Perspectives of Indian Internationals on Mental Illness and Christian Missions

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Abstract

When psychology is integrated with Christianity as a form of missions, it is vital that the

destination country's cultural perspectives be considered in the practice of these fields.

This phenomenology obtained Indian cultural perceptions and experiences of mental

health, as well as their perspectives and experiences regarding the integration of

psychology and Christianity. The participants framed mental and emotional health in the

context of relationship, addressed it with faith practices and values, and evaluated it

based on cognitive functioning and lack of positive emotions. They expressed cultural

concerns with victim mentality, stigma, and shifts in moral values. Regarding the

integration of mental health services and Christian missions, the participants emphasized

the importance of respect, a biblical worldview, and love.

Keywords: globalization, Christian mission, psychology, integration, India

Perspectives of Indian Internationals on Mental Illness and Christian Missions

As the growing field of psychology expands to non-western, or majority world cultures, so do western approaches to the treatment and study of mental and emotional health issues. Similarly, Christian mission has always been a field of reaching out to "the end of the earth" (Acts 1:8, English Standard Version), and as Christian missionaries from the west enter into majority world cultures, they bring with them their own culture-specific approaches to ministry and theology. These fields have integrated in pursuit of providing healing and relief in majority world countries. However, due to the tendency of both fields to approach the world in a distinctively Western way, this integration is sometimes obstructed from both its goal of reaching majority world cultures and from the benefits of learning from those cultures. This is true in the country of India, a complex country with a vast variety of subcultures. The challenge, then, is to determine how mental health is perceived in a majority world culture, and then to tailor research and interventions to that perception in informative, culturally sensitive ways. To better serve the country of India, Christian psychological missions must consider Indian cultural perceptions and experiences of mental health and the integration of its treatment with Christianity.

A Look at Psychology in the West

As psychology globalizes, it diversifies. However, its framework—the theories, research, and publications that fuel progress—is still overwhelmingly influenced by Western perspectives. Arnett (2008) conducted a review of APA publications that found that, of first authors, 73% were based in American institutions, and, of participants, 68%

were sampled from the U.S. Overrepresentations such as this can negatively affect global

practice, as Western and majority world cultures often operate out of different belief

systems and conceptualizations of health issues. One simple example is the preference of

biological conceptualizations of mental health in westerners: in the U.K., white

individuals were more likely to believe their psychotic illnesses were biological in origin

than were immigrants from majority world cultures (McCabe & Priebe, 2004). How

mental illness is conceptualized will certainly affect the way it is discussed, approached,

and treated in a people group. Therefore, it is vital that research seek out the perceptions

of the majority world individuals so that practitioners can tailor their communication and

interventions to the communities' understanding of mental health issues.

Christian Missions and Psychology

Integrating with psychology on the mission field has a fourfold benefit for

Christian missions. Firstly, by providing means of healing to communities in need,

Christianity reflects Christ's embodiment by interacting with the needs of the world

(Smith & Gingrich, 2014). The Old Testament also reflects a call to reaching the needs of

the world: "'He defended the cause of the poor and needy, and so all went well. Is that

not what it means to know me?' declares the LORD" (Jeremiah 22:16, New International

Version). Secondly, psychological theory can be applied to goals within the faith to

improve spiritual growth (Boswell, 2017). The importance of fostering spiritual growth is

seen in Ephesians 4:15-17:

> Rather, speaking the truth in love, we are to grow up in every way into him who is
>
> the head, into Christ, from whom the whole body, joined and held together by

every joint with which it is equipped, when each part is working properly, makes

the body grow so that it builds itself up in love. (ESV)

Thirdly, integrating with faith can improve the ways psychology can minister to those in

need: integration has been shown to improve mindfulness techniques, and relational

attachment to God affects person's mental health (Huennekens, 2018; Parenteau, Hurd,

Wu, Haibo & Feck, 2019). The connections between aspects of mental health,

mindfulness rooted in Christ, and relationship with God are shown in the Bible as well

(John 14:27, Matthew 6:34, Isaiah 26:3). Fourthly, it allows Christianity a chance to

minister the Gospel, which is a primary responsibility of Christians: "Go ye therefore,

and teach all nations, baptizing them in the name of the Father, and of the Son, and of the

Holy Ghost: Teaching them to observe all things whatsoever I have commanded you"

(Matthew 28:19-20, King James Version). Despite its potential for benefit, psychology as

a form of missions is an under-researched discipline (Smith & Gingrich, 2014). Smith

and Gingrich (2014) suggested that the life of the psychologist, in both explicit and

implicit ways, is the primary way psychological practice can be a witness to the Gospel.

However, this answer simply does not encapsulate the full potential of psychology's role

in missions.

The role of psychology on the mission field is one of meeting both the temporal

and spiritual needs of the destination country, whether that be through crisis relief,

treatment of severe mental illnesses, or general counseling. This role in missions is fairly

new for psychology, as its role has traditionally been restricted to member care (Smith &

Gingrich, 2014). As psychology and missions further integrate, the ethnocentrism present

in psychology may be exacerbated by the ethnocentrism present in Christian missions, which often operate off of Western ideals. To quote Gingrich and Smith (2014), "the psychology/ theology integration conversation has been overwhelmingly focused on American and European theologies despite the center or gravity of Christianity now having moved to the global south" (p. 141). However, it is vital that attempts to minister to psychological needs be both culturally aware and biblically sound, not simply a reproduction of Western-oriented theology in a novel context (Smith et al., 2011). Not only does cultural awareness in how the Gospel is shared increase its ability to communicate to a people group, but it also allows for more personal and authentic growth in new Christian faith communities as their faith informs their culture and their culture informs the expression of their faith. Consequently, religious leaders have come together in support of the Cape Town Commitment, a document resolving to address the world's pressing problems with biblical practice and humble attitudes; this cultural humility is key to reaching the majority world and is the impetus for the present study (Hook, 2014; Lausuanne Movement, 2011).

A Look at Psychology in India

Indian perceptions of mental health issues are shaped by cultural phenomena—one such phenomenon is the prominence of stigma in how Indian culture approaches mental health issues. Studies show that the stigma against mental health issues affects the individual as well as his or her loved ones in a phenomenon known as courtesy stigma (Mathias, Kermode, San Sebastian, Koschorke & Goicolea, 2015; Raguram, Raghu, Vounatsou, & Weiss, 2004). Mental illnesses like schizophrenia can prevent or damage

marriage relationships and result in stigmatization by society not only for the individual,

but also for his or her family (Koschorke et al., 2017). Secrecy about the illness is a

prominent way of coping, causing patients to redirect attention to symptoms of physical

illness instead of mental symptoms (Raguram et al., 2004). In order to administer

treatment to those in need, mental health workers in India are forced to operate around

stigma by avoiding charged words tied to mental illness and instead addressing the

problem through euphemism (Weaver, 2017). Administering psychological tests is a

challenge in India as well. In addition to cultural unfamiliarity with psychological testing,

it is possible the stigma surrounding psychological help contributes to the preference of

Indian patients for medical treatment instead of psychological testing that Kumar and

Sadasivan (2016) noted. The challenges stigma poses are significant and must be

addressed with cultural awareness.

The values found in social, religious, and cultural norms may also contribute to

how mental health issues are perceived and treated. While India's Mental Healthcare Act

gives insight into the Indian government's approaches to interpreting and treating mental

health issues, it does little to reveal the perceptions of India's local populations (Duffy &

Kelly, 2019). India is largely Hindu in religion, which teaches integration of mental and

physical health, approaches pain with acceptance, as pain is believed to be a result of

Karma, and is the root of Ayurvedic medicines, which influenced the traditional Indian

approaches to health, including mental and emotional health (Fàbrega, 2001; Office of

the Registrar General & Census Commissioner, 2001; Lakhan, 2008; Whitman, 2007).

Sikhism, another important religion in Indian culture, encouraged a process of relieving

pain through religious devotion (Kalra, Bhui, & Bhugra, 2012). Differences between

collectivistic and individualistic cultures are also critical, especially in consideration of

the sub-categories of these divisions (Sivadas, Bruvold, & Nelson, 2008). Time

management is another area of cultural difference that could affect practice (D'Cruz,

Paull, Omari, & Guneri-Cangarli, 2016; Leonard, 2008). Additionally, understanding the

ways Indian value systems are changing, in part due to globalization, could give critical

insight into the stressors on mental health in India (Majumdar, 2018; Ozer, Meca, &

Schwartz, 2019). Coping mechanisms will naturally look different across cultures, as

values and social norms naturally influence the effectiveness of different practices.

Several techniques have been discussed in the literature that may naturally lend

themselves to the preferences and needs of Indian populations, such as addressing self-

esteem issues (including through mindfulness practice), the efficacy of prayer, and the

value of social effectiveness (Bajaj, Gupta, & Sengupta, 2018; Boelens, Reeves,

Replogle, & Koenig, 2009; Espinosa, Valiente, Varese, & Bentall, 2018; Sánchez et al.,

2019). In light of the need for cultural humility when seeking to reach a majority world

culture with diverse values and beliefs, this study sought to build a framework for

understanding how Indian internationals conceptualize mental and emotional health, its

treatment, and its integration with Christianity, especially in the context of missions.

Method

This study utilized a semi-structured interview format to obtain a phenomenology

of the individual's experiences and views of mental and emotional health problems, their

treatment, how the Christian faith influences these views, and how Christian missions

should approach psychological problems in Indian individuals. The questions referred to

"mental and emotional health" instead of "mental illness"; this terminology was

employed to minimize western bias. The interview guide was organized into three

sections. The first section addressed demographics and personal background. The second

section addressed the individuals' definitions of, experiences with, and opinions on

psychology and mental illness and its treatment, as well as Christian perspectives. The

third section (participant A chose not to complete this section due to time constrictions)

addressed the differences between U.S. psychology practice and experiences and Indian

practice and experiences. Participants were provided with an early draft of the results

section to ensure trustworthiness of the data. The interview guide and all recruitment

processes were approved by the Institutional Review Board at Liberty University.

Results

Participants

Individuals from India residing in the U.S. were recruited to participate in this

study. Each was over 18 years old; one was a young adult and two were middle aged

adults.

Participant A came from South India with Marwari and Tamil parents, originating

from a rural background, but he has observed a transition in his home towards urban life.

He is currently a Christian and came to this faith in a mission school in India. His

background prior to this was Hindu, although his mother was a Kerala Christian

following the Mar Thoma tradition. Participant A received formal education in

Psychology in the U.S.

Participant B identified as Punjabi but spent the majority of his time in India in Western India. He considered his home to be suburban, reflective of both city and rural life. He grew up in a Sikh family, but he personally became a Christian as a teenager after his mother and sister's conversion to Christianity. Participant B received formal education in psychology while in the U.S.

Participant C was from Southern India; she considered her home to be centrally located in a highly populated city in Southern India, where she was middle-class. She grew up Anglican and attended Catholic school.

Perceptions of Mental Health

The first research question was designed to obtain a phenomenology of how Indians perceive and experience mental health. The responses indicated that the participants had a holistic, relationship-oriented approach to understanding and experiencing mental and emotional health.

Approached holistically. The participants displayed a holistic conception of mental health, as their responses incorporated emotional, cognitive, physical, and spiritual wellness, with spiritual themes integrated throughout.

Cognitive ability. Maintaining capacity for optimal cognitive functioning and having positive thought content were important to how the participants conceptualized mental health. Participant A mentioned this in an academic sense: "[mental health] has to be in some ways connected and reflected with the process of learning, you know, the education." Furthermore, Participant B identified "getting rid of confusion" and not being "indecisive" as signs of mental health, although he struggled with those things personally.

Participant B emphasized the importance of having a "proper mind" that conformed to Scripture: "Think of things that are holy, that are noble, that are . . . pure." He concluded that, "If somebody doesn't have that sound mind, I think they cannot function, whether it is school work, employment, or any sort of thing in life." He claimed a person could be well educated and still lack this "proper mind" if they were not conforming to faith values or in a relationship with God. Overall, cognitive function and thought content were important to the participants' conceptions of mental health.

   Emotional components. Mental and emotional health were in part defined by the experience of positive emotions, lack of negative emotions, and a problem-solving, resilient attitude.

   Participant B discussed being "relaxed" and "calm" as signifiers of mental and emotional health: ". . . being calm and being at a place where you're not complacent . . . You're trying to soothe yourself by relieving yourself from all the pain that you have . . . from the past or . . . recently." Another factor was "just being happy;" in clarification, he said Christians should "Not just [be] rejoicing in anything, because there are things that are not good . . . but specifically the Lord, because through Him all the blessings are given to humankind." Additionally, he discussed the importance of being "slow to anger," as well as "being in awe of all that God has done. And being thankful, so being surprised."

   Participant C accepted that, emotionally, "everybody has ups and downs," and emphasized the importance of having a resiliency: "A person who's mentally healthy can maybe say, 'OK. Well this has happened. It's not fair. You know--don't like it. But I've

got to learn to deal with it.'" Despite being able to accept that having negative emotions

can be a part of normal mental health, there was an overall push to maintaining a resilient

attitude and pursuing positive emotional states.

Physical wellness. While not a point of emphasis, physical health was brought up

by one of the participants as a part of mental health. Participant A said that "fitness" was

a part of "wellbeing," and lack of physical health could be an indicator of mental illness:

"I think the other symptom [of mental unwellness] is physical health. You know, mental

health shows itself in all kinds of diseases."

Informed by spirituality. While faith concepts were described indirectly

throughout the responses, the participants also specifically addressed it. Participant A

included spiritual growth as a crucial aspect of mental health: "Mental health has to be in

terms of personal spiritual formation." Participant C reinforced this by explaining that,

without "the Lord," she thought "we'd definitely be insane. I do not know where we

would be. You know, where we would turn to." She also iterated E. Stanley Jones'

philosophy in *Abundant Living* as one she respected: "Everything is linked together, and

everything is linked to the Lord." This final statement further signifies the value of a

holistic conception of mental health in the context of emotional, cognitive, physical, and

spiritual wellness.

Conceptualized through relationships. Throughout the interviews, relationship

was a key element in interpreting and experiencing mental health and illness. This was

evidenced in that relational health was considered a part of mental and emotional health.

Participant A said "[wellbeing] would begin with healthy relationships, with the aspect of

not just surviving, but thriving in these relationships." Participant A described poor

communication as a sign of mental and emotional unwellness: "They either hide or hurl.

And they don't want to talk, but if they do talk, you can see everything is reactionary."

Participant C reinforced this by touching on good communication, saying people should

"be able to express themselves without totally losing it." Further highlighting relational

health, Participant B referenced individuals who do not empathize with others: "I hear of

people who get bored of other people and . . . they don't try to sympathize with a

person."

Other symptoms of unwellness were addressed in relational contexts. Participant

B acknowledged reduced emotionality (anhedonia) as a sign of unwellness but did so

through relational terms: "A very boring person with cold emotions, you know, like less

feelings, less words to even praise someone." Participant C expressed significant concern

over self-absorption as a sign of mental health problems: "I think when they're very

me-centered or . . . it's always about them and their comforts and conveniences, and

they're not looking at the world around them." These responses pointed to the value of

relationship in assessing and experiencing mental health.

Proper Treatment

The second research question sought perceptions and experiences of treating

mental and emotional health problems. Participants B and C expressed a preference for a

combined approach of counseling and medicine, however, they also expressed that they

would not personally pursue either if they could use alternative coping strategies instead.

Combined counseling and medicine. A combined approach of counseling,

particularly Christian counseling, and medical intervention was recommended by both

Participant B and C. Participant B's response expresses this well: "There are two

different aspects . . . the medical aspect, getting medical treatment, but also I'd say

counseling . . . I mean, it's not required but it's recommended." However, upon further

examination, the participants expressed hesitations about both medical and counseling

treatments. Despite these reservations, Participant B still supported the practice. He

further clarified why he supported biblical counseling:

> I'm saying that counseling, especially biblical counseling, is recommended. You
>
> know because you could go to any counselor, but someone who is Christian—
>
> chances are they're going to pray for you. And that's going to make you feel
>
> happy and then they're going to dive into God's word.

Hesitancies regarding medication. While the participants recommended

medicine as a part of their perception of good treatment, they did not indicate that they

were likely to seek it out if they personally experienced mental health problems.

Participant B said that "the help of medicines is definitely good," but he expressed some

reservation with the extent of medication, as it hurts the body: ". . . too much of

medicines. . . is not good because . . . it would destroy the system . . . after all, medicines

are also drugs . . . they're going to destroy our internal mechanism and then the organs."

Participant C would also not personally pursue medication or recommend it to a friend as

a first option; she cited negative side effects and the variety of non-medical options as her

reasons: "This [medication] has this side effect, this [other medication] has this side

effect. So, we're all like, 'No medicine please.' But I think there are so many things that

you can, you know address without medication." She would see medication as a proper

choice if the person is "completely incapacitated": "Maybe if they're like completely,

like, unable. Like they've just been laying down for . . . three weeks in a row."

Regarding the general population of his home culture, Participant B felt that their

perceptions and experiences of medicine would look similar to the U.S.: "I mean as far as

the medicines are concerned, they're going to be pretty much secular about it, as in

they're going to be supportive of it."

Hesitancies about diagnoses. Regarding a diagnosis, Participant C said, "It might

help, it may not help" and felt that it was best to "err on the side of caution." When asked

what she felt warranted a diagnosis, she responded, "Maybe in extreme cases? You know

violence, aggravated behavior. Maybe complete inability to function." She described

concern with how freely diagnoses are given in the U.S., and how that contributes to

shirking responsibilities: "I think in [America] especially a lot of people get labeled very

early in life and very unnecessarily and then . . . 'this is our excuse to behave this way.'

And they don't necessarily need to." While diagnosis is helpful in extreme cases,

Participant C was very hesitant about its usefulness in less severe mental illness.

Hesitancies about biblical counseling. While both participants B and C

recommended biblical counseling, they expressed mixed preferences regarding attending

it themselves. They also expressed that it would not be as accepted in India as secular

counseling or alternative coping mechanisms.

If struggling with mental and emotional health issues, Participant B personally

would forgo counseling: "I'd say, I would not go anywhere." Expense was a primary

deterrent ("I don't want to really spend money on this") although he said there were

"many reasons." Participant B also cited the temporary nature of emotion as another

motivator to postpone counseling:

> . . . just because I may not necessarily feel good, it may be temporary. . .. I don't
>
> have to think of it in a serious matter . . . just because I feel sad a day or so. Or
>
> maybe like for many days doesn't mean that I necessarily have to go over
>
> counseling . . . that sadness could be temporary. It doesn't have to be everlasting.

While he would avoid counseling for emotional disturbances, Participant B would see a

psychologist if the problems affected his mental capacities or reflected disorders, such as

"PTSD," "hallucination," and "trauma": "If I'm struggling with different emotions, I

wouldn't really go to a psychologist . . . But if it's . . . about a disorder then I would go

just for the sake of help." Even so, he clarified, "I'd try my best to keep it as economic as

possible." However, Participant C would attend counseling in addition to self-help

through a trusted Christian author: "I think I would go to, like, a Christian counselor."

While counseling itself was not looked down upon in the responses, there were several

barriers to attendance, primarily financial in nature.

Additionally, the participants indicated that their home cultures would be less

open to biblical counseling than they were. Religious agnosticism would contribute to

rejecting biblical counseling, according to Participant B. He explained the reason: "Today

when I see my country and its people, especially the ones that are of my age, I see them

more as agnostic people, not even Hindus and Muslims." Additionally, differing attitudes

regarding what is severe enough to necessitate treatment within Indian culture could play

a role in those individuals rejecting biblical counseling. Participant B described how Indian individuals would seek help: "instead of going to a doctor or a psychologist they would . . . try to talk to other people . . . And that's how they're going to find a solution," whereas "here in America people . . . would find a doctor that would find time for treatment as soon as possible, immediately." While the participants suggested biblical counseling, their responses indicated that this may not be the preference of their cultural origins.

Alternative Coping Strategies. Despite their perceptions of the benefits of counseling and, at times, medication, the participants preferred alternative coping mechanisms, including the following:

Self-help resources and activity. Both participant B and C described a number of alternative coping mechanisms they would use, including self-help resources like "Focus on the Family," "books" (namely, *Abundant Living*), and "tapes," all of which Participant C recommended. Additional resources mentioned by Participant B included playing sports and taking breaks from school.

Spiritual solutions. Spiritual coping mechanisms were including prayer, encouragement from other Christians, worship, and reading scripture. Praying individually and with family was mentioned by both participants B and C. Participant B stated: "something I like about . . . close-knit Christian families . . . I see the power of prayer . . . I don't see those at home." This prayer support could also be found in friends, Participant B's personal coping mechanism: "Honestly, I just talk with my friends, like my brothers in Christ . . . pray about it . . . and be honest with my mom and my family

members and just get it sorted out." He stated: "That's something that really, Christians should do. You know, like always encouraging other brothers and sisters in Christ Jesus through the Word." Participant B referenced worship as a coping mechanism, and both Participant B and C referenced reading the Bible, with Participant B calling it "the most powerful tool that we have."

Relevant Cultural Concerns

Throughout the interviews, cultural factors were mentioned by the participants that could play a role in understanding and serving this country well, including the differences in managing time, the prioritization of relationship, and the experiences of stigma due to poverty and the shame/honor culture.

Time. Participants A and B revealed an approach to time that is more flexible and relationship-oriented than the typical American approach. Participant A showed cultural awareness: ". . . we're not *chronos* we're *chairos.* So, we love the moment." Furthermore, participant B noted: "[The U.S.] focuses more on planning ahead in time. [Indian] culture focuses on planning at time." Participant B expressed a concern that biblical counseling is too businesslike, and this judgment largely centered on how time is managed in session: "They're just gonna treat it as a profession. 'Come in,' you know, note down the time you entered and just make sure that your time is fixed. You cannot even exceed a minute further . . ." This was problematic for him, and a sign that this cultural difference should be considered by psychologists serving India.

Relationship. Relationship was a common thread throughout responses to the other research questions, but Participant A shared that "relationships really matter, and

the relational is more important than the transactional." These relationships seemed to be forged through shared experiences and hospitality, as he clarified: "we celebrate festivals; 'you should come to my child's birthday;' 'why did you pray for me when I had my exam?' You know, those are the things that matter," and "You don't open your wallet, you open your home and invite them in. And hospitality is a missing art here in America." Participant A's responses indicated that relationship-building is incredibly important to Indian culture.

Concerns regarding stigma. Stigma and related cultural concerns were discussed by the participants. The first relevant cultural phenomenon was the shame/honor structure within the society's values. The second was the prevalence of poverty in India. Both of these contribute to the problem of stigma.

Stigma. The participants mainly cited stigma as a potential difference in how people with mental and emotional health issues are treated in India. While Participant C stated, "I don't think there's any different treatment," she also acknowledged some difference: "Maybe in some ways people are kinder." Participant C cited the example of someone she knows with Down Syndrome: "The labels that they use to describe her are cruel. You know because they don't understand. They're not—they haven't been trained; they haven't been educated. So, it's sad. The quick—the immediate response is always hurtful, ignorant." This stigma is influenced by the privacy of the shame/honor cultural structure and the poverty in India.

Privacy. Participants A and C indicated that the shame/honor culture of India results in increased reservation regarding disclosure about mental health issues.

Participant A identified this issue: "the key is that we are a shame-honor society so a lot of the things that happen to us—we don't air our dirty laundry outside. Indian families, even here in the US, . . . don't actually discuss issues openly or report stuff." Participant C said something similar: "Mental illness is not discussed . . . they're not gonna [*sic*] say 'How's your mental health?' Or if somebody is not mentally well, . . . they're gonna [*sic*] try as much as possible to hide it." The shame/honor society of India results in a tendency to hide mental health issues, according to the participants.

Poverty. Participant A directly tied poverty to stigmatization: "We didn't have money to pay the house rent, so you could imagine living in poverty . . . So, poverty is there. The caste system is there . . . So, there are all kinds of stigmatization in society." Participant C described some of the challenges faced in India: "Life is definitely difficult over there . . . the lack of water, the lack of natural resources, the lack of electricity." Participant C connected mistreatment of those with mental health issues with poverty:

> Like sometimes people will try to beat them, to kill them. You know, I mean, "look don't behave this way. Don't do this, don't . . . Can we beat them into submission?" . . . But you're also looking at a lot of the population is poor.

She further elaborated how poverty contributes to the stigma she was describing: ". . . there you have a lot of poor people who are not educated, who are not trained, or have no awareness . . .You know you see the cruelty."

Shifting values. Participant A discussed ways that Indian culture is currently shifting away from absolutes, both in sexual ethic and in conscientiousness about health. He talked about how shifting cultural values are stressors in India, as "India very quickly

has become very rich" and this has created shifts in moral structures:

> So the internet has revolutionized culture, and I think there's a loss of absolutes.
> For example: sexuality in India, adultery is now said 'okay, it's an old [way].'
> Homosexuality is given a thumbs up by the supreme court two weeks ago in
> India. So, I think, morally, we are in for a new revolution that's going to either
> fragment us if we don't really conserve some of our values.

Furthermore, Participant A highlighted the stress that these moral shifts could have on families:

> . . . you know I told you about joined families; imagine now we just have people
> cohabiting. Ooh that's a lot of stress. I told you my dad picked my wife. Where it
> is now you have people having affairs, and it's okay. I mean—you can—that
> doesn't surprise you in the West. But coming from the cultural intelligent
> background I mentioned, that's too much to swallow for anyone, any religion.

Additionally, Participant A expressed concern that being more "health conscious" as a culture was overriding relationship values and causing problems: "We've gotta cut the carbs, the masala dosas . . . That should be part of our social life is eating. You know meeting without eating was cheating. But now they're like, 'well I'm good I've gotta [go]—'." Overall, he indicated that the moral shifts occurring in India today, in part due to the globalization of the internet, were contributing to mental and emotional health problems.

Victim mentality. Participant C drew attention to the growing "victim mentality" in India; Participant A mentioned this as well. Both said that taking personal

responsibility is difficult for some Indians, with Participant A describing some of the cultural issues that may be used as an excuse:

> That whole understanding of taking ownership of your situation, I think, is a big issue in India. You know we almost feel victimized because 'Hey, I was born in this family, or in this caste, or I'm a girl, or my parents are poor,' you know. So I think that is a challenge to realize, 'Listen, I accept who I am and then from here where do I go?'

Psychology in Missions

The participants indicated several ways that missionary-psychologists could best serve India. Their responses included both guidelines for how to interact with the Indian culture and implorations that Christian values be employed.

Relationship and responsibility. Both respectful relationship and an encouragement for the individuals to take personal responsibility were indicated as important things to consider when interacting with Indian clients.

Respectful relationship. Participant B emphasized the importance of respect: ". . . if someone is not respecting the person who has been affected by mental illness, they're not even treating them as human beings, and they're just treating them as garbage." Participant A also emphasized respect and "appreciat[ing] the culture" as a key part of ministering to Indians with mental and emotional health issues: "I think that's the starting point: you have a positive regard. Psychologically, that's affirmation rather than that negative reinforcement, like, 'I'm from America, you have a problem; I'm [*sic*] come to help you.' . . . a little humility and respect would help." Participant A stated:

You know Indians respond best when they can trust you. When they're not

objectified as people who are different, "I'm here to help you." But they are

included around a table and say, "hey, there's a mutuality to this. You know I

want to learn from you, how can I serve you, can I journey with you?"

Participant A and B's responses indicated that a relational, collaborative approach rooted

in respect would help a Christian psychologist better serve clients in India.

Responsibility. Participant A pointed out the importance of counseling with

the intent of building individual responsibility. He said to "reach out to them in a way

that they take responsibility . . . most Indians will only take responsibility if you give

them a sense of ownership . . . If not, you create this unhealthy dependency on you in

psychology and mental health." He warned against going too far and creating entitlement:

"At the same time you don't want the American style of entitlement; that's even worse

than dependency. You know, 'You owe me something.'" Helping Indian clients assume

personal responsibility without overcompensating into entitlement could be a goal of

psychologists in India.

Spiritual integration. It was important to the participants that clinical practice in

India be rooted in Christian love, proclaim the Gospel, and come from a Biblical

worldview, even though the general public and media in India might be less than

receptive to this at first.

Love. Love was given special attention by the participants as a healing agent,

especially when that love reflected and was sourced in the Christian faith. Participant B

listed God's love as "the last and most important thing," continuing, "This is the greatest

form of love, better than the humanly love, better than any sort of loving—God's love."

Both Participant B and C felt that Christian love would positively affect the client.

Participant C said that "kindness," being "loving," and being "caring" would all "make

an impact on that individual." Participant B also talked about the way love affects the ill:

"However just by seeing the love you have for them, it would just change their mentality

. . . in a good way." In summary, a Christian psychologist could better serve Indians by

employing biblical love, as stated by Participant B:

> And how are we supposed to love others: by loving God first. And how are we
>
> supposed to love God: by knowing him . . . And only if you are able to love God,
>
> we're able to love others, and only we able to love others where we are able to
>
> love ourselves, and just by loving ourselves, we could be able to fight all those
>
> problems that we have in our mind, whether it is a disorder, mental illness, or
>
> trauma.

The Gospel. Participant B described the universal need for the Gospel: ". . . from

biblical perspective, everybody has to hear about Jesus. . . Indians or Americans. It

doesn't matter at the end." He urged missionaries to "tell them about Jesus so that you

know they can give everything to him, all the troubles they have in life. And instead

receive all the blessings that he has for them."

Biblical worldview. Participant C emphasized the importance of a counseling

ministry being biblical in worldview: "I think [it will] only be beneficial if you do it at a

Christian point of view." She elaborated as to why: ". . . it's not just, you know,

addressing one part of the person; it's the whole person." Participant B also expressed a

preference for biblically-oriented psychology, because he felt it shaped the way psychologists would love and encourage their clients. He contrasted this with secular psychologists: ". . . if a secular psychologist or psychiatrist were to enter India, [they] would have more . . . practical methodology . . . [and] ideology. . .. so, they would not for the most part use love." He felt that secular psychology would encourage differently as well: "they would not [encourage] from a perspective that comes from the Bible . . . they would do it from their own perspective." Participant C also described the problems she had with secular psychology: "I think psychology by itself is you know feel good or, you know, 'You're a victim' or things like that."

Reception of spiritual integration. Despite his personal preference for Christian perspectives, Participant B felt biblical counseling would not be well received in India. Participant B explained that he thought the general public and media would react negatively towards Christian-based practice. He attributed this to western influence in the media: "the media has been infiltrated . . . by Western ideologies. And I feel like that makes them—this may sound bad, but I think that makes them more secular." However, he believed the "humble" testimony of the Christian psychologist would spark questions about Christ in individuals. He felt they would then be interested in interacting with the psychologist and, eventually, becoming a Christian: "like I want to learn about this person who has come all the way from a different country and what he or she has to present." He felt differently about secular psychology: "from a non-Christian perspective. I think the media is going to approve of it."

Medical resources and diagnosis. The participants suggested providing

diagnosis and medication as forms of intervention needed in India. Participant B

suggested "providing them with medical equipment." Regarding diagnosis, Participant C

suggested that clinicians should be more willing to diagnose in India than they should be

in the U.S.: "I think you have to do a reverse. I think in—[America] every minor thing is

blown up to be major . . . And there I think every major thing people treat [as] minor."

Despite the hesitancies she expressed regarding medication, if someone was experiencing

psychotic symptoms, she recommended it. Providing more diagnosis-based treatment

could be helpful in India, according to the participants.

Raising awareness. Regarding the effects that U.S. psychology and psychiatry

would have on their community, Participant C said she thought it "would only help." She

suggested raising public awareness of mental illness in India:

> Maybe if there was a way that they could do public perception of mental health
>
> and say, 'OK this is something.' That the person is not faking to get attention . . . I
>
> think, you know, public perception, treating with compassion and kindness and
>
> caring, and love will go a long way.

Increasing the compassion and kindness of the public through awareness and anti-stigma

campaigns could be seen as helpful to clients in India.

Discussion

How Did Indian Internationals Perceive and Experience Mental Health?

Through terms of relationship. Many of the participants' responses were

centered around how an individual interacted with and affected others. Signifiers of

mental and emotional health status were tied to relational health by Participant A: while

"thriving" relationships and clear communication were signs of wellness, "withdrawal,"

and "reactionary" communication were deemed unhealthy. Altruistic behavior was

mentioned as a sign of health, while self-centric thought processes and lack of empathy

were deemed unhealthy. Even emotional cues of illness were contextualized in

relationship, such as Participant B's noting of reduced emotionality as having "less words

to even praise someone." What he was describing is consistent with anhedonia,

recognized to be a symptom of depression and other disorders; however, his

interpretation of illness was contingent on how it affected the individual's interactions

with another person (American Psychological Association, 2013). Clearly, the state of

relationships was central to the conception and experience of mental and emotional health

in these participants. Interestingly, this is not reflected in the definition of mental illness

provided by India's Mental Healthcare Act from 2017, which uses idiocentric

terminology for its definition (Duffy & Kelly, 2019). However, this does not negate that

the general culture of India is potentially more concerned with how mental illness affects

people other than the mentally ill.

Relationship also was a key factor in how participants personally coped with

emotional health problems. All three participants emphasized the importance of

relationship in addressing mental and emotional health problems, expressing a preference

for seeking help from friends and family. The value of maintaining and fostering social

capability is noted in psychological research. Individuals with more social effectiveness

are more likely to obtain employment, integrate with their community, and cope with

their illness (Sánchez et al., 2019). Social effectiveness can be improved by addressing

self-stigma; practical applications of relationship building and stigma reduction are addressed later (Sánchez et al., 2019).

  Through a holistic lens. The participants described stable emotional states, spiritual growth, physical health, and cognitive ability as markers of mental and emotional health. This holistic approach reflects traditional values in Indian culture, which can be traced back to Hinduism: Ayurveda's guidelines for medical treatment emphasized holistic approaches to understanding and treating mental health problems (Fàbrega, 2001). Participant B's emphasis on emotional stability also reflected traditional holistic religious values: Participant B described the necessity of "relieving yourself from all the pain that you have." The relief of emotional pain is a particularly spiritual process and a primary concern in the Sikh religion—the religious background of Participant B as well as 1.9% of India's population (Kalra et al., 2012; Office of the Registrar General & Census Commissioner, 2001). The lens through which these participants viewed mental health was multifaceted in nature, reflecting traditional beliefs in Indian culture.

  Through integration with their Christian faith. The participants identified a Christian perspective on mental health as one that incorporates thought content, Bible reading, prayer, encouragement, and God's love. The participants personal recommendations and coping mechanisms of prayer, especially prayer in community, is an intervention that has been shown to be effective in reducing symptoms of anxiety and depression (Boelens et al., 2009). The sound mind Participant B described was one of not simply cognitive ability, but of positive thinking and obedience to God. This concept could also be related to the practice of mindfulness, which, while already effective on its

own, can be even more so when integrated with Christianity (Huennekens, 2018). In fact,

research has shown that happiness—an emotional state valued by the participants in

health—can be increased through mindfulness techniques that can enrich one's self-

esteem (Bajaj et al., 2018). All of the participants touched on the importance of love in

applying their faith to mental health issues. It has been suggested that this love can be

fostered through positive-thinking models of hope—the thought-discipline of a sound

mind could very well lead to the expression of love that the participants emphasized

(Boswell, 2017). However, their primary concern was in receiving love from God—a

relational view of the faith that has been studied using attachment theories. Having a

healthy, secure—i.e., loving—attachment to God has been shown to increase a person's

ability to cope well with challenges in life, especially by encouraging the individual to

use emotion-focused coping mechanisms like positive reframing—again touching on the

idea of a sound mind focused on the good in the world (Parenteau et al., 2019).

How can Christian Psychologists Better Serve India?

   Through acknowledging the effects of globalization. Globalization has

encouraged a shift in cultural values in several aspects of Indian life. Participant A noted

a "loss of absolutes," especially regarding sexuality, and expressed concern that these

changes in moral values create stress. What Participant A noticed is backed by current

literature: India is changing in its views on sexuality, becoming more accepting of sex

before marriage, homosexuality, and prostitution (Majumdar, 2018). Majumdar's (2018)

study found that religiosity was negatively associated with acceptance of premarital sex.

It comes as no surprise, then, that Participant B saw a decrease in religiosity in his Indian

peers. The massive shifts in values concurrent with globalization in India may have

negative effects on the mental health of its population, as Participant A noted: "[W]e are

in for a new revolution that's going to either fragment us if we don't really conserve

some of our values." However, not all integration with the West is negative, especially

when precautions are taken to prevent negative influence. According to one study in a

western-influenced locale in Northern India, adopting an identity that integrated both

western and local cultural values promoted mental health by allowing for "identity

exploration" (Ozer et al., 2019, Globalization and Personal Identity Development, para.

1). If Western influence from globalization can avoid provoking stress in Indian

individuals, it can aid the mental health of Indians by providing new options.

      Through eliminating stigma. Decreasing stigma is universally important, but not

all stigma is universal. Reducing stigma through awareness programs, as suggested by

Participant C, would help reduce the adverse societal effects of disorders. She specifically

noted that there needed to be education regarding the reality of the illness, as it could be

perceived as manufactured by the ill person, a possibility backed by a study in North

India that revealed discrimination against the mentally ill due to an idea that they were

"faking" it (Mathias et al., 2015, p. 8). This places guilt and stigma back on the

individual, but appropriate education campaigns could reduce this. The participants in the

present study expressed that mental health issues are something to be hidden in India, not

openly discussed, as the culture tends to keep problems to themselves. However, this

could be increasing stigmatization that needs to be eliminated for the sake of those

suffering.

Research has been done on what an appropriate anti-stigma campaign might entail. Koschorke et al.'s (2017) study suggested that appropriate campaigns should not focus on spreading biological models unless the campaign is directly tied to reducing guilt in illness, but should instead focus on providing hope that mentally ill individuals can achieve functionality in culturally significant ways, that correct management of the illness can reduce embarrassing symptoms, and that resources to manage mental health issues are accessible. By reducing stigma in these ways, the perception of mental health issues in India may change.

Through managing time according to cultural values. Time orientation can be categorized on a spectrum between monochronicity, a task-oriented conceptualization of time, and polychronicity, a relationship-oriented conceptualization of time (Leonard, 2008). A polychronic mindset is characterized by increased flexibility, multitasking, and bringing relationship and duty together (Leonard, 2008). Both participant A and B addressed the differences in how Indians conceptualize time, noting that Indians are less likely to plan far in advance and care more about social values than making the next appointment on their schedule. Their responses coincide with research that calls India a polychronic society (D'Cruz et al., 2016). Considering these differences could alter the way a counseling session is conducted. For example, counseling sessions should embrace flexibility, such as in length of appointment. Adopting longer, more flexible session times may increase the effectiveness of counseling in Indian settings, especially considering Participant B's aversion to the strict one-hour schedule common in western practice. The tendency to not plan ahead and the desire for flexibility in Indian culture would be met

well if counseling appointments were conducted on a walk-in basis. Incorporating these

cultural time values into how psychology is practiced would ultimately reach Indian

people better.

           Through addressing victim mentality. Participants A and C saw having a victim

mentality as a potentially detrimental feature rising in Indian society. This phenomenon is

not unheard of in Western culture. However, India's collectivistic culture makes victim

mentality an integral factor in addressing mental health problems. India is a vertically

collectivistic society, meaning, while individuals function from a group-first mentality,

they are also acutely aware—and resigned to—social hierarchy (Sivadas et al., 2008).

This was evidenced in the way Participant A discussed the lack of equality in India. He

pointed to the caste system, poverty, and gender inequality as reasons Indians feel

victimized. All of these issues could be tied to the importance of social rank and a

tendency in India to "accept inequality" as a part of a vertically collectivistic mindset

(Sivadas et al., 2008, p. 202). Counselors from the West are more likely to have a

vertically individualistic mindset: seeking out a personal rise in social rank is valued

(Sivadas et al., 2008). When addressing victim mentality in Indian clients, clinicians must

consciously step into a mindset where operating within one's own social rank is valued,

prompting their clients to take personal responsibility in a way that is congruent with

their cultural identity. Perhaps the freedom to change one's situation would first begin

with the ability to accept one's position. This would seem to resonate with participant A's

expression of the need "to realize—listen, I accept who I am, and then from here where

do I go?" This approach of acceptance would likely resonate with the Hindu population

in India, making up 80.5% of the Indian population as of 2001, as Hinduism teaches an

acceptance of pain as a part of Karma (Office of the Registrar General & Census

Commissioner, 2001; Whitman, 2007). However, this acceptance can lead to increased

victim mentality, unless clients are encouraged to attempt to change their circumstances

as well (Whitman, 2007). Encouraging clients to be content throughout the process of

change will allow them to make progress without creating intervention-preventing

conflict with their religious and cultural values (Whitman, 2007). Addressing the critical

issue of victim mentality would empower Indian clients to better mental and emotional

health.

Through engaging in respectful relationship. Participant A gave clear direction

to have respect for and to form relationship with the clients in order to serve Indian

clients well. He suggested an approach of equal partnership. Relating to and respecting

the client, seeking to learn from them while aiding their recovery, is the primary way of

ensuring appropriate care takes place. Given the vertically collectivistic culture, it may be

necessary for psychologists to adopt the lifestyle of the social class to which they provide

services. Equal partnership may not be possible if a significant class divide is felt by the

client towards the practitioner. This emphasis on relationship fosters humility in one's

approach to counseling, which coincides with the concepts put forth by Hook (2014)

regarding the pursuit of cultural humility.

Through employing a biblical worldview. Participant B felt that both secular

and biblical counseling could make a positive difference in their community, but that

biblical counseling would ultimately be better, as Christian counselors would be more

equipped to encourage and love their clients. However, Participant C was only receptive

to the idea of biblical counseling, fearing that secular Western counseling would create

tendencies to use mental illness as an excuse and to have a victim mentality in Indian

communities. While the participants themselves expressed receptiveness to Christian

counselors from the West going to India to practice, they recognized that the majority of

their culture would likely disagree. However, in light of genuine humility and love, it was

believed that the public would slowly become receptive on an individual basis, even if

the media did not.

One of the most prominent themes in participant responses was the efficacy of

love for healing—both mental and spiritual. Participant B highlighted that loving oneself

could be a source of healing, which is supported by research suggesting that improving

self-esteem can decrease symptoms of psychosis (Espinosa et al., 2018). Participant B's

theory centered on love of God and others that would then result in love of oneself and

consequent healing. Further research could seek to quantify the effects of loving God on

self-confidence and mental health problems.

Despite the importance of accommodating cultural differences within practice,

there is a universality to clients' spiritual needs, as Participant B noted: "everybody has to

hear about Jesus. . . Indians or Americans." This statement reflects the attitude of the

Cape Town Commitment, which pointed towards a heaven of ethnic diversity unified by

a common redemption in Christ (Lausanne Movement, 2011). Pursuing a biblically-

oriented psychological practice in India will, in the eyes of the participants, be ultimately

beneficial.

Limitations and Recommendations

Several limitations affect this study. Firstly, the sample size of three was low, especially considering one participant's choice to discontinue the interview due to time constraints. Additionally, the perspective of an Indian international residing in the U.S. will naturally differ from that of an Indian residing in India. While some of this was corrected for in the interview guide, it is impossible to eliminate the biases that arise from living in the United States.

Future research could further address several points of interest noted in this study. Firstly, more work could be done to understand why, despite believing biblical counseling and medical interventions are good approaches to mental and emotional health problems, these Indian internationals preferred to use alternative coping strategies. Secondly, future studies could explore more facets of how Indians might differentiate mental health from emotional health, as well as what kinds of cognitive functioning are viewed as optimal or suboptimal. Finally, practical techniques incorporating collaborative session styles, flexible time management, and culturally appropriate approaches to stigma-reduction and victim mentality should be developed and tested for effectiveness within Indian cultural settings to both verify and apply the present study's results.

Conclusions

The participants expressed a relationship-oriented perspective on, and a holistic approach to, dealing with mental and emotional health. Faith was an integral part of coping with and defining mental and emotional health struggles. As for serving India more effectively, respect, relationship, and cultural humility are necessary. Relevant

cultural values included victim mentality, as India's vertical collectivism shapes the way

this phenomenon looks in society, how time is managed within sessions, as well how

stigma-reduction campaigns are designed. Ultimately, ministering from a biblical

worldview, while it may not be received as well in India, provides long-term benefits for

the people there.

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