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Tolerance for depression : Are there cultural and gender differences?

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Abstract

This study examined tolerance for depression among UK Jewish and Protestant men and women. A measure of tolerance for depression was developed, which examined willingness to admit to and seek help for depression. More specifically, the items in the measure (developed from extended interviews) covered empathy towards sufferers, potential virtues of the illness, hopes for treatment, seeing the illness as 'normal', and telling other people about it. Existing evidence suggested that tolerance for depression might be greater amongst Jews compared to Protestants, and women compared to men. Also, Jewish men were expected to be more tolerant than Protestant men, whereas Protestant and Jewish women were not expected to differ from each other. It was found that tolerance for depression was greater amongst Jews than Protestants, and this is consistent with the elevated levels of depression amongst Jewish men as compared to Protestant men. However findings relating to gender were mixed and were not always consistent with our expectations. The findings suggest that there may be some cultural variations in willingness to admit to seek help for depression, and this may be worth examining in other cultural-religious groups. Individual variations in tolerance for depression may be clinically significant.

Key words: tolerance for depression, cultural differences, gender differences, Jewish, Protestant.

Introduction

There has been longstanding fascination with the idea that behaviours, ideas and feelings that are tolerated in some cultures, may be seen as disturbed in other cultures (Vanos

& Neeleman, 1994). Cultural variation in attitudes to mental illness have been demonstrated in a number of studies (e.g. Fan, 1999). This study focuses on the specific question whether – in the UK – Jewish culture supports greater tolerance for depression than British Protestant culture.

Studies examining attitudes towards depression in Western Christian cultures have indicated public fear, and a desire to maintain a social distance from sufferers (Link et al., 1999). Negative attitudes have been targeted by national campaigns, both in America and the UK, for example the "Defeat Depression" campaign, which began in the UK in 1992. Reluctance to seek help is related to sufferers' fears of negative work-related consequences. Having a diagnosis of depression has been found to significantly reduce the likelihood of employment in the UK, due to perceptions of potential poor work performance (Glozier, 1998). Such prejudice is not helped by the negative way in which depression is consistently portrayed within the media (Wilson et al., 1999).

Guttmacher and Elinson (1971) examined ethno-religious influences on perceptions of mental illness in Jewish and Protestant samples (along with other ethnic groups). Vignettes were used to examine perceptions of deviant behaviour. The authors concluded that "there may be some truth to the rumour that Jews are less hostile toward psychiatry and the concept of (mental) illness as an explanation for behaviour". Frost (1992) has suggested that melancholy may be a state chosen and endorsed in Jewish tradition. Angermeyer et al. (2001) recognised that sociocultural factors are important in shaping help-seeking behaviour. Of particular interest is the finding that Jews have shown higher levels of help-seeking behaviour than non-Jews for psychological problems. This has been noted both in America (Yeung & Greenwald, 1992) and the UK (Bowling & Farquhar, 1993), and has been used to account for the increased incidence of *observed* depression within this cultural-religious group (Kohn et al., 1999). It is also noteworthy that Jews are more likely to express negative affect than Catholics (Glicksman, 1991). These observations suggest that Jews may display more tolerance for depression than Protestants and those of Protestant background, and the first aim of theis study is to examine whether this is the case, using a measure of tolerance for

depression. By this we mean a greater level of acceptance of the symptoms of depression, andwillingness to admit to and seek for such symptoms.

A secondary aim of the study was to investigate gender differences in tolerance for depression. Gender differences in tolerance of mental illness have been noted in a number of studies. For example, Ng & Chang (2000) noted that females hold more positive attitudes towards mental illness than males, including showing more kindness, whereas males have more stereotyping, restrictive, pessimistic and stigmatising attitudes. Other studies have also found an association between being male and holding negative attitudes towards seeking help for mental disorders (Blazina & Watkins, 1996; Butcher et al, 1998; Garland & Zigler, 1994). Males show a reduced treatment rate for emotional problems (Moller-Leimkuhler, 2000) and women use more outpatient mental health services than do men (Rhodes & Goering, 1994). Such patterns of reduced help-seeking in males have even been noted in adolescents (Rickwood & Braithwaite, 1994) and such observations are not due to higher levels of psychological distress in females; the effect of gender persists after levels of distress have been controlled. Lee (1997) notes that “Individuals do not seek help, even when help is needed and available, because help-seeking implies incompetence and dependence and therefore is related to powerlessness” . Moller-Leimkuhler (2000) suggests that traditional social norms associated with masculinity, such as the inhibition of emotional expression, may hinder reporting and help-seeking in males.

These observations suggest lower tolerance for depression, and lower willingness to admit to symptoms and to seek help, among men than among women.

The principle way in which tolerance for depression may impact upon *observed* rates of depression is via its influence on the acceptance or denial of one’s own symptoms and subsequent help-seeking behaviour. Jorm (2000) notes that only a minority of individuals with a mental illness may seek professional help, and that attitudes which hinder recognition and appropriate help-seeking behaviour for their illness are common. It is hypothesised that tolerance for depression may influence the extent to which an individual may be willing to admit to their symptoms, which would then impact directly upon help seeking behaviour. This notion draws heavily on the Theory of Reasoned Action by Ajzen & Fishbein (1980) which

acknowledges the importance of attitudes and intentions as determinants of behaviour.

Cultural-religious variation in the distribution of mental illness has been widely noted within the literature. Of particular relevance is the finding that Jews have significantly higher rates of depression than Protestants (Yeung & Greenwald, 1992). This results from an increased prevalence within Jewish males, as compared to Protestant males (Levav et al., 1997; Loewenthal et al, 1995). With regards to gender, research studies have consistently indicated that women are more likely to suffer from depression than men in terms of both period prevalence (Meltzer et al., 1995) and lifetime prevalence (Weissman et al., 1991).

Gender and cultural-religious variations in *observed* rates of depression may not necessarily reflect *actual* differences in the extent to which these groups suffer from depression. For example, men and women, and Jews and Protestants may simply differ in the extent to which they are willing to admit to *and report* symptoms of depression, and seek help for this illness. As has already been noted, research has suggested that females and Jews may actually be more tolerant of mental illness than males and non-Jews respectively.

It is suggested that observed rates of depression are determined – at least in part - by reporting and help seeking behaviour. The likelihood of this happening is, in part influenced by gender and religious-cultural group membership. The reduced prevalence of depression within certain groups (males as compared to females, and non-Jews (in particular Protestant males) compared to Jews) may not necessarily reflect better mental health. It may simply reflect a reduced willingness to acknowledge a depressed state and to seek help, stemming from lower tolerance of the illness in (Protestant) males and non-Jews. This is in addition, of course, to other factors, such as cultural and gender variations in stress-response behaviours such as alcohol consumption.

The current study examined tolerance towards depression, rather than mental illness in general (as has been examined in previous research). The aims were to investigate the influence of gender and cultural-religious group on tolerance towards depression by comparing UK Jews and Protestants, men and women. Specifically we were interested in attitudes concerning empathy towards sufferers, potential virtues of the illness, hopes for treatment, seeing the illness as ‘normal’ and telling other people.

In view of the previously described variations in observed rates of depression, tolerance was expected to be greater in women and Jews as compared to men and non-Jews respectively. Interaction effects were also expected whereby Jewish men were expected to be more tolerant than Protestant men, but Jewish and Protestant women were not expected to differ. This would be consistent with higher rates of depression in Jewish males as compared to Protestant males, but not in Jewish females as compared to Protestant females.

Method

The study examined the effects of cultural-religious background (Jewish vs Protestant), gender, and their interaction, on tolerance for depression. Potential extraneous variables (age, religiosity and levels of depression and anxiety) were controlled where necessary by analysis of covariance.

Quota samples of people of Jewish and Protestant background, with similar numbers of men and women, comparable ages, levels of religious activity and occupational status were recruited. Jewish participants were recruited via synagogue membership lists and by snowballing among the non-affiliated. Protestant participants were recruited via church membership lists and by snowballing among the non-affiliated. Such methods have been used in research of a similar nature (see Loewenthal et al.,1995). This method of recruitment secured participants ranging in religiosity from high, through moderate, to low or negligible, but with a Protestant or Jewish family of origin. All participants lived in greater London or one of the home counties of England.

A total of 271 questionnaires were sent out, of which 171 were returned, which represents a response rate of 63%. Nine of the returned questionnaires were excluded from analysis, because the stated religious background of the participant did not meet the criteria for inclusion (e.g. one Protestant and one Roman Catholic or Jewish parent).

The final sample was 161: 70 Jewish (35 males and 35 females) and 91 Protestants (44 males and 47 females), with a mean age of 40.8; 64% were in stable relationships (married, engaged or cohabiting), 36% were not (single, divorced, separated or widowed). 75% were graduates and/or in professional employment, 25% were in other occupations:

white- and blue-collar workers, homemakers and retired people. The four comparison groups, Jewish Men (JM), Jewish women (JW), Protestant Men (PM) and Protestant women (PM) were comparable in age ($F(3,155) = 1.96$, $p>.05$), marital status (χ^2 (3, n=161) = 5.16, $p>.05$) and profession (χ^2 (3, n=158) = 3.80, $p>.05$). Levels of religiosity (which took into account frequency of prayer, attendance at a place of worship and scripture study) were comparable across gender ($F(1,157) = 2.60$, $p>.05$) and religious group ($F(1, 157) = .659$), $p>.05$.

Measures

Hospital Anxiety & Depression Schedule. (HADS; Zigmond & Snaith, 1983). Depression and anxiety were assessed with the HADS, in order to partial out any possible confounding effects. The HADS has good psychometric properties (Milne, 1995), and reliabilities were acceptable within the current sample (Cronbach's alpha for depression subscale = 0.77; Cronbach's alpha for anxiety subscale = 0.82).

Religious activity (Loewenthal *et al*, 2001). Participants indicated the frequency (on a five-point scale) of attending a church or synagogue, praying, and studying religious texts. Scores could range from 0 to 12. This scale had good reliability in this study (Cronbach's alpha = 0.91).

Demographic information: age, gender, religious affiliation, marital status, occupation and religious affiliation of parents.

Tolerance for depression. A questionnaire was developed to measure participants' tolerance for depression. Eight semi-structured interviews were carried out with four Jewish and four Protestant participants, in order to elicit a range of attitudes and beliefs about tolerance for depression. From these interviews, 123 items were generated, forming a Likert-format questionnaire which was administered to a volunteer campus sample (n=70, age range 17-57, mean age 22.8 years, 59 women and 11 men). From these items, 27 were selected to cover a full range of types of beliefs and attitudes, using those with the highest corrected item-total correlations. Cronbach's alpha for the final 27-item scale was 0.94, which is very satisfactory. The scale included general statements about depression and its acceptability (e.g., "It's natural to feel a bit depressed at times"), statements about the potential depression (e.g. "You gain

extra insight into yourself as a result"), statements about responses to and from others (e.g. "Others would respond to you with exasperation"), and statements about the bearability of it being known that one was depressed, and the likelihood of telling others. Responses were on a seven-point Likert scale, and after reverse-scoring, the possible range was from 27 to 189, with higher scores indicative of a greater tolerance to depression, greater sympathy towards people with depression and a belief that depression may have some positive features. Reliability of the scale was good within the sample (Chronbach's alpha = 0.77). A copy of this questionnaire is in Appendix 1.

Procedure

Participants were assured of anonymity and confidentiality, and were instructed to omit any questions that they preferred not to answer. Questionnaires were completed in participants' own time, in a place of their own choosing, and returned in reply-paid envelopes. Participants were offered names and contact details of the research team, in case any further information was required. The questionnaire pack took approximately forty minutes to complete.

Results

Correlations between tolerance for depression, and possible confounded variables (age, religiosity, anxiety and depression) were calculated. Where there were significant correlations, the relevant variable (age, religiosity, anxiety and/or depression) was partialled out in analyses examining the effects of religious group and gender through the use of ANCOVAs.

Mean tolerance for depression scores, in each of the four groups of participants are shown in Table 1. Reverse-scored items are in italics.

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There was a significant effect of cultural-religious group on overall tolerance for depression. Jewish participants demonstrated more tolerance (that is, higher scores) than Protestants. Jewish people also demonstrated greater tolerance on items 3, 11, 13 and 14, either significantly or marginally significantly so.

There were no significant effects of gender on overall scores on the tolerance to depression questionnaire. There were significant or marginal effects of gender on five individual items within the questionnaire. For one of these items (19) women indicated greater tolerance than did men. However, for items 15, 17, 23 and 25, men were significantly or marginally significantly more tolerant than women. Also, when gender x group interactions were considered, the observed effects shown no consistent pattern, and did not clearly accord with expectations. For instance, on item 24, Jewish men and women did not differ from each other, while Protestant men’s responses indicated greater tolerance than did those of Protestant women.

Discussion

The main aim of this study was to examine the influence of cultural-religious group membership on tolerance for depression. Previous research has highlighted the importance of cultural influences on attitudes towards mental illness, and the present study compared tolerance for depression in a sample of Jews and Protestants.

As predicted, Jews were found to be more tolerant of depression than Protestants. This is consistent with previous research highlighting a more positive orientation towards mental illness among Jewish people. Tolerance for depression may impact upon observed rates of depression. We have been able to support the hypothesis that Jews are more tolerant of depression, and we have already seen how this group admits to suffering negative affect and seeks help for psychological problems more readily than other groups. We propose that these two observations are causally linked, although it is appreciated that this issue has not been directly addressed in the current research. This is an area that requires more attention and direct focus in future research studies.

The finding also sheds light on the way in which depression is perceived by the general public. Previous campaigns within the UK have highlighted the need to improve attitudes and eradicate negative stereotypes surrounding mental illness and depression in particular. Although comparisons with previous research are not possible - this is the first study to utilise the tolerance to depression questionnaire - examination of the mean scores are quite encouraging. For example, the majority of the sample (both Jews and Protestants) agreed that depression was natural and something that many people go through and disagreed that they would feel contempt for sufferers. Agreement with items that portrayed depression as virtuous in one way or another was less strong, but nonetheless, people were more likely to agree than disagree. These findings should not, however lead to complacency, and effort is still needed to combat prejudice and lack of general understanding.

A secondary aim of the study was to investigate gender differences in tolerance for depression. Previous research has consistently indicated that women have more positive

attitudes towards depression than men. The findings of this study were not strongly consistent with this. Overall, women and men did not differ in their tolerance of depression, and on some individual items men said they were more willing to seek help and to tell other people. This may have been perhaps the result of the nature of the sample – with a high proportion of professionals and university graduates, and also a high proportion of Jews. However the expected gender differences and lack of differences did not show up in group by gender interactions. It was expected that tolerance for depression would be greater in Jewish men compared to Protestant men but comparable in Jewish and Protestant women. Since there is raised depression among Protestant women compared to Protestant men, but similar levels of depression amongst Jewish men and women, Protestant women were predicted to display greater tolerance towards depression than Protestant men, whereas Jewish men and women were expected to be comparable to each other. However a significant interaction between cultural-religious group and gender was noted for only one item. Contrary to predictions, gender differences were noted in Jews and not Protestants, with Jewish women showing a greater degree of tolerance than Jewish men, and Protestant men were actually found to be more tolerant than Jewish men. Other trends for interaction effects indicated that Jewish and Protestant men did not differ from each other, in their tolerance towards depression, and Jewish women were on occasion more tolerant than Protestant women. Such findings clearly deviate from the patterns predicted, and cast doubt on the ability of differences in tolerance towards depression to account for differences in observed rates of depression among Jewish and Protestant men and women.

The current study has been instrumental in introducing a new and internally consistent questionnaire to assess tolerance towards depression. This may be used to assess cultural variation in attitudes, as this study has demonstrated, but also has wider utilisation, potentially as a tool for assessing attitudes within the general public, and among different cultural-religious groups. Negative attitudes and a lack of understanding still persist with regards to depression and mental illness in general in the UK, and this questionnaire may serve to evaluate the effectiveness of public-targeted campaigns, such as the Defeat Depression campaign, which ran between 1992 and 1996 in the UK.

The measure may also be useful in clinical practice, in helping to identify treatment-relevant beliefs, for example that depression is not treatable, or that depressed people might feel guilty or ashamed of their condition.

It is appreciated that cultural and gender variations in rates of observed depression may result from a number of different factors, including biological differences, and differences in responses to stress and depressive symptoms. We do not think that our findings strongly support the idea that tolerance for depression plays a major role in explaining the relatively high levels of depression among Jewish men compared to men in other cultural-religious groups.

However, the current study has highlighted the possible importance of investigating tolerance to depression, and shown that this is indeed related to culture. Tolerance for depression varies between individuals, and includes beliefs that are of clinical relevance, such as willingness to seek treatment, and the hope that depression is treatable..

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Table 1: Tolerance for depression (overall scale scores, and individual items) by gender and cultural-religious group

	Jewish		Protestant		Effect of gender (G), religion (R), or interaction (I)*
	Male	Female	Male	Female	
Overall tolerance for depression	142.64	142.20	139.60	135.53	R (F(1,157)=4.54, p=.03)
Q1 – Hope for treatment (self)	4.40	5.04	4.92	4.41	
Q2 – Hope for treatment (others)	4.95	5.34	5.22	5.17	-
Q3 - Feel contempt for sufferers	5.71	5.80	6.32	6.08	R(F(1,157) = 3.11, p=.08)
Q4 – Others would be exasperated	4.14	4.19	4.20	3.38	I (F(1,157) = 2.99, p=.09)
Q5 – It's not the right response	4.28	4.37	4.18	4.54	-
Q6 - It's natural	5.86	5.81	5.61	5.69	-
Q7 – Many people go through it	5.89	5.58	5.70	5.73	-
Q8 - It's the right response	3.64	4.12	3.41	3.60	-
Q9 - One shouldn't feel guilty	6.17	6.40	5.93	6.16	-
Q10 – Unbearable if family knew	5.50	5.79	5.57	4.93	
Q11 – Unbearable if partner knew	6.27	6.45	6.05	5.75	R(F(1,157) = 4.07, p=.03)
Q12 – One shouldn't feel ashamed	5.97	6.53	6.30	6.24	-
Q13 – Might be bearable	5.29	5.74	5.20	4.84	R (F(1,157) = 3.43, p=.07)
Q14 – More bearable sometimes	4.89	5.27	4.63	4.33	R(F(1,157) = 4.98, p=.03)
Q15 – Bearable but unpleasant	5.07	4.46	4.93	4.48	G (F(1,157) = 4.44, p=.04)
Q16 – Diagnosis helps	5.17	5.12	5.11	4.73	-
Q17 – More bearable with help	6.25	6.15	6.37	5.86	G F(1,157) = 3.45, p=.06)
Q18 – Virtuous if you gain insight	4.50	3.40	4.50	4.39	-

Q19 – People deserve depression	5.86	6.26	5.54	6.30	G (F(1,157) = 6.19, p=.02)
Q20 - Helps re-evaluate life	4.90	4.50	4.86	4.80	-
Q21 – Improves understanding	5.05	4.77	4.98	4.91	-
Q22 – Helps appreciate good mood	4.82	4.39	4.72	4.32	-
Q23 – Might tell a friend	5.22	4.74	4.91	4.37	G(F(1,157) = 3.91, p=.05)
Q24 – Might tell family	4.97	5.26	5.23	4.53	I(F(1, 155) = 3.50, p=.06).
					-
Q25 – Might tell partner	5.91	5.82	6.09	5.27	G(F(1,157) = 3.37, p=.07).
Q26 – Might tell doctor	5.56	5.91	5.67	5.21	-
Q27 – Might tell Samaritans	4.54	5.36	5.46	4.98	I F(1, 155) = 5.21, p=03)

*****Statistically significant (p<.05) and marginally significant (p<.1) effects are reported in this table.

Appendix 1

Tolerance for depression questionnaire

You may have little or no experience of depression, however, we are still interested in your views. Here is a definition of depression, followed by some questions. We would be grateful of your opinions.

Depression is a persistent, severe and uncontrolled depressed or sad mood and four or more of the following:

- Difficulty in concentrating
- Brooding
- Loss of interest
- Hopelessness
- Suicide plans
- Self-deprecation

- Appetite changes (weight loss or gain)
- Sleep disturbance
- Retardation or agitation

How would a person feel about suffering from this?

Please rate how much you agree with the following statement:

Hope that it's treatable

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

How do you think you would feel if you suffered from depression yourself?

Please rate how much you agree with the following statement:

Hope that it's treatable

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

What would you feel about someone else who was suffering from these symptoms?

Please rate how much you agree with the following statement:

Contempt

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

How do you think others would respond to you if you were suffering from these symptoms?

Please rate how much you agree with the following statement:

With exasperation

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

How much do you agree with the following statements about depression?

Please rate how much you agree with the following statements:

It is never the right way to respond to a situation

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It's natural to feel a bit depressed at times

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It is something that many people go through at some stage in their life

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It is sometimes the right way to respond to a situation

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

A person should not feel guilty about being depressed

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It would be unbearable if the following people knew about my depression

Please rate how much you agree with the following statements:

Family

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

Partner

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

Should a person feel depressed ashamed of being depressed?

Please rate how much you agree with the following statement:

No because it can happen to anyone so no-one should feel ashamed of it

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

How much do you agree with the following statements about depression?

Some people might find depression more bearable than others depending on their personality

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It may be more bearable to be depressed under certain circumstances

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It may be bearable for long periods of time, but very unpleasant

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It is more bearable to put up with depression if you know what you are suffering from

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

It may be more bearable if you have the appropriate help and support

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

If it could ever be considered virtuous to be depressed (particularly from a religious point of view) when might it be considered this way?

Please rate how much you agree with the following statements:

Only if you gain some extra insight from yourself as a result

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

How much do you agree with the following statement about depression?

Some people deserve to be depressed

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

Can any good come out of depression?

Please rate how much you agree with the following statements:

Depression can help people to re-evaluate their lives

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

Depression can help a person to be more understanding towards others

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

Depression helps a person to be more appreciative of good moods and feelings

Strongly disagree 7 6 5 4 3 2 1 Strongly agree

Who might a person tell if they were suffering from depression?

Please rate how much you agree with the following statements:

Friends

Strongly disagree	7	6	5	4	3	2	1	Strongly agree

Family

Strongly disagree	7	6	5	4	3	2	1	Strongly agree

Partner

Strongly disagree	7	6	5	4	3	2	1	Strongly agree

Doctor

Strongly disagree	7	6	5	4	3	2	1	Strongly agree

Anonymous phone line (e.g. Samaritans)

Strongly disagree	7	6	5	4	3	2	1	Strongly agree