. For reports published in an academic publication or media publication.
    d. Teaching or training materials for use in university activities including public engagement activities such as conferences/presentations. ☐
5. I give consent for my interview to taken online on Zoom, and for it to be audio recorded, which will then be used for data analysis of this study. ☐
6. I agree to take part in the above project. ☐
7. (Optional) I wish to provide my email address which is personal identifiable information because I would like to receive further results of this study. I have been made aware that

the email address will be separately stored securely and deleted after the information requested has been provided to me after the results are written and published. ☐

8. (Optional) I wish to provide my bank details which is personal identifiable information because I would like to be financially compensated for my time given to this study. I have been made aware that the bank details will be stored securely and deleted after the money has been transferred by September 2023. ☐
9. I consent to share my current residing location with the researcher and my identity will be shared with the emergency services (e.g., the nearby mental health support), if I pose any harm to myself or others. ☐

Participant ID Number ___________ *(For the Interviewer to fill)*

PARTICIPANT INFORMATION

I request you to fill in below mentioned details. It will take approximately 5 minutes to complete.

1. **Age** (Years)- __________
2. **Current City**- __________
3. **City of birth**-___________
4. **Lifetime mental health or welfare service use**: Yes☐ No ☐

If yes, how long have you been in treatment (Please answer in Years or Months)________

Type of treatment_______

5. **Contact of your mental health service provider**

Name- ______________

Location- ____________

6. **Education level** (Click one)
   - A. Secondary School ☐
   - B. Further Education (High School, Vocational and others) ☐
   - C. Higher Education (University) ☐
7. **Socio Economic Status** (Click one)
   - A. High ☐
   - B. Medium ☐
   - C. Low ☐
8. **Relationship status** (Click one)
   - A. Single ☐
   - B. Married ☐
   - C. Dating ☐
   - D. Co-habiting ☐
   - E. Divorced ☐
   - F. Widowed ☐
9. **Employment status** (Click one)
   - A. Working ☐
   - B. Unemployed ☐

Appendix C

Question Set

<u>Introduction</u>

Just as you read in the information sheet, this interview is going to be about your thoughts and feelings about the experiences and situations you had to deal with after being diagnosed with depression and how you felt along the way.

- If any point you feel distressed, please let me know. Also, if you don't have anything to say, we can always move on to the next question.
- All the information you share is going to be confidential. Whatever you discuss with me here, will be used for only for academic purposes.
- If it's okay with you can I start the interview, can I press record?
- I would like to repeat your participant number for my record. You are number ____.

So, let's start by getting to know a little bit about you-

1. Can you tell me about the people that you live with?
2. What does your typical day look like?
3. How has depression affected your daily life?
    i. For instance, can you tell me about any changes that you may have noticed in your day-to-day life since you have been diagnosed with depression?

Now, I would like to ask you about your history of depression-

1. Is this your first time being diagnosed with depression?
    a) If no- can you tell me more about, how did you dealt with it in the past?
    b) If yes- can you tell me something about how you first felt when you were told you are having depression?

<u>Illness onset</u>

So now I would like to know more about your experiences before you started treatment for depression.

1. First, can you tell me about the point at which you noticed that these feelings might be depression?
    a. What was going on in your life? What had happened?
    b. Did anyone help you recognise that these feelings are symptoms of depression?

Now, let us talk about the **treatments** for depression.

2. Did you seek any formal type of treatment for depression, and can you tell me about that?
    a. Can you tell me about what motivated you to go and seek that treatment?

Before they sought treatment-

3. Did you have concerns to how people would react to you seeking treatment?
    i. If yes-- were you afraid people would judge you?
        1. If yes-- In what ways?
    ii. If no—did you feel supported?
        1. If yes—by whom? How did they support you?
        2. If no—did you feel like you wanted to be supported? And did that lack of support affect your ability to seek help?
4. Can you tell me more about what you thought initially about how your family was going to react to you seeking treatment?
    b) Did you feel your family was going to feel a particular way? Maybe you could give me some examples?
5. What can you say about your experiences of being encouraged to seek treatment?
    - Positive--- Can you tell me more about who encouraged you? What kind of things were they saying?

  - Negative---- Did you have people who were not encouraging? Why do you think people were preventing you from seeking help?

6. Did you *think* there would be any effect on your relationships with your family?

If yes, what changes did you think you would encounter?

   a. So, what about with your partner? Is there anything specific changes you would say you were afraid that they might feel when they found this out?
   b. Then, what about your kids, what kind of changes in your relationship did you think would take place with your kids?

OR

If the answer is no--- did you *notice* or experience any changes in your relationships with your family?

1. So, you didn't think your partner, or your children were going to react to it?
2. Did you think diagnosis would have had consequences for the ways in you which you interact with your family or attending any family or friend's events?

During treatment:

Thank you for sharing how you were feeling before you started treatment.

- So, since you got diagnosed did you then notice any changes in your relationships?

1. Can you tell me more on - How was it for your partner to know that you have been diagnosed and you are willing to start with treatment?
   - Have you noticed any changes in your relationship since the time he found out that you have depression?
     - If any changes observed- what changes did you observe? What more can you say how you feel around him?

OR

        - If no, (he doesn't know) What was it like being around him when you knew that you are taking treatment?
        - Also, why did you think your partner does not need to know that you are diagnosed, and you are undergoing treatment for depression? --- How did you think it would change things?

2. So, do people in your family, (like your relatives, parents & siblings) and friends know that you are seeking treatment?
    a. Can you tell me how you feel about the fact that they know you are seeking help for depression?
3. So, what do you seek to achieve at the **end** of the treatment?

Closing questions

We have reached the end of the interview.

1. Is there anything more you'd like to tell me in terms of how you are feeling since being diagnosed with depression?
2. Do you have any questions about anything we discussed?

Thank you again for your time and for allowing me to talk to you.

Appendix D

Attitudes Towards Professional Psychological Help-Scale- Short Form

Question for diagnosed participant: *Please complete each question by selecting the answer that most closely corresponds to how you thought/felt before you were diagnosed with depression.*

OR

Question for non-diagnosed participant: *Please complete each question by selecting the answer that most closely corresponds to how you imagine yourself to be feeling right now if you were to be diagnosed with depression.*

1. If I thought I was having a mental breakdown, my first thought would be to get professional attention.
2. Talking about problems with a psychologist seems to me as a poor way to get rid of emotional problems.
3. If I were experiencing a serious emotional crisis, I would be sure that psychotherapy would be useful.
4. I admire people who are willing to cope with their problems and fears without seeking professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counselling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she is more likely to solve it with professional help.
8. Given the amount of time and money involved in psychotherapy, I am not sure that it would benefit someone like me.
9. People should solve their own problems, therefore, getting psychological counselling would be their last resort.
10. Personal and emotional troubles, like most things in life, tend to work out by themselves.