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A Comparative Study of Mental Illness in the United States Compared to Developing Countries: Analyzing the Role of the Health Care Systems and Conjunctive Psychology

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Abstract

The research presented is part of a comparative study of mental illness in the United States compared to developing countries. Comparison is between the type of health care systems and the type of psychology practiced in order to help understand why mental illness is prevalent worldwide, in both developed and developing countries. What is missing that prevents mental illness from being treated successfully? The main purpose of this research is to answer that question by exploring the relationship between healthcare and psychological practices in these areas of the world. In both developed and developing countries there is a large gap between the need for treatment of mental disorders and the resources available; in developed countries between 44% and 70% of patients with mental disorders do not receive treatment, and in developing countries the gap has neared 90%[23]. These gaps are due to the lack of trained professionals in these areas and the cost of treatment. In addition to this problem, the two very different practices of Eastern and Western psychology in different regions of the world make it difficult to apply universal treatment in order to effectively treat mental illness. Research for this project came from scholarly journals and interviews with clinically licensed psychologist who practice combined Eastern-Western psychology. Statistics provided by the World Health Organization were utilized in order support the found correlation. The conclusion provided at the end of research was that there is a supported correlation between the healthcare provided and the type of psychology practiced. In order to effectively treat mental illness there must be a global understanding and implementation of treatment. Research supported the claim that mental illness can only be effectively treated if both the healthcare system and psychology are aligned and aimed at accomplishing the same goal.

Keywords: Mental illness, mindfulness, Conjunctive Psychology, healthcare

1. Introduction

Mental illness is prevalent worldwide, yet there is no universal treatment or recognition of it. The ways in which mental illness is treated in the United States compared to developing countries is entirely different. The types of resources and the psychology practiced are two key elements that differentiate mental illness care in these different regions of the world. Creating universal treatments and identifying the different techniques used is crucial to providing the most effective treatment due to the increasing rate of deaths caused by self-harm. According to the World Health Organization (WHO), the projected number of deaths by self-harm is projected to be 836,000 individuals and by 2030 this number is expected to rise to 1,007,000[24]. Mental illness is a prevalent topic at the current time as medical technology is advancing, healthcare systems are being reformed, and new branches of psychology are being developed. All of these elements help contribute to the efforts of lowering the number of deaths inflicted by self-harm

and reducing the number of patients suffering from mental illness[12]. When these different techniques are compared across different regions, the findings are of significant value. North and South America, when compared to African and South-East Asia regions, have the highest deaths caused by mental and behavioral disorders[24]. Even with the advanced technology, healthcare, and resources available in the United States, the number of deaths caused by mental illness is higher than in the developing countries lacking in these resources.

What are the contributing factors to these high rates of mental illnesses, specifically depressive disorders and schizophrenia, which create the large gap in numbers across different regions? The following pages address the different factors that contribute to mental illness rates and demonstrate a correlation between healthcare services and the type of psychology practiced. In order to effectively treat mental illness worldwide, effective treatments must be identified and be accepted on a universal base[13]. This research provides evidence of successful methods for treating mental illness and offers a solution to the problem.

Mental illness has become more common in the United States and terms like "depressed" and "schizo" (shortened form schizophrenia) have become words of daily use by the general public. Today, mental illnesses have become more widely accepted and therefore their relevance has seemed to diminish. In a study conducted in 1950 by Shirley Star, very few Americans identified the conditions of anxiety, compulsive phobia, and alcoholism as mental illnesses but a majority defined schizophrenia as one[8]. Since psychiatric conceptions of mental illness have changed dramatically since the 1950s, a group of psychologists reexamined public conceptions of mental illness in 1999[8]. They found that their respondents were more likely to identify disorders as mental illness than Star's respondents and that they were more likely to identify the person described with a specific condition even if they had not previously described them as having a mental illness[8]. Over a span of 50 years the labeling of mental disorders became more common. In the study, only three in ten people thought major depressive disorder was somewhat or very unlikely to represent mental illness[8]. This low number of participants failing to recognize this condition as a mental illness demonstrates societies knowledge about current mental health issues. Over the past year, depression and anxiety, specifically, have become more relevant among our population with 8.3 million American adults diagnosed with a psychological disorder[22]. Over the past decade the population suffering from a serious psychological disorder has increased from three percent of Americans to 3.4 percent[22]. In order to highlight the importance of treatment for mental illness and for understanding the prevalence of it in the United States, this research offers solutions to this growing problem.

Worldwide, mental illness is prevalent in some form and has detrimental effects as the associated number of deaths continues to rise. This research is key to understanding contributing factors and analyzing the techniques that are effective and those that are not. As the number of individuals living with a mental disorder continue to rise, it is important to find solutions that will provide effective treatment. The United States provides more resources and funding to treat mental disorders when compared to mental health funding in developing countries[25]. While developing countries lack this funding, they are practicing better-suited coping methods through the use of Eastern psychology techniques[2]. Yet, according to the World Health Organization, both of these regions of the world hold mental illness as one of the leading causes of death. What is missing in these regions of the world that is preventing mental illness from being treated effectively? The focus of this research is to identify the relationship between healthcare systems and types of psychology practiced and demonstrate the positive correlation between the two.

2. Background

Mental illness is prevalent today and major depression is considered one of the leading causes of disability in developed countries[11]. Globally, self-harm is ranked number 15 on the 20 leading causes of death as reported by WHO and is expected to rise from 804,000 individuals to 836,000 individuals in 2015 and by the year 2030 predicted number of deaths is to be 1,007,000[24]. Deaths and injury caused by mental illnesses such as depression and schizophrenia continue to rise every year. The number of individuals diagnosed as mentally ill continues to rise as the number of resources available does not. The following pages address this growing gap and bring awareness to the rising prevalence of mental illness in society.

According to the World Health Organization, both African and South-Eastern Asian regions have the lowest deaths associated with mental and behavioral disorders compared to the region of the Americas, both North and South America. In order to compare the different types of resources and psychology practiced among these different regions, Japan has been identified as the control of this research. Japan is both a developed country and practice Eastern psychology, making it the best example of the intersection between these two elements. Another important factor to note about Japan, is that the number of deaths caused by intentional self-harm remained relatively close to the United States' until 2004 when it began to decline, while suicide rates in U.S continued to rise[25].

3. Healthcare Systems

3.1 Comparison Of Healthcare Among Regions

According to the WHO Mental Health Atlas country profile of 2014, funding for the United States is provided for severe mental disorders through the government at an estimated $272.80 spending per capita, which is more than India (majority household funding) and Japan ($153.70). The numbers can be estimated to be more than Kenya and Guatemala based on economic standing, but the World Health Organization does not provide the exact numbers. The mental health workforce in the United States is composed mainly of social workers and "other mental health workers," with a small majority of psychologists and psychiatrists[25]. Even with 125.2 mental health workers per 100,000 population, individuals' lack of understanding of resources when they feel sick have lead to primary care physicians in the United States providing half of all mental health care and writing more prescriptions than psychiatrists[11]. In the U.S. a majority of mental health care is provided through professionals not fully trained in this area of disorders. Healthcare in the United States is also focused on treatment rather than prevention, as Americans only receive half of the preventative services that are recommended[7]. While North America has the available resources and funding, mental health care is not being fully provided or implemented as the United States does not have a stand-alone policy for mental health, which defines the vision for the future mental health of a population and specifies a framework which will manage and prevent priority mental and neurological disorders[25].

Guatemala, a developing country, has implemented a stand-alone policy for mental health, but success in meeting the visions of it has not been achieved as the number of mental health workers per 100,000 population in this country is only 2.3 and more than half of this workforce is composed of nurses, rather than trained psychiatric healthcare professionals[25]. While in North America where anyone can obtain health care assistance through an emergency room visit, in Guatemala it has been shown that wealthier population groups have a higher probability of obtaining health care when they need it[9]. Since the health care system in Guatemala is only effective for those who can afford it and with a low number of trained mental health professionals practicing Western practices, receiving treatment for mental illness is difficult.

Defining the type of healthcare provided in Kenya, also a developing country, is difficult as many of the statistics are not reported and the number of mental health providers is uncertain due to this[19]. The World Health Organization has reported that there is no mental health policy for this country, but there is government support for care of severe mental disorders, but the amount is unknown[25]. This lack of information is seen in other developing countries due to the "shortages of sufficient health care in rural areas being clustered into the following five categories: provider shortages, maldistribution, quality deficiencies, access limitations and the inefficient utilization of health care services. The reasons for the occurrence of these shortage problems are manifold and are related to physical/infrastructural, professional, educational, social–cultural, economic and political issues."[21] Healthcare systems in some developing countries are unable to prosper or implement their plans due to these obstacles. Even with an increase in developmental assistance for global mental health (DAMH) between 2007 and 2013, the funding still remains low in both absolute terms and as a proportion of total developmental assistance for health (DAH); the average DAMH was $133.57 million and the proportion of DAH attributed to mental health is less than one percent[5]. Healthcare in developing countries is currently being funded, but the resources are not enough and are not successfully providing assistance to those in need.

Compared to the previously discussed developing countries, India's main source of funds for care of severe mental disorders comes from households, rather than the government[25]. Although the total mental health workers per 100,000 population is only 0.6, with more than half being psychiatrists, India implemented an Eastern-based mental health policy in 2014 that is assisting in addressing future mental illness treatment[25]. Similar to the problem seen in Kenya, much of the information is unreported due to India being a developing country and many parts being extremely rural[19].

Identifying the type of healthcare and effectiveness of healthcare programs in developing countries is increasingly more difficult than when identifying the programs in the United States. If mental health services are being provided, or not being provided, in these regions of the areas, there is a lack of evidence and as a result a general disregard for these areas. This is a growing problem as DAMH continues to increase each year with no evidence of increase in services, especially in areas of mental health development[5].

In comparing the United States to these developing countries, it is important to note Japan's mental health statistics as it compares relatively the same to the U.S. economically and culturally to the South-Eastern Asian region. Japan, a developed country, has both a mental health policy and mental health legislation that are fully in line with human rights covenants and receives an estimated $153.70 mental health spending per capita from the government[25]. This

funding is roughly $120 less than American government funding, yet total health expenditure per person in Japan is half of the American expenditure[25]. Japan has the fifth lowest physician-per-person ratio, 43 percent less than the American rate, and with over half of the mental health workforce composed of "other mental health workers" and a small number of psychiatrists, Japan still managed to achieve the top ranking on health status at a cost that is among the lowest of wealthy industrialized nations[16]. According to the Organization for Economic Co-Operation and Development 2015 health statistics, Japan still has one of the most successful healthcare plans in the world and continues to have some of the lowest rates of mental illnesses. Japan has had lower rates of death caused by intentional self-harm since 1997, with the exception of two years, and there has been a rapid decline in the number of intentional deaths since 2009 (Figure 1). Japan serves as an example of the effective healthcare that can be provided at a minimal cost from an economic-developed country perspective and from the psychological and philosophical perspective of its surrounding developing countries.

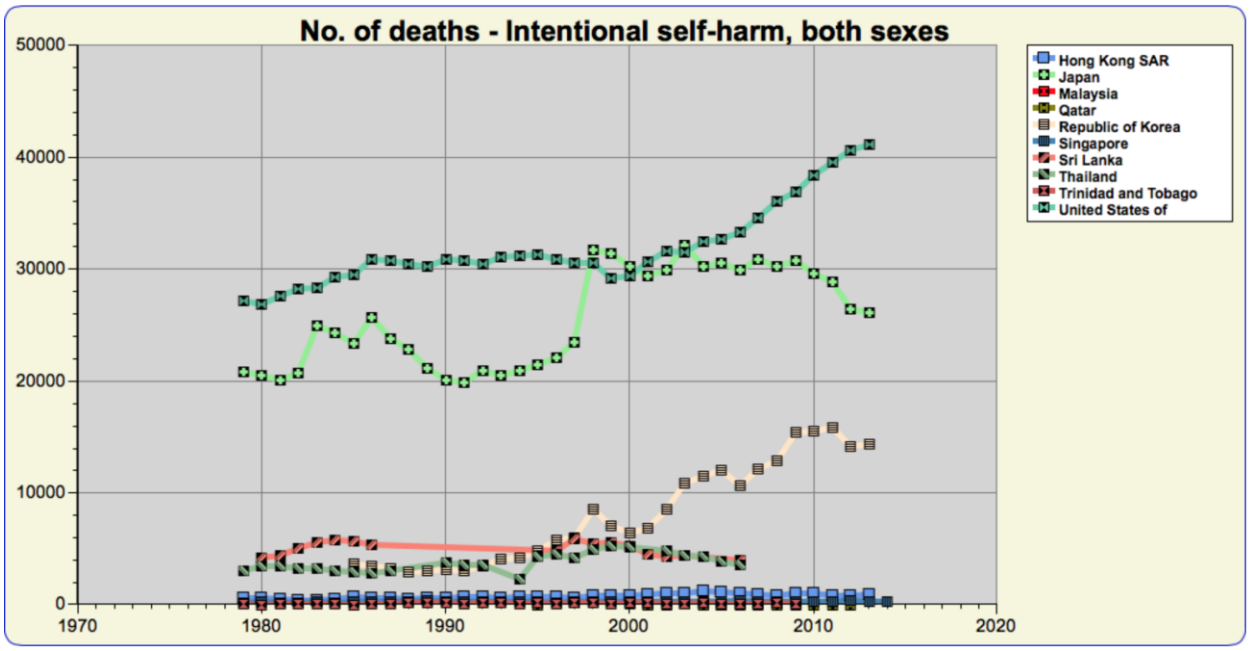

Figure 1. Number of deaths caused by intentional self-harm from data provided by the World Health Organization.

3.2 Two Gaps in Treatment

Within the United States and developing countries, there are two gaps that make it harder, and can even prevent patients from receiving medical treatment for mental illnesses. The first gap is between the need for treatment of mental disorders and the resources available[13]. In developed countries between 44% and 70% of patients with mental disorders do not receive treatment; even though the resources are ample, there is a lack of knowledge by the public of these available resources. In developing countries the gap has neared 90% and is due to the lack of physical and financial resources[23]. The major contributing factor to this gap, in developing countries, is the lack of trained professionals in these areas of the world. One example is seen in India where there are around 3,000 psychiatrists and 565 neurologists to serve a population size of one billion people. Other evidence is seen in Zimbabwe, where there are 10 psychiatrists and 29 neurologists to serve 11 million people[13]. In these developing countries, the populations continue to rise, as does the number of mentally ill patients, but the number of health care professionals remains the same[17]. The gap in treatment and resources is of more significance in developing countries because of environmental and biological factors that can lead to a mental illness. The lack of medication and doctors in these areas of the world allow for viruses and other diseases to thrive more than they typically do in the United States. Schizophrenia has been linked to viral causes, with current research into the role of human endogenous retroviruses (HERVs) in the development of schizophrenia[18]. People living in developing countries do not have access to the many different vaccines available in the United States, making them more prone to infections and diseases that could be associated

with mental illnesses. Even if a virus is not the direct cause of the disorder, suffering from a life-threatening disease can become a contributing factor to depression because it is a major stressor and has negative mental health outcomes.

In the United States this gap is created under different circumstances; many Americans are either unaware of mental health resources or are stigmatized against because of their mental illness[13]. As discussed previously, many people visit their physician when they begin to experience depressive-like symptoms. Primary care physicians and medical doctors are not adequate mental health providers as they are not fully educated or trained on mental illness treatment. Americans are unaware of the resources available to them and when they visit their primary physician, there is an average of seven minutes spent with the doctor, a diagnosis must be made and, as a result, these illnesses are typically treated with medication because 25% of referrals to a mental health professional will not be followed through[11]. Part of this problem arises from the media and advertisement of medication as the treatment for depression. Based on the findings of this research, resources are not known and contributing factors of the media further increase this gap as they advertise physicians rather than psychologists.

The second circumstance increasing the gap is discrimination against mentally ill patients, in which those suffering from a mental illness receive a different quality of medical care[13]. This is one of the contributing factors to the shorter lifespan of mentally ill patients, creating a 20-year gap between those not diagnosed and those diagnosed with a mental illness and accounting for 7.4% of the world's burden of health conditions in terms of disability-adjusted life-years[13,14]. This circumstance creates a physical barrier between patients and treatments by preventing them from medical treatment and further increasing the gap. Since North America also does not have a stand-alone policy or law for mental health, this discrimination continues to take place and access to treatment becomes harder[25]. The United States and developing countries both have environmental and societal circumstances preventing patients from receiving treatment for mental disorders, further increasing the gap and failing to adequately treat mental illnesses even when resources are available.

The second gap, seen in both developing countries and the United States, is the gap caused by cost of healthcare to the public. The United States spends the most on its healthcare system compared to other developed countries, yet health insurance costs more, and more American residents are uninsured[4]. In the United States, the type of healthcare delivered requires more expensive services and general hospital bills are much higher than in other developed countries[4]. The cost of treatment for the basic procedures is higher than every other developed country in the world. With high cost treatment, insurance is the most feasible way to pay for the expenses, yet in 2012, 47 million people in the United States younger than 65 years of age were uninsured. Even with reforms such as the Affordable Care Act (ACA) this number is only expected to drop to 31 million by the year 2020[15]. The number of uninsured Americans and the cost of treatment remain relatively high, allowing the gap to continue to increase and the number of patients receiving treatment declines.

In developing countries, the cost gap arises from failed integration of sustainable mental health care into existing health systems at relatively low cost. Mental health has not received significant developmental assistance and approximately 48% of total DAMH has been applied to humanitarian assistance, education, and civil services, rather than mental health promotion, with more annual DAMH channeled into the nonpublic sector rather than the public[5]. With a lack of funding and support, the cost gap continues to rise as resources are not available and funding assistance is rarely implicated. Until the financial gap between actual spending and proposed spending for mental health funding is bridged, healthcare costs will continue to play a key role in widening the gap between mentally ill patients and treatment.

3.3 Advancements in Treatment & Healthcare

Advancements in the healthcare system have been seen more commonly in the United States because of technological advances and economic development. These two methods of advancement are interrelated as technological change inherently means an increase in cost. Technological advances can provide many advantages to healthcare as long as the benefits outweigh the costs. In relation to mental health, technological change in treating depression is estimated to have benefits that are far greater than cost[12]. Some technologies are high cost and high benefit, but in order to advance the healthcare system and lessen the gap between cost and treatment, advancements must be low cost and high benefit[12]. In the United States these advances are being made through care in lower-cost settings, replacement of expensive procedures with less expensive ones, progress in programs that keep patients healthier, reducing hospital stay and recovery time, and returning people to work sooner[12]. Through these practical technological advances, the healthcare system is both improving and more patients are able to afford care. Since a majority of technological advances lead to cost increases, it is important to address the economic development that has advanced our healthcare programs. Medicare and Medicaid were established in 1965 and since have been successful in increasing healthcare

access for large numbers of people. The percentage of total national health expenditures (NHE) of Medicare and Medicaid have been increasing since the establishment, increasing the total NHE, but also providing health insurance coverage to millions of elderly and poverty-level people[12]. In terms of economic development of the general population, the introduction of the ACA in 2010 addressed the importance of prevention by removing cost as a barrier to preventative services[15]. Under this policy, insurance plans are required to cover a range of recommended preventive services at no cost to the beneficiary, which include alcohol-misuse counseling, depression screening (when systems are in place to ensure accurate diagnosis, effective treatment, and follow-up), and immunizations[7]. Each of these preventative services is applicable in reducing the increasing rates of depression, while also lessening the gap between cost and treatment.

While developed countries are working to advance their healthcare systems, the lack of funding directly toward physical and mental health in developing countries, such as India, Guatemala, and Kenya, has made this a much more difficult task in these regions of the world[19]. Financial advancements are being made, but under the estimated amounts that would benefit the healthcare programs. There are a majority of projects currently being implemented in developing countries, but not enough to provide adequate change. Between the years of 2007 and 2013, the mental health developmental assistance programs that were introduced were composed of a majority of programs that addresses general health. More specific projects that addressed assistance for mental illnesses included: 72 (1.38% of total projects) post-secondary education projects, which provided psychological intervention and developmental projects for poor university students; 95 (1.82%) educational programs that strengthened mental health in teenagers; and 161 (3.09%) population and reproductive health programs, which provided comprehensive community-based mental services[5]. These numbers of projects are the total for all countries classified as developing and are extremely low in providing successful treatment and prevention of mental illnesses, but are providing a small percentage of advancements in these regions of the world.

3.4 Equality in Healthcare

Since there are more advancements in the healthcare system in North America compared to developing countries, some will argue there is an inequality in the system. This argument is important in addressing the lack of advancement in developing countries, but defining health inequalities is a daunting task, as there are different definitions for health and happiness. Different regions of the world define health in different terms and understanding each of these definitions is what makes it possible to determine if different health inequalities are unjust or acceptable. Health is not only produced by having access to medical prevention and treatment, but also to a great extent related to the cumulative experience of social conditions across a person's lifespan[3]. It is important to analyze the social conditions of an area when identifying the just and unjust inequalities. The just inequalities include those that are avoidable and unnecessary and tend to reflect health issues brought on by a person's decisions. For example, an alcoholic who sinks into a depression due to their addiction and fails to participate in treatment, even when provided, is not considered an unjust inequality. It is important to note here that in different regions of the world alcoholism may be viewed differently across cultures and the types of treatments that are provided, or not provided, cannot be classified as unjust. Unjust inequalities include socioeconomic inequalities that correlate with health inequalities, such as racial, gender, or economic discrimination. These inequalities are the global issues, which must be addressed on a larger scale and can be combated with globally implicated mental health programs.

Global psychiatry implications are lagging in comparison to global training of basic health[13]. Global psychiatry is currently not implemented, as seen in the comparison of mental health advancements in America compared to developing countries. Developing a global implication for mental health is ethically crucial in order to make any advancement in the healthcare program and to lessen the amount of unjust inequality seen globally. Constructivism is one of the most practical and basic ways to start providing global mental health. The important factors of this concept are cultural empathy and asymmetries of power in order to guide and adjust global understanding[6]. Different regions of the world have different approaches to treating mental illness, and through a development of cultural empathy combining medical knowledge with cultural knowledge can provide the most effective treatments. In order to see equality in the healthcare programs, global healthcare practices that are mindful of inequalities and culture must be implemented in order avoid discrimination and provide the most successful treatment. Developing a psychology that works universally and is effective in treating mental illnesses is crucial in order to provide equal and effective care.

4. Western Psychology

Western psychology is the study of the frontal self and its unconscious process through exploration of the surface of consciousness[2]. Practices of this form of psychology are often seen through medication and individualized, extroverted practices as a response to mental illness. As described by psychologist Vikram Patel, the typical visit to an American psychologist includes an hour-long session of talking and receiving feedback from the counselor and the possible prescribing of a prescription drug to treat their depression[13]. Much of Western psychology depends on codependency of another person, as western practices rely heavily on counseling and weekly sessions to help a patient cope with mental illness. The relationship between the counselor and the patient is crucial in this form of practice, as the patient depends on their psychologist to guide them through their depression. This codependent practice may not be helping a patient reach their full potential as practicing counselor Judith Rubinger, M.A. has suggested through her research of depression and codependency and their very close frequencies (personal communication, March 7, 2016). Her research argues that Western psychology relies on codependency, the strong reliance of the patient on the counselor, and when the brain is experiencing those wavelengths, it is possible to bring the patient back into a depressive state. Western psychology practices with pharmaceuticals and codependent relationships have been in use since the founding of psychology, but as previously discussed, the number of patients diagnosed with depression in the United States continues to rise. These practices are beneficial to some people, but the research in this paper focuses on prescriptions written without any investigation into the individual's case.

5. Eastern Psychology

Eastern psychology, as practiced in developing countries, majorly in the South-East Asian region, will be defined as "more sophisticated methods of consciousness that explore deeper, wider, and more fundamental knowledge of the psyche than Western psychology"[2]. Eastern psychology explores a deeper part of the mind and includes practices such as meditation, concentration, and awareness. These practices are more thorough and require a client to put extensive time into exploring their own self outside of a teacher's presence. This type of psychology focuses on a person discovering their own self through demanding practices with little guidance from a teacher. The teacher may offer some form of advice, but the effectiveness of Eastern psychology is based on a person's ambition and willingness to change their self. Another important aspect of Eastern psychology is the focus on the present rather than the past or future. This focus helps a person to better adapt to stress-inducing situations and prevents the development of extensive amounts of worry. By living in the here-and-now, a person can avoid overthinking about past decisions and prevent stress-inducing situations that are not guaranteed to occur in the future. The focus on one's inner self and discovering deeper meaning through extensive, daily dedication rather than weekly sessions and pharmaceuticals, are a crucial part of Eastern psychology that separate it from Western practices.

6. Conjunctive Psychology

The integration of Eastern and Western psychology is referred to as the term Conjunctive Psychology and takes place across four "levels of being," biological, behavioral, personal, and transpersonal[10]. By developing an understanding of the behaviors of the mind unique to Conjunctive Psychology, more effective treatments can be used in treating mentally ill patients. The relationship between the biological and behavioral levels is important in demonstrating the effectiveness of this psychology because it is a clear example of the combination of the medical aspects of Western practices with the mental aspects of Eastern practices. The physical parts of the mind can be explained from a biological level and are the source of the various thoughts that continually arise in a person's mind, while behaviors of the mind construct awareness of the content physically generated. Behaviors of the mind can be described as clinging, concentration, and mindfulness, which are all things that must occur consciously, while biological aspects occur naturally and in the unconscious[10]. The behavioral only exists with the biological and is the reaction to the constant stream of thoughts in a person's mind. The human brain is constantly operating and generating thoughts and Conjunctive Psychology helps to discriminate between the biological and behavioral levels of the mind by distinguishing behaviors of the mind as specific interactions that are acted upon and not just thought processes. Distinguishing between biological and behavioral levels is extremely important in the treatment of depression as it relates to social identification and decreased wellbeing. If depressive thoughts arise in a biological state, they do not

have to enter into a behavioral state where they will be acted on. Conjunctive Psychology practices create attentional balance, the development of sustained, voluntary attention, which is a crucial feature of mental health. Attentional balance is cultivated mainly through the Eastern practice of mindfulness and meta-attention, which allow for the mind to swiftly recognize the changes in consciousness and the rising and falling of different thoughts[20]. If a person is capable of being aware of a rising depressive thought, they are also capable of preparing their self in order to embrace feelings of depression, rather than having the feelings consume their thoughts. With development of attentional balance, mentally ill persons become more aware of their thoughts associated with their illness and are capable of identifying the biological affects before the behavioral actions occur.

Awareness of one's self continues into the personal level and is seen through concentration and mindfulness, which contribute to a person's sense of self and will. Through the development of mindfulness, mentally ill people can reduce their clinging by being aware of attachments in their life and freeing themselves from those attachments. Meditation is also a key component of this level as it improves the body, mind, and spirit. Meditation is not typically seen in Western practices, but the persistent dedication that accompanies it provides the willingness often lacking in Western psychology. Mentally ill patients either want help in treating their illness or are coerced by the government, family members, or other agencies to attend therapy. Meditation practices are more effective as the practicer is dedicated and willing to reaching a state of mental wellbeing. Meditation allows a person to have self-desire and when combined with Western practices, helps to eliminate the full dependency between counselor and client and rather allows the client to work toward mental health on their own, with guidance from a counselor. Eliminating the full dependency often seen in Western practices allows for personal growth and has been proven successful through practices such as motivational interviewing, which matches a person's conative-motivational level to a therapist's and has proven to be a highly effective practice[20]. There are many successful methods used in both Eastern and Western practices, but recent research into the effectiveness of Conjunctive Psychology has proven that a combination of these two practices have proven most successful in the treatment of mental illnesses.

7. Mindfulness-Based Stress-Reduction (MBSR)

Mindfulness-Based Stress-Reduction is one example of effective Eastern and Western combined practices currently being used. Developed in 1979, the two main intentions of this practice were to create an effective vehicle for training individuals to practice mindfulness meditation for health enhancement and to develop a model that could be adapted in health care settings associated with stress, pain, illness, and disease[1]. This practice was developed in order to be used in medical settings and since has been applied in many clinical settings. The use of MBSR has proven highly successful when combined with medical referral and has built a foundation for applying mindfulness in a wide variety of physical and psychiatric conditions[1]. The individuality of MBSR for each practicer and the universal teaching of the practice make this Eastern-Western practice highly effective globally. One of the major observations from this research is the difference in treatments in North America compared to developing countries. MBSR offers a solution to this problem and addresses the need for universal treatment, while also proving to be a successful method for reducing stress in many clinical diagnoses.

8. Mindfulness-Based Cognitive Therapy (MBCT)

Mindfulness-Based Cognitive Therapy is guided group skills program developed to prevent relapse in major depression and based on the previously discussed MBSR practices. Mindfulness is a key component of this therapy and practiced through meditation exercises such as observing, describing, and acting with awareness and accepting without judgment[16]. MBCT is a combination of Western and Eastern practices as it uses cognitive behavioral aspects and practices of mindfulness to prevent depression relapse and also treat other conditions such as anxiety, sociality, and eating problems. This therapy eliminates the completely codependent counselor and client relationship and allows for the client to develop their own personal meditation practice in relation to their counselor[16]. The client still depends on the counselor for assistance, but the codependent relationship is not as strong in this practice as in the typical Western counselor-patient relationship. Research has proven the success of this therapy. In one study, program attendance was associated with improved levels of mindfulness and psychological wellbeing, and at follow-up improvements in mindfulness was sustained and psychological distress was reduced[16]. The results of this study showed an association between the amount of time spent meditating and the improvement in psychological wellbeing, strengthening the argument that combined Eastern-Western practices are most successful forms of treatment.

9. Conclusion

9.1 Correlation between Resources and Practices

Although correlation does not lead to causation, it is important to recognize the potential of association between healthcare resources and the type of psychology practiced as it offers practical solutions to the mental illness epidemic. Japan demonstrates the utopic society where affordable healthcare, resources, and Western psychological practices are combined with Eastern practices to produce some of the lowest rates of depression and number of deaths caused by self-harm[24]. Currently, Japan is one of the most successful countries in treating mental illnesses and demonstrates the most effective treatment methods. Through a combination of availability to resources, both physically and financially, and an implantation of Eastern psychology with the already practiced Western psychology, treatment of depression and schizophrenia can become more effective. Currently, global treatment of mental illnesses is not as effective as it could become, and through realization that resources and type of psychology practiced are related treatment can become more successful on a global basis.

9.2 Limitations and Further Research

Extraneous variables play a key role in this research and it is important to address those variables that have an effect on the results and findings of this research. One of the most important variables is that of collectivist and individualist cultures; the South-Eastern Asian region practice collectivism, while the United States practice individualism. This difference is key in understanding the labeling of mental illnesses. In many Asian regions, the term "depressed" is not used and it important to note that this can skew the data. Although, much of the World Health Organizations data comes from surveys that describe symptoms rather than specific titles, identifying with such an illness differs across regions. Another variable that is crucial to note is the speculations made in happiness research. The definition of happiness differs greatly across the world and finding a universal definition that all can agree on is difficult. According to clinical psychologist Michael DeMaria, Ph.D., research has shown that many people in poverty situations report higher levels of happiness than those who are very wealthy (personal communication, March 23, 2016). Although this suggests that poorer regions may be happier than wealthy, without a uniform definition, it is impossible to prove that association is true. The inverse relationship between expectations and happiness is important to analyze when drawing conclusions as it helps to explain some of the findings of this research, but does not provide evidence of a relationship due to the ambiguity of the term.

Much of the research on availability of resources in developing countries may not be entirely accurate due to the difficulties in communication between urban centers and remote areas."[19] The data reports, provided by the World Health Organization, that were used in this research may not be entirely complete and can have some affect on the findings, but overall the statistics still demonstrate the correlation between mental illness and number of resources. Another limitation is the different treatments required for schizophrenia and depression. Schizophrenia requires more medical treatment, while depression, in most cases, can be treated though mindfulness practices. Identifying the differences in treatment and diagnoses is crucial in understanding the relationships presented in this research.

If a relationship is seen, the concept can be put into action and through experimentation there can be proof of the most successful ways to treat mental disorders. Currently, Conjunctive Psychology and combined Eastern-Western practices are relatively new and more research is required to demonstrate their effectiveness and use in global psychology. This research only provides the basis on which more experimental research can be based. With this basic hypothesis that the healthcare system and the type of psychology practiced are related further research can be conducted in order to prove causation.

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