Abstract

Although there are efficacious treatments, many individuals who have mental illnesses either do not finish their treatment course or do not seek treatment at all. A primary reason for this is thought to be the stigma that exists around mental health. There is variability in this stigma around the world. This research had three goals. First, we aimed to examine group differences in attitudes toward mental health by comparing Russians, Russian Americans, and Americans. Second, we aimed to understand whether cultural values are related to attitudes toward mental health by examining collectivism, individualism, and support preferences. Finally, we aimed to examine whether these cultural values explain the group differences in attitudes toward mental health. The questions were addressed by a two-part study involving a questionnaire and an interview. Results showed that Russians and Americans were more likely to attribute mental health problems as medical problems and to endorse seeking help for mental health problems compared to Russian Americans. While we did not find any group differences in collectivism or individualism, Russians preferred emotional support more than Russian Americans with Americans falling between the two groups. Finally, across all three groups, individualism was related to more personal mental health stigma and less endorsement of seeking support for mental health problems. These findings suggest that cultural values are important factors to be considered when understanding attitudes toward mental health and designing interventions that increase utilization of mental health services.

The Role of Cultural Values in Shaping Mental Health Related Attitudes: A Cross-Cultural Study

Mental illness is a pervasive issue that affects the livelihood of hundreds of millions of people all around the world. A meta-analysis of the combined literature of common mental disorders from 1980-2013 found that 29.2% of adults experienced a common mental disorder across their lifetime (Steel et al., 2014). However, research shows that the majority of individuals who are in need of mental health care frequently do not complete their recommended treatment plan or often do not seek services at all (Kessler et al., 2001; Sickel et al., 2014).

The World Health Organization (WHO) has suggested that stigma is one of the largest barriers to seeking treatment for mental health problems (WHO, 2001). Mental health related stigma includes negative attitudes toward mental health problems that may lead to prejudice and discrimination. Stigma is especially detrimental when it is internalized by the person with the stigmatized condition, causing them to feel guilty or inadequate about their condition (Ahmedani, 2011). It has been shown that stigmatizing beliefs are widely endorsed by the general public in most Western countries (Corrigan et al., 1987; Bhugra, 1989). However, stigma around mental health is a neglected area of research in non-Western countries, such as Russia. Therefore, a primary goal of this study is to examine attitudes toward mental health problems among Russians and compare the beliefs across the three groups of Russians, Russian-Americans, and Americans.

Research suggests that Russians view individuals experiencing mental health problems more negatively than Americans and are less likely to seek help for mental health problems compared to Americans. A study comparing Russian and American beliefs toward mental health problems found that Russians are more likely than Americans to view depression as a sign of

personal weakness (Nersessova, Jurcik, & Hulsey, 2019). Russians are also more likely to attribute depression toward an individual leading an 'immoral lifestyle.' Other research has supported these findings. A study comparing attitudes toward mental health problems among Russians, South Koreans, and Americans found that Russians and South Koreans were more likely than Americans to perceive depression as an indication of a weak person (Turvey et al., 2012). In addition, although Russians have a high prevalence of depression and substance use (Boback et al., 2006), Russians tend to underutilize mental health services compared to Americans (Hundley & Lambie, 2007). Russians are less likely than Americans to endorse that depression needs to be treated and more likely to believe that depression improves without treatment (Turvey et al., 2012). One study found that Russians endorse professional help-seeking (e.g., psychiatrists, psychotherapists, and doctors) for mental illnesses less often than Americans (Nersessova, Jurcik, & Hulsey, 2019). Thus, we predict that Russians will hold more negative attitudes toward mental health problems and seeking support for mental health problems compared to Americans and that Russian Americans will fall between the two groups because they will retain the values of both cultures.

A second goal of this research is to understand more about the reasons that Russians have more negative attitudes toward mental health problems than Americans. Here we focus on Russian cultural values. One of the values Russian culture traditionally endorses is *sobornost* (communal spirit, sense of togetherness). By contrast, Western culture fosters a sense of individualism and competition (Vlachoutsicos, 1998). This difference in values has historical roots. Instability during much of Russia's early history, such as through Mongol invasions, led to the isolation of Russia from the West. Russians were prohibited from traveling and interacting with the West, and thus, needed to rely on each other to survive the authoritarian regimes,

climate challenges, and frequent scarcity of resources (Vlachoutsicos, 1998). This turmoil fostered a strong sense of interdependence and made reciprocal reliance on family and friends very important (Chentsova-Dutton & Vaughn, 2012; Vlachoutsicos, 1998). The rise of communism beginning in the early 1900s only furthered this emphasis on togetherness. Communism was a state attempt at centralizing the existing communal spirit, which previously only existed in small collectives called *mir*. It forced interdependence through centralizing power and implementing forced collective farming, meaning Russians needed to rely on each other to survive and maintain stability (Vlachoutsicos, 1998). This history explains why Russians have more interdependent cultural values compared to Western countries, such as the United States.

Another way to think about this Russian cultural value is in terms of collectivism. Interdependent cultures, such as Russia, have been described broadly as collectivistic. Unlike individualistic cultures which stress personal autonomy, individual rights, and self-fulfillment, collectivistic cultures place importance on having a collective identity and strong sense of group solidarity, working toward a common goal (Hofstede, 1980). Compared to Western Europeans and North Americans, Russians have been shown to score higher on measures of collectivism (Matsumoto et al., 1998; Realo & Allik, 1999; Tower, Kelly, & Richards, 1997). We predict that Russians will be more collectivistic and less individualistic than Americans and that Russians Americans will fall in between the two groups.

In addition to collectivism, another Russian cultural value is a preference for informational support. Russians perceive informational support to be significantly more important than other types of support such as emotional support (Chentsova-Dutton & Vaughn, 2012). One study showed that Russians were more likely than European Americans to believe providing advice was an important part of being supportive (Chentsova-Dutton & Vaughn,

2012). Russian culture also normalizes imposed social support, such as unsolicited support, compared to Western cultures. Whereas Western cultures tend to focus on solicited support and view unsolicited support as a violation of their autonomy (Chentsova-Dutton, 2012), reciprocal unsolicited advice is commonplace in Russian culture. Compared to European Americans, Russians receive more unsolicited encouragement and advice (Chentsova-Dutton & Vaughn, 2012) and are less likely to view these behaviors as intrusive (Chentsova-Dutton, 2012). Thus, we predict that Russians will have a greater preference for informational support than Americans, and that Russian Americans will fall between the two groups.

All of these cultural values—collectivism and a preference for informational support—have implications for the attitudes toward mental health and seeking support that these groups hold. First, collectivistic cultures, such as Russian culture, may be less tolerant of mental illness compared to individualistic cultures, such as American culture, because deviations from the norm are more threatening to the attainment of in-group goals among cultures that strongly value connection. The weaker connections between group members and decreased importance in attaining in-group goals may lead to more toleration of mental illnesses in individualistic cultures. Second, the preference for informational support from network members that characterizes Russians may explain why Russians are more reluctant to utilize mental health services compared to Americans. Research suggests Russians are more comfortable seeking advice on how to handle problems from their support network and dealing with problems on their own rather than seeking professional support (Shulman & Adams, 2002; Nersessova, Jurcik, & Hulsey, 2019). Thus, we not only predict that Russians will have greater negative attitudes toward mental health and seeking support for mental health problems compared to Americans, but that the previously described cultural values will explain these differences.

Thesis Goals and Hypotheses

This thesis has three goals. First, we aim to examine group differences in attitudes toward mental health problems and seeking support for mental health problems by comparing Russians, Russian Americans, and Americans. We hypothesize that Russians will hold more negative attitudes toward mental health problems and be less likely to endorse seeking support for mental health problems than Americans and that Russian Americans will fall between the two groups. Second, we aim to understand how cultural values are related to attitudes toward mental health problems and seeking support for mental health problems by examining collectivism, individualism, and support preferences. We predict that Russians will endorse more collectivism, less individualism, and have a greater preference for informational support than Americans and that Russian Americans will fall between the two groups. Further, we predict that greater collectivism, less individualism, and informational support preferences will be related to more negative attitudes toward mental health and seeking support for mental health problems. To the extent that this is the case, we will examine whether these cultural values explain the group differences in attitudes toward mental health and seeking support for mental health problems.

Method

Participants

Participants were 20 Russians, 19 Russian Americans, and 19 Americans. Participants were included in the study if they were 18 years of age or older and either born in a Russian-speaking country (Russian group), born in the United States to at least one Russian-speaking parent or had moved to the United States from a Russian-speaking country before the age of 1 (Russian American group), or were born in the United States to American born parents (American group).

Procedure

Participants were recruited through a combination of the CMU Psychology Department Research Requirement website, social media postings (e.g., Facebook), word of mouth, emailing list postings, flyers, and community organizations (e.g., Carnegie Library of Pittsburgh). Participants were contacted to determine whether they met the eligibility criteria. Of the 72 people who contacted us, 58 participants were deemed eligible and recruited into the study. They were emailed a link to the first part of the study (i.e., the online questionnaire) to complete. The questionnaire was administered through Qualtrics, an online platform. Participants provided online consent to participate in the study before responding to the questionnaire that assessed attitudes toward mental health problems, attitudes toward seeking support, cultural group identification, cultural values, and demographic characteristics. Participants were then emailed to schedule a time to complete the second part of the study, an online interview. Interviews were conducted over Zoom, an online platform, and were audio recorded. The interview consisted of a series of open-ended questions relating to attitudes toward mental health problems, support provision, and cultural values.

Of the 58 participants recruited, we retained 57 of them: 19 Russians, 19 Russian Americans, and 19 Americans upon completion of the interview. One participant did not respond after repeated attempts to contact them to schedule the interview. After filtering for participants who failed attention checks in the questionnaire, we retained 16 Russians, 19 Russian Americans, and 18 Americans. Participants received either credit toward the research requirement or $25 upon completion of both parts of the study. Participant demographics by group are shown in Table 1.

Measures

The means and standard deviations for attitudes toward mental health and attitudes toward seeking support for each group are shown in Table 2, and the means and standard deviations for cultural group identification and cultural values for each group are shown in Table 3. Tables 2 and 3 also show the internal consistencies for the scales.

Attitudes toward mental health problems. We had four measures of attitudes toward mental health problems. First, we assessed the extent to which participants *attributed mental health problems as medical problems* using the following three items from Turvey et al. (2012): "Depression is a kind of physical disease," "Physicians should ask patients about depression," and "Depression could benefit from medical treatment." Responses were scored on a 10-point scale (1 = "strongly disagree" to 10 = "strongly agree"). Second, we assessed personal stigma toward mental health problems by selecting the 5 items that loaded highest on a factor analysis of the 16 items used in Aromaa et al. (2011) to measure attitudes and stereotypes toward mental health. A sample item is "Mental health problems are a sign of weakness and sensitivity." Responses were scored on a 10-point Likert scale (1 = "strongly disagree" to 10 = "strongly agree"). We also assessed the extent to which participants attributed mental health problems as a matter of personal strength using the following three items from Turvey et al. (2012): "Depression is a personality trait," "Having depression means that the person is weak," and "Depression is a normal part of aging." Responses were scored on a 10-point scale (1 = "strongly disagree" to 10 = "strongly agree"). Due to the poor internal consistency of these items ($\alpha = .31$), we chose to examine the single item that we thought best represented lack of personal strength: "Having depression means that the person is weak." Because the personal stigma toward mental health scale was strongly correlated with this single item on personal strength described above (*r*

= .85), we averaged the item with this scale to create a *personal mental health stigma index*. Third, we assessed *public mental health stigma* by selecting the 6 items that loaded highest in a factor analysis conducted by Vogel, Wade, and Ascheman (2009) of the 12-item Devaluation and Discrimination Scale (Link et al., 1987). A sample item is "Most people would think less of a person who has been in a mental hospital for depression." Responses were measured on a 10-point scale (1 = "strongly disagree" to 10 = "strongly agree").

Attitudes toward seeking support. We assessed *attitudes toward seeking support for physical health problems* by abbreviating the 12-item Action/Intention Medical Help-Seeking Subscale (DiLorenzo, Dornelas, & Fischer, 2015). We selected the 3 most face valid items (e.g., "I would want to get medical help right away if I had a health problem that was worrying me"). Responses were measured on a 10-point Likert scale (1 = "strongly disagree" to 10 = "strongly agree"). We assessed *attitudes toward seeking support for mental health problems* with the 10-item Attitudes Towards Seeking Professional Psychological Help Short Form Scale (Fischer & Farina, 1995). We removed one item that seemed redundant with the others. A sample item is "I would want to get psychological help if I were worried or upset for a long period of time." Responses were scored on a 10-point Likert scale (1 = "strongly disagree" to 10 = "strongly agree"). We assessed *self-disclosure about emotional problems* by choosing the 6 most face valid items from the 12-item Distress Disclosure Index (Kahn & Hessling, 2001). A sample item is "I usually seek out someone to talk to when I am in a bad mood." Responses were scored on a 10-point Likert scale (1 = "strongly disagree" to 10 = "strongly agree").

Cultural group identification. Participants responded to the following two items tapping their cultural group identification (Jetten, Postmes, & McAuliffe, 2002): "I identify with my fellow [Americans/Russians]" and "I feel connected with my fellow [Americans/Russians]."

Each participant completed these items for both cultural groups. Responses were measured on a 10-point Likert scale (1 = "strongly disagree" to 10 = "strongly agree"). The two items were averaged to create Russian and American cultural group identification indices due to their strong correlation (Russian values, $r = .82$; American values, $r = .65$).

Cultural values. We assessed the degree to which participants endorsed values of individualism and collectivism using the 16-item Horizontal and Vertical Individualism and Collectivism Scale (Triandis & Gelfland, 1998). Responses were measured on a 10-point Likert scale (1 = "strongly disagree" to 10 = "strongly agree"). Eight items assessed individualism, and eight items assessed collectivism. We examined the two scales separately because individualism and collectivism were not strongly correlated ($r = .25$, n.s.).

We assessed social support preferences by abbreviating the 35-item Desired and Experienced Support Scale (Xu & Burleson, 2001; used in Chentsova-Dutton & Vaughn, 2012). Participants were asked the extent to which each support statement described a "very supportive person." We selected 12 items that measured emotional (e.g., "Telling you that he/she loves you and feels close to you"), informational (e.g., "Giving you advice about what to do"), and tangible (e.g., "Offering to lend you something (including money)") support. Each 4-item type of support preference was scored using a 10-point Likert scale (1 = "not at all supportive" to 10 = "very supportive").

Open-ended questions. During the interview, participants were presented with a mental health scenario adapted from a vignette used by Cheng (2015). Briefly, the scenario describes a friend struggling with symptoms of depression. We then asked participants the following four questions: (1) Based on this scenario, what would you do (*Response*)? (2) Think of a time when something like this happened to someone you know. Tell me about what happened. How did you

respond (*Recall*)? (3) Imagine the person in the scenario you heard earlier was you. What would you find to be most helpful (*Helpful*)? (4) Imagine the person in the scenario you heard earlier was you. What would you find to be unhelpful (*Unhelpful*)? Two raters and the author reviewed the responses to identify categories for subsequent coding. The coding system for Questions 1-3 consisted of the 12 categories shown in Table 7. The codes "offer informational support" and "problem solving" were combined to form one code because the individual interrater reliabilities were low and there was overlap between the two codes. The coding system for Question 4 consisted of the 12 different categories shown in Table 8. Inter-rater reliabilities are shown in Tables 7 and 8. We interpret codes with poor reliability with caution.

Results

Group Comparisons in Attitudes toward Mental Health and Attitudes toward Seeking Support for Mental Health Problems

Before presenting the group comparisons in attitudes toward mental health, we first present the correlations among the attitudes toward mental health and attitudes toward seeking support for mental health problems in Table 4. The measures were all related to one another, with the exception of public mental health stigma which was not related to any of the attitudes. In other words, attributing mental health problems as medical problems was related to lower personal mental health stigma and higher self-disclosure about emotional problems. Personal mental health stigma was related to more negative attitudes toward seeking support for mental health problems and marginally related to lower self-disclosure about emotional problems. Finally, more positive attitudes toward seeking support for mental health problems was related to higher self-disclosure about emotional problems.

The group comparisons in attitudes toward mental health and attitudes toward seeking support for mental health problems are presented in Table 2. There was an overall group effect for attributing mental health problems as medical problems, such that Russians and Americans more were more likely to attribute mental health problems as medical problems than Russian Americans. There was no overall group difference for personal mental health stigma or public mental health stigma, and post-hoc comparisons revealed the three groups did not significantly differ on either measure.

There was no group effect for attitudes toward seeking support for physical health problems, but there was an overall group effect for attitudes toward seeking support for mental health problems, such that Russians and Americans had more positive attitudes toward seeking support for mental health problems than Russian Americans. There was no overall group effect for self-disclosure about emotional problems, and post-hoc contrasts revealed that the three groups did not significantly differ from each other.

Group Comparisons in Cultural Group Identification and Cultural Values

Before presenting the group comparisons in cultural group identification and cultural values, we first present correlations among the cultural group identifications and cultural values in Table 5. More identification with Americans was not related to any of the cultural values. More identification with Russians was related to both higher collectivism and higher individualism. Interestingly, collectivism and individualism were marginally positively associated. Collectivism was related to a preference for support in general such that higher collectivism was related to higher preferences for informational and tangible support and marginally higher preferences for emotional support. Higher individualism was not related to any other cultural value besides collectivism. All three support preferences were positively related to

one another, meaning preference for one type of support was related to a higher preference for another type of support.

The group comparisons in cultural group identification and cultural values are presented in Table 3. There was no overall group difference in identification with Americans, but unexpectedly post-hoc contrasts revealed that Russians identified more as Americans than Americans did; Russian Americans fell between the two groups and did not differ from either. As predicted, there was an overall group effect for identification with Russians, such that Russians and Russian Americans identified more with Russians than Americans.

There was no overall group effect for individualism or collectivism, and post-hoc contrasts revealed that the three groups did not significantly differ on either measure. There was an overall group effect for emotional support preferences, such that Russians had higher preferences for emotional support than Russian Americans; Americans fell between the two groups and did not differ from either. There was no overall group effect for informational or tangible support preferences, and post-hoc contrasts revealed that the three groups did not significantly differ on either measure.

Relation of Cultural Values to Attitudes toward Mental Health and Attitudes toward Seeking Support for Mental Health Problems

Our third hypothesis was to examine the extent to which cultural values mediated the group differences in attitudes toward mental health and attitudes toward seeking support for mental health problems. Because we did not find the group differences that we expected, we could not test this hypothesis. Instead, we review the relations of the cultural values across groups to attitudes toward mental health and attitudes toward seeking support for mental health

problems. The correlations of cultural values to attitudes toward mental health and attitudes toward seeking support for mental health problems are presented in Table 6.

Higher individualism was related to more personal mental health stigma, more negative attitudes toward seeking support for mental health problems, and marginally lower attribution of mental health problems as medical problems. Higher collectivism was marginally related to more personal mental health stigma. Higher emotional support preferences were marginally related to higher attribution of mental health problems as medical problems, more positive attitudes toward seeking support for mental health problems, and more self-disclosure about emotional problems. Higher informational support preferences were marginally related to less self-disclosure about emotional problems. Higher tangible support preferences were not related to any of the attitudes toward mental health.

Because the cultural values were only modestly related to one another, we entered all five of them into a regression analysis to identify the independent predictors of attitudes toward mental health and seeking support for mental health problems. There were no significant predictors of attribution of mental health problems as medical. However, greater attribution of mental health problems as medical problems was marginally predicted by lower individualism (β = -.32, SE = .18, $p < .10$) and higher emotional support preferences (β = .38, SE = .19, $p < .10$). More personal mental health stigma was predicted by higher individualism (β = .27, SE = .09, p < .01) and marginally predicted by lower emotional support preferences (β = -.20, SE = .10, $p <$ .10). More public mental health stigma was not predicted by any of the cultural values. More positive attitudes toward seeking support for mental health problems was predicted by lower individualism (β = -.51, SE = .15, $p < .01$), higher emotional support preferences (β = .40, SE = .17, $p < .05$), and lower informational support preferences (β = -.41, SE = .18, $p < .05$). More

self-disclosure about emotional problems was predicted by higher emotional support preferences (β = .43, SE = .19, p < .05) and lower informational support preferences (β = -.62, SE = .21, p < .01).

Responses to Mental Health Scenario

When we asked participants how they would respond to the depression scenario, the most frequent response was to refer their friend for professional help (see Table 7). Nearly ¾ of the sample offered this response. After that, roughly half of the sample mentioned the provision of emotional support and the provision of informational support. There were no group differences in the extent to which participants gave any of these responses. Other responses are shown in Table 7.

When participants were asked to recall a similar situation that happened to someone they knew and discuss how they responded, the most frequent responses were to refer their friend for professional help and to offer emotional support—with just over half the sample identifying each of these responses. After that, around 25% said they offered informational support and 17% said they offered companionship. Chi-square analysis revealed there was a marginal group difference in companionship, with Americans most likely to say they would provide companionship (33%), Russian Americans least likely to say they would provide companionship (5%), and Russians falling between the two groups (13%).

When participants were asked to discuss what they would find most helpful if they were personally facing this scenario, the most frequent response was to be offered emotional support, with this being identified by 68% of respondents. After that, 28% said refer to professional help and 23% companionship. The fourth most frequent response was to be monitored and checked on. Chi-square analysis revealed there was a significant group difference in this response, with

Americans most likely to say this would be helpful (28%), no Russian Americans saying this would be helpful, and Russians falling between the two groups (13%).

Finally, when participants were asked to discuss what they would find unhelpful if they were personally facing this scenario, the most frequent response was someone minimizing or trivializing their problem, with this being identified by 30.2% of respondents (see Table 8). After that, 18.9% said being ignored or left alone and 17% said being shamed or blamed, and 17% said being given advice. There were no group differences in the extent to which participants gave any of these responses. Other responses are shown in Table 8.

Discussion

Cultural Group and Mental Health Attitudes

Our first goal was to examine group differences in attitudes toward mental health, predicting that Russians would have more negative attitudes toward mental health and more negative attitudes toward seeking support than Americans and that Russian Americans would fall between the two groups. That is, Russians would less frequently attribute mental health problems as medical problems, would endorse more personal mental health stigma, would endorse more public mental health stigma, would have more negative attitudes toward seeking support for mental health problems and be less likely to self-disclose about emotional problems than Americans and that Russian Americans would fall between the two groups. In partial support of our predictions, we found that Russian Americans less frequently attributed mental health problems as medical problems compared to Americans. We also found that Russian Americans endorsed more negative attitudes toward seeking support for mental health problems than Americans. We did not have a prediction for attitudes toward seeking support for physical health problems as that was intended to be used as a comparison with attitudes toward seeking support

for mental health problems. Consistent with our predictions, when we compared the three groups' responses to both questions, we saw that Russian Americans endorsed more negative attitudes toward seeking support for mental health problems compared to physical health problems, while Americans endorsed more positive attitudes toward seeking support for mental health problems compared to physical health problems. These findings are consistent with our hypotheses and support previous literature suggesting people from a Russian background may hold more stigmatizing attitudes toward mental health problems and attitudes toward seeking support for mental health problems compared to Americans (Hundley & Lambie, 2007; Nersessova, Jurcik, & Hulsey, 2019; Turvey et al., 2012). However, Russian Americans did not differ from Americans on any of the other attitude measures, so these findings must be interpreted with caution.

By contrast, Russians did not significantly differ from Americans on any of these measures. That is, there were no group differences between Russians and Americans in their attitudes toward mental health problems and attitudes toward seeking support for mental health problems. Similar to the Americans, Russians also endorsed more positive attitudes toward seeking support for mental health problems compared to physical health problems. The fact that there were no differences between Russians and Americans may be because of our recruitment methods. We recruited some of the participants in our Russian group from Facebook groups joined by Russian-speakers from the former Soviet Union who tended to be considerably more progressive than the average Russian. Research has suggested that progressive values are related to more positive attitudes toward mental health compared to conservative values (Löve et al., 2019), which could explain why the Russian group did not hold more negative attitudes compared to the Americans.

Group and Cultural Values

Our second goal was to examine group differences in cultural group identification and cultural values. As expected, we found that Russians and Russian Americans identified as more Russian than the Americans. Surprisingly, we also found that Russians identified as more American than Americans, with Russian Americans falling between the two groups. There are a few possible explanations for this unexpected finding. First, Russians may strongly identify as American because the Russians in our sample have lived in America for a longer period of time than their Russian-speaking country of origin. One can see in Table 3 that Russians identified more with being American than with being Russian. Second, all the Russians in our sample made the decision to immigrate to the United States rather than stay in their Russian-speaking country of origin. We do not know the reasons for their immigration to the United States, but it is possible that they may want to distance themselves from their former country and identity with their new home. Perhaps most perplexing is why the Russians consider themselves to be more American than the Americans. Here we turn to the age confound. The Russians in our sample were older on average than the Americans, so this finding may reflect an age effect where older people have a stronger desire to identify with the country they live in (Huddy & Khatib, 2007). It is also possible that the Americans identified as American to a lesser extent than the Russians because the younger group of Americans are more critical of a country that they have witnessed become increasingly polarized in terms of politics. In fact, public trust in the United States government is near historic lows, especially for Millennials through Generation Z (Pew Research Center, 2021). The fact that Russians identified as being more American than the Americans also may explain why we did not find any differences between the two groups in attitudes toward mental health problems.

Contrary to our predictions, we did not find any group differences in collectivism or individualism. It is possible that this finding reflects a shift in the cultural values of Russians in general. Russians were historically more collectivistic, but some research has suggested they have become more individualistic since the period of economic reform of *perestroika* and the dissolution of the Soviet Union (Naumov & Puffer, 2000). This could also explain why Russians and Russian Americans were not different in terms of individualism compared to the Americans.

It is unclear why Americans did not differ from Russians or Russian Americans in terms of their endorsement of collectivism. The lack of the predicted group difference in collectivism could be reflective of intracultural variability. While Americans are thought to be more individualistic on average, the Americans in our sample might have had more of a collectivistic orientation. Approximately half of the Americans in our sample were college students, and collaboration and reliance on group members are important in many college courses, which may have meant our participants had a stronger collectivistic orientation. Additionally, the majority of Americans in our sample were women, and past research has suggested that women are more collectivistic compared to men (Zeffane, 2017). Finally, it is important to note that we are not the first study to find evidence contrary to the long-held assumption of Americans being strongly individualistic compared to other cultures. Shafiro, Himelein, and Best (2003) examined group differences in collectivism and individualism in a sample of Ukrainian and American female college students and found Ukrainians were more individualistic and less collectivistic than Americans. Other studies have also found Americans to be more collectivistic than cultures traditionally considered to be collectivistic, such as Japan (e.g., Oyserman, Coon, & Kemmelmeier, 2002). It is possible that the extent to which Americans identify as collectivistic varies depending on the sample being studied.

Regarding support preferences, we predicted that Russians would prefer informational support more than Americans and that Russian Americans would fall between the two groups. We found no group differences in preference for informational or tangible support among the three groups. However, there was a group difference in emotional support preferences, such that Russians preferred emotional support more than Russian Americans and Americans fell between the two groups. However, an alternative way to evaluate the data is to compare across support preferences within groups. Russian Americans preferred tangible support over emotional support, which is consistent with our predictions, whereas Americans preferred tangible and emotional support equally. Again, the responses of Russians were more similar to those of the Americans. Given the finding that Russians strongly identify with the American cultural group, it makes sense that their cultural values would mirror American cultural values, especially their preference for emotional support. The Russian group and the American group are also more similar in their demographic breakdown with respect to gender compared to the Russian American group, with both consisting mainly of women and the Russian American group having a relatively even percentage of women and men. Research has suggested that there are gender differences in social support preferences, such that women desire emotional support from others more than men (Xu & Burleson, 2001), so the similarity in the gender breakdown of the Russian and American groups may explain why the Russian group looks more similar to the American group rather than the Russian American group. The lack of expected group differences again underscores the heterogeneity within groups. Thus, it is more important to focus on the values themselves rather than the groups.

Cultural Values and Mental Health Attitudes

Because we did not obtain the predicted group differences in mental health attitudes and cultural values, we were unable to test our final mediational goal. Instead, we examined the connection of these cultural values to attitudes toward mental health. We predicted that individualism would be related to more positive attitudes toward mental health because there would be fewer concerns about the threat of mental illnesses to the attainment in-group goals. Individualistic cultures have weaker bonds between group members, so individuals with mental illnesses pose less of a threat to in-group goals than in collectivistic cultures, thus leading to greater toleration of mental illnesses. Instead, we found that across people, individualism was related to more negative attitudes toward mental health, while collectivism was not related to attitudes toward mental health. Specifically, individualism was related to more personal mental health stigma and more negative attitudes toward seeking support for mental health problems. Furthermore, we found that people who are predisposed to have negative attitudes toward mental health and negative attitudes toward seeking support for mental health problems were more individualistic. These findings may be due to the fact that individualists prioritize the attainment of personal goals, and mental illnesses may hamper the attainment of those goals. Additionally, individualism emphasizes independence, which may translate into the belief that one must deal with their mental health problems on their own.

The one cultural value that was connected to mental health attitudes was the preference for emotional support. There was a trend for emotional support preferences to be related to greater attribution of mental health problems as medical problems, more positive attitudes toward seeking support for mental health problems, and higher endorsement of self-disclosing emotional problems. Additionally, we found that people who are predisposed to have positive

attitudes toward seeking support for mental health problems and self-disclosing about emotional problems had greater emotional support preferences and lower informational support preferences as predicted. These findings suggest that understanding cultural differences in emotional support preferences may be an especially important target of future research when trying to understand attitudes toward mental health and seeking support for mental health problems.

Responses to Mental Health Scenario

The mental health scenario was intended to provide a greater understanding of the support people provide and the support people prefer receiving for mental health problems. Responses to the mental health scenario revealed discrepancies in support provision—what participants said they would do in response to the provided scenario was not always what they did when the scenario happened to someone they knew. For example, 72% of participants responded that they would refer the friend in the scenario to professional help, but only 55% actually referred someone they knew to professional help when they were faced with the scenario. A similar trend was seen with offering informational support or problem solving where 51% of participants responded they would offer informational support or problem solve, but only 25% actually did. These findings suggest that while participants say that they are willing to provide tangible and informational support to a hypothetical member of their social network who is experiencing a mental health problem, they are less likely to do so when someone in their social network is actually experiencing a mental health problem. However, there was correspondence concerning emotional support—participants said they would provide emotional support to a hypothetical member of their social network and actually provided emotional support to a member of their social network to a similar extent. Future research should try to

understand the reasons why people may be more hesitant to provide these concrete actions to those in their social network experiencing a mental health problem.

Responses also revealed discrepancies between support provision and support preferences—what participants said they would do in response to a friend facing a mental health problem was not always what they reported to be the most helpful if they faced a mental health problem. For example, while the majority of participants said they would refer their friend to professional help (72%), only 28% reported that this would be helpful. Similarly, approximately half of the participants responded they would provide informational support or problem solve (51%), but only 11% of participants said this would be most helpful. In fact, what participants reported wanting most was emotional support (68%). Similarly, while 15% of participants reported they would provide companionship, 23% said they would find companionship most helpful. Across people, there was a preference for receiving emotional support in response to a mental health problem but comparative lack of provision of that support to others experiencing a mental health problem. Given our previous finding that emotional support preferences were marginally related to more positive attitudes toward mental health and seeking support for mental health problems, it is important to understand why participants are not providing emotional support to as great of an extent as their preference for it.

Limitations and Future Directions

This study had three primary limitations. First, our Russian group may not be representative of Russians living in Russia. Initially, we planned to recruit Russians from those living in Russia, but the COVID-19 pandemic disrupted the author's plans to study in Russia and collect these data. Thus, we had to recruit Russian-speaking immigrants to the United States instead, which could have contributed to our lack of group differences between Russians and

Americans. Additionally, though the Russian group living in the United States all had the desire and means to leave their Russian-speaking country of origin, this group may be incredibly heterogenous compared to Russians living in Russia. Russians living in the United States vary in terms of their duration living in the United States, acculturation into the United States, and the specific Russian-speaking country from which they immigrated. Future studies should aim to study Russians who are living in Russia to allow for a better comparison among Russians, Russian Americans, and Americans.

Second, there were confounding variables linked to our groups—age, gender, and education. First, Russian participants were the oldest and Russian Americans were the youngest, with Americans between the two groups in age. This age confound could have contributed to our unexpected findings relating to cultural group identification, where Russians identified as more American than the Americans. Second, the Russian and American groups were composed of a majority of women, while the Russian American group had a similar percentage of women and men. The similarity of gender breakdown of the Russian and American group may explain why Russians often appeared more similar to the American group rather than the Russian American group on measures of attitudes toward mental health and cultural values. Finally, all three groups were highly educated, which may not be representative of the general populations of all three groups. In particular, the Russian group was the most highly educated out of the three groups, with participants either having completed college or post-graduate training. The highly educated nature of the Russian group may also explain why Russians had more positive attitudes toward mental health than expected. Unfortunately, we did not have enough power in our sample to examine the impact of these covariates on our findings. Future studies should aim to recruit a

larger and more representative sample, especially in terms of gender, to better understand each group.

Finally, there were other potential confounds that we did not measure, such as political leanings, personal experience with mental illnesses, and acculturation. Our recruitment methods (i.e., snowball sampling, social media postings) may have resulted in a self-selection bias, especially for the Russians, such that those in the study were more progressive than the average Russian and had more positive attitudes toward mental health than expected based on previous research. This self-selection may have contributed to our finding that the Russian group often appeared more similar to the American group than the Russian American group. Additionally, our sample may have self-selected to consist of those comfortable speaking about mental health problems or those with previous experience with mental illnesses. All but two participants either implied personal experience with mental illnesses in the interview or stated they had a close friend or family member who had experienced mental health problems. These personal experiences may have overshadowed country of origin, contributing to our lack of group differences in attitudes toward mental health. Finally, the participants in our Russian group have lived in the United States for differing durations, ranging from 4 years to more than 30 years. Given this wide range of time spent living in the United States, it is also reasonable to expect that they differed in their levels of acculturation to American culture. Future studies should aim to include additional measures of potential confounds to have a better understanding of the distinct groups and the cultural values associated with group membership.

In sum, this study builds on the literature on the link of culture and cultural values to attitudes toward mental health problems—especially in non-Western populations. It is one of the first studies to attempt to connect the cultural values of individualism, collectivism, and general

support preferences to mental health attitudes, and the first to do so for Russian culture. In partial support of previous literature, we found Russian Americans held more negative attitudes toward mental health problems and seeking support for mental health problems compared to Americans and Russians. Also in partial support of previous literature, we found Russian Americans preferred tangible support over emotional support, while Americans and Russians preferred tangible and emotional support equally. Finally, we found that across people, individualism was related to more negative attitudes toward mental health problems and seeking support for mental health problems, while emotional support preferences trended to being related to more positive attitudes toward mental health problems and seeking support for mental health problems. And, in fact, qualitative data collection revealed that people preferred receiving emotional support in response to a mental health problem, despite the fact that they most often referred others for professional help and offered informational support instead. Though more research is needed to fully understand the connection between cultural values and mental health attitudes across Russians and Americans, these findings suggest that targeting these cultural values, especially emotional support preferences, may be important to consider in creating interventions that increase mental health treatment utilization in these groups.

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Table 1

Demographics by Group

	Group			*p*-value
	Russian (*n* = 16)	*Russian American* (*n* = 19)	*American* (*n* = 18)	
Mean Age (SD)	39.7 (9.9)	21.4 (4.0)	29.8 (14.8)	***
Gender	68.8% female 25% non-binary 6.2% male	47.4% female 42.1% male 5.3% trans man 5.3% non-binary	88.9% female 5.6% trans man 5.6% non-binary	**
Educational Level	75% post grad 25% grad 4 year college	42.1% high school grad 42.1% tech/vocational grad (not hs) 10.5% post grad training 5.3% grad 4 year college	44.4% grad 4 year college 27.8% some college 16.7% post grad training 11.1% high school grad	***

Notes: ***p < .001; **p < .01; *p < .05

Table 2

Group Comparisons of Attitudes toward Mental Health and Attitudes Toward Seeking Support for Mental Health Problems

		Group			
	Reliability	Mean (SD)			*F*
	α	*Russian* (*n* = 16)	*Russian American* (*n* = 19)	*American* (*n* = 18)	
Medical Attribution	.65	8.8 (1.3)$_a$	7.0 (2.2)$_b$	8.2 (1.3)$_a$	4.97*
Personal MH Stigma	.82	2.9 (0.7)$_a$	2.3 (1.4)$_a$	1.7 (0.7)$_a$	2.14
Public MH Stigma	.69	4.7 (1.4)$_a$	4.9 (1.0)$_a$	4.4 (1.6)$_a$	.86
Attitudes to SS - PH	.89	7.7 (2.3)$_a$	6.5 (2.0)$_a$	7.0 (2.3)$_a$	1.42
Attitudes to SS - MH	.89	7.8 (1.5)$_a$	6.4 (2.0)$_b$	7.6 (1.5)$_a$	3.53*
SD - Emotional	.86	6.9 (1.8)$_a$	6.6 (1.7)$_a$	6.6 (2.2)$_a$	.11

Notes: MH = mental health; SS = support seeking; PH = physical health; SD = self-disclosure; common subscripts within a row indicate no significant difference; ***p < .001; **p < .01; *p < .05

Table 3

Group Comparisons in Cultural Group Identification and Cultural Values

		Group			
	Reliability		**Mean (SD)**		***F***
	α	*Russian* (*n* = 16)	*Russian American* (*n* = 19)	*American* (*n* = 18)	
CG Identification - American	-	6.8 (2.1)$_a$	6.2 (1.6)$_{ab}$	5.4 (1.9)$_b$	2.37
CG Identification - Russian	-	5.6 (2.0)$_a$	6.2 (2.4)$_a$	2.1 (1.5)$_b$	16.64***
Individualism	.79	6.3 (1.9)$_a$	6.2 (1.4)$_a$	6.0 (1.0)$_a$	.21
Collectivism	.73	7.4 (1.3)$_a$	7.3 (1.3)$_a$	7.1 (1.2)$_a$	.30
Emotional SP	.82	8.9 (1.1)$_a$	7.4 (1.7)$_b$	8.3 (1.4)$_{ab}$	4.97*
Informational SP	.72	7.4 (1.4)$_a$	7.3 (1.4)$_a$	7.8 (1.7)$_a$	.63
Tangible SP	.70	8.3 (1.6)$_a$	7.8 (1.4)$_a$	8.4 (0.9)$_a$	1.18

Notes: CG = cultural group; SP = support preference; common subscripts within a row indicate no significant difference; ***p < .001; **p < .01; *p < .05

Table 4

Relations Between Attitudes toward Mental Health and Attitudes toward Seeking Support for Mental Health Problems

	1	2	3	4	5
1. Medical Attribution	1	-.51***	.04	.52***	.35*
2. Personal MH Stigma	—	1	.13	-.45***	-.27+
3. Public MH Stigma	—	—	1	.02	-.00
4. Attitudes to SS - MH	—	—	—	1	.45***
5. SD - Emotional	—	—	—	—	1

Notes: MH = mental health; SS = support seeking; SD = self-disclosure; ***p < .001; **p < .01; *p < .05; +p < .10

Table 5

Relations between Cultural Group Identification and Cultural Values

	1	2	3	4	5	6	7
1. CG Identification - American	1	.21	.17	.00	.18	-.00	-.05
2. CG Identification - Russian	—	1	.29*	.48***	.04	.13	.04
3. Collectivism	—	—	1	.25+	.24+	.41**	.37**
4. Individualism	—	—	—	1	.04	.08	.03
5. Emotional SP	—	—	—	—	1	.36**	.58***
6. Informational SP	—	—	—	—	—	—	.62***
7. Tangible SP	—	—	—	—	—	—	1

Notes: SP = support preference; ***p < .001; **p < .01; *p < .05; +p < .10

Table 6

Relations between Cultural Values and Attitudes Toward Mental Health and Attitudes toward Seeking Support for Mental Health Problems

	Medical Attribution	Personal MH Stigma	Public MH Stigma	Attitudes to SS - MH	SD - Emotional
Individualism	-.26+	.40**	.03	-.44**	-.17
Collectivism	-.07	.24+	-.03	-.18	-.04
Emotional SP	.24+	-.18	-.02	.27+	.26+
Informational SP	-.06	-.07	.06	-.19	-.26+
Tangible SP	.06	.01	-.03	.09	.07

Notes: SP = support preference; MH = mental health; SS = support seeking; SD = self-disclosure; ***p < .001; **p < .01; *p < .05; +p < .10

Table 7

Response Frequencies to the Mental Health Scenario

	Kappa			Frequency (n = 53)		
	Response	Recall	Helpful	Response	Recall	Helpful
Refer to professional help	1***	.89***	.86***	71.7%	54.7%	28.3%
Offer emotional support	.72***	.82***	.81***	49.1%	52.8%	67.9%
Offer informational support/problem solving	.69***	.57***	.47***	50.9%	24.5%	11.3%
Offer companionship	.68***	.88***	.90***	15.1%	17.0%	22.6%
Monitor/check-in	.70***	.91***	1***	11.3%	13.2%	13.2%
Offer tangible support	.63***	.70***	.65***	9.4%	9.4%	7.5%
Share experiences	.85***	.66***	.49***	7.5%	3.8%	5.7%
Do nothing	.66***	.49***	1***	3.8%	5.7%	3.8%
Force to do tasks	0	NA	.66***	1.9%	0.0%	3.8%
Talk generally (not related to mental health)	NA	1***	0	0.0%	1.9%	1.9%
Refer not to seek professional help	0	NA	0	1.9%	0.0%	0.0%
Seek own information/educate themselves	NA	0	NA	0.0%	1.9%	0.0%

Notes: Response = response to scenario; Recall = recall similar scenario and response; Helpful = what would find most helpful in similar scenario; ***p < .001

Table 8

Response Frequencies to the Mental Health Scenario

	Kappa	Frequency (n = 53)
	Unhelpful	Unhelpful
Minimizing/trivializing	.83***	30.2%
Being ignored/left alone	83***	18.9%
Being shamed/blamed	.74***	17.0%
Being given advice	.94***	17.0%
Being controlling/overbearing	.68***	15.1%
Dismissing/denying	.86***	9.4%
Positively reappraising the situation	.57***	9.4%
Not listening	.88***	7.5%
Sharing experiences/comparing situations	.24+	7.5%
Misunderstanding/ignorance of the situation	.64***	7.5%
Catastrophizing	.64***	5.7%
Getting angry	1***	5.7%

Notes: Unhelpful = what would find unhelpful in similar situation; ***p < .001; +p < .10