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Generational Differences and Gender Role Beliefs on Mental Health Stigma among Sri Lankan Women

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Abstract

Mental health stigma (MHS) remains a key barrier to psychological well-being in Sri Lanka, where cultural norms and gender expectations heavily influence help-seeking. Against this backdrop, the present study examined how gender role beliefs and generational differences shape mental health stigma among Sri Lankan women and whether these variables interact. A total of 250 Sri Lankan women aged 18-60 from Generations X, Y, and Z were recruited through online data collection, with generational groups assigned based on birth year. Gender role beliefs were measured using the Gender Role Beliefs Scale – Short Version (GRBS), and stigma was assessed using the Social Stigma for Receiving Psychological Help (SSRPH). A 2x3 factorial arrangement was designed, and data were analyzed using a two-way ANOVA. Results indicated that women endorsing traditional gender role beliefs reported significantly higher stigma, while the interaction between gender role beliefs and generation was not significant. The findings highlight gender role beliefs as a stronger predictor of stigma than generation, underscoring the need for belief-focused, culturally sensitive interventions in Sri Lanka.

Keywords: Generational difference, gender role beliefs, mental health stigma

Introduction

Mental health stigma (MHS) continues to pose a significant barrier to help-seeking and psychological well-being, particularly in socially conservative and resource-limited settings. Mental health stigma operates not merely as a personal judgment but as a broader social process rooted in power, labelling, and exclusion, reinforcing inequality and deterring individuals from seeking support (Corrigan & Watson, 2002). Among women, this burden is often intensified by gendered expectations that equate emotional strength and caregiving with personal worth (Marecek, 2006). In many cultural contexts, including Sri Lanka, women are expected to prioritize others' needs, remain resilient, and conceal emotional distress. When these expectations are not met, it can lead to feelings of shame, isolation, and reluctance to seek help, ultimately

reinforcing the cycle of mental health stigma and reducing the likelihood of accessing psychological support (Ali & Adshead, 2022).

In the Sri Lankan context, mental illness is often misinterpreted through a spiritual or moral lens, viewed as a result of karma, black magic, or spirit possession rather than as a legitimate medical condition (Minas et al., 2017). These beliefs contribute to stigma by encouraging individuals to conceal their symptoms and rely on traditional or spiritual healers instead of accessing formal mental health services (Minas et al., 2017; Subu et al., 2021). For women, the stigma is compounded by rigid gender roles that discourage emotional vulnerability and reinforce the idea that seeking help signals weakness or failure in fulfilling familial roles (Samarasekare et al., 2012). As a result, many women face not only internalized stigma but also social disapproval that reinforces silence around psychological distress.

Despite growing global efforts to normalise mental health care, intergenerational differences continue to shape how women perceive and respond to stigma. Older generations, raised within more traditional worldviews, often maintain stricter attitudes toward mental illness, viewing it as shameful or private (Ali & Adshead, 2022). In contrast, younger women, particularly those exposed to mental health campaigns and online discourse, may adopt more open attitudes, yet they still struggle with cultural expectations that discourage vulnerability (Herrera et al., 2024). This generational tension highlights a crucial gap in the current literature, especially within Sri Lankan society, where few studies explore how traditional versus egalitarian gender role beliefs interact with age-related perspectives to influence mental health stigma. By addressing this gap, the present study investigates how gender role beliefs and generational differences influence mental health stigma among Sri Lankan women. Understanding these factors is essential for developing culturally relevant stigma-reduction strategies and promoting inclusive mental health support. As a result, this study aimed to examine the influence of gender role beliefs and generational differences on mental health stigma among Sri Lankan women, including potential interaction effect between these factors.

Materials and methods

Design

This study employed a 2 × 3 factorial design with two independent variables: Gender Role Beliefs (GRB: traditional vs. egalitarian) and Generational Differences (Generation X, Y, Z). The dependent variable was Mental Health Stigma. The following hypotheses were formulated to investigate the main effects and the interaction effects of the independent variables.

Table 1: 2X3 factorial design layout

		Factor B: Generation			
		Generation X	Generation Y	Generation Z	
Factor A: Gender role belief	Traditional	Mental Health Stigma (M)	Mental Health Stigma (M)	Mental Health Stigma (M)	The main effect of factor A $M_{Traditional} \neq M_{Egalitarian}$
	Egalitarian	Mental Health Stigma (M)	Mental Health Stigma (M)	Mental Health Stigma (M)	
		The main effect of factor B $M_{Gen\_X} \neq M_{Gen\_Y} \neq M_{\_Gen\_Z}$			

H_1: Gender role beliefs has a statistically significant effect on mental health stigma
H_2: Type of generation has a statistically significant effect on mental health stigma
H_3: An interaction effect exists between gender role beliefs and generation on mental health stigma

Sample

Data were collected from 250 Sri Lankan women aged 18 to 60, selected through convenience sampling. Participants were categorized into three generational groups: Generation X (born 1965–1980), Generation Y (born 1981–1996), and Generation Z (born 1997–2007). The required sample size was estimated using G*Power (effect size = 0.25, α = 0.05, power = 0.80), which suggested 211 participants; the final sample exceeded this. Inclusion criteria required participants to be Sri Lankan citizens, cisgender women, and have fluent English comprehension. Individuals who did not meet these criteria were excluded.

Materials

Two validated self-report instruments were used to measure the study variables. Mental health stigma was assessed using the Stigma Scale for Receiving Psychological Help (SSRPH), a 5-item scale rated on a 4-point Likert scale (0 = Strongly Disagree to 3 = Strongly Agree), with higher scores indicating greater perceived stigma. Gender role beliefs were measured using the 10-item Gender Role Beliefs Scale – Short Version (GRBS) (Brown & Gladstone, 2012), rated on a 7-point Likert scale, with higher scores reflecting more egalitarian beliefs; one item was reverse-coded. A total gender role beliefs score was computed by summing all items, and participants were categorized as Traditional or Egalitarian using a median split (scores below 49 = Traditional; 49 and above = Egalitarian). Participants' age was used to determine their generational group (Generation X, Y, or Z). Demographic data, including education, marital status, employment, and ethnicity, were also collected to contextualize the findings.

Procedure and analysis

The study received approval from the Ethics Panel of the Faculty of Humanities and Science at SLIIT. Following that, participants were recruited via social media and in-person outreach. Informed consent was obtained before participation, and all data were collected anonymously through an online survey. Upon completion, participants were debriefed and provided with information about mental health resources. The collected data was cleaned and transferred to SPSS for statistical analysis. A two-way factorial ANOVA was conducted to examine the main effects of gender role beliefs and generation on mental health stigma, as well as their interaction.

Results

Descriptive statistics

Tables 2 and 3 present the descriptive statistics for the variables: gender role beliefs, mental health stigma, and generation. Participants in Generation X (n = 50), Generation Y (n = 56), and Generation Z (n = 144) demonstrated relatively similar stigma levels, with only minor variations between groups, indicating moderate perceived stigma toward receiving psychological help across generations.

Table 2: Descriptive statistics for mental health stigma by generation (X, Y, Z)

Generation	Mean	Std. Deviation	Min	Max	Skewness	Kurtosis
Gen X	6.04	2.89	1	15	0.45	0.43
Gen Y	6.24	3.42	0	15	0.14	-0.08
Gen Z	5.99	3.31	0	14	0.11	-0.61

In terms of gender role beliefs, participants with traditional beliefs (n = 132) reported greater perceived stigma toward receiving psychological help compared to those with egalitarian beliefs (n = 118), indicating that traditionally oriented women tend to hold more stigmatizing attitudes.

Table 3: Descriptive statistics for mental health stigma by gender role beliefs

GRB Type	Mean	Std. Deviation	Min	Max	Skewness	Kurtosis
Traditional	7.42	3.55	0	15	-0.19	-0.51
Egalitarian	5.76	3.10	0	15	0.18	-0.23

Note. GRB – Gender Role Beliefs

Inferential statistics

The skewness and kurtosis values indicate the data to be approximately normally distributed (Tables 2 and 3). Levene's test confirmed that the assumption of homogeneity of variances was satisfied (see Table 4); therefore, a Two-Way ANOVA was conducted.

Table 4: Homogeneity of variance test (Levene's)

F	df1	df2	p
1.136	5	244	.342

A 3 × 2 between-subjects factorial ANOVA was conducted to examine the effects of generation and gender role beliefs on mental health stigma (See Table 5). The overall model was statistically significant, F (5, 244) = 2.81, p = .017, Partial η^2 = .054, indicating that the combination of gender role beliefs, generation, and their interaction explained a meaningful portion of the variance in stigma scores.

Table 5: ANOVA table

Source	df	F	p	Partial η^2
GRBS	1	9.11	.003	.036
Generation	2	1.32	.268	.011
GRBS * Generation	2	1.88	.155	.015
Overall Model	5	2.80	.017	.054

a. R Squared = .054 (Adjusted R Squared = .035)

However, the Partial η^2 = .054 suggests that only 5.4% of the variance in mental health stigma was accounted for by the model. Among the individual effects, gender role beliefs had a statistically significant influence on stigma, F (1, 244) = 9.12, p = .003, Partial η^2 = .036, with participants holding traditional beliefs reporting higher levels of stigma. In contrast, the main effect of generation was not significant, F (2, 244) =

1.32, $p > .05$, Partial $\eta^2 = .011$, nor was the interaction between gender role beliefs and Generation, $F(2, 244) = 1.88$, $p > .05$, Partial $\eta^2 = .015$. These findings suggest that while gender role beliefs significantly influenced stigma levels, neither generation nor its interaction with gender role beliefs had a significant effect. A post hoc analysis was not conducted due to the non-significance of Generation and the interaction term. Additionally, gender role beliefs only had two levels, making post-hoc comparisons unnecessary.

The profile plot (Figure 1) illustrates a distinct pattern between gender role beliefs and Generation. Generation Y participants with traditional gender role beliefs exhibited higher stigma compared to Generation X and Z, while those with egalitarian beliefs showed relatively stable and lower stigma across generations.

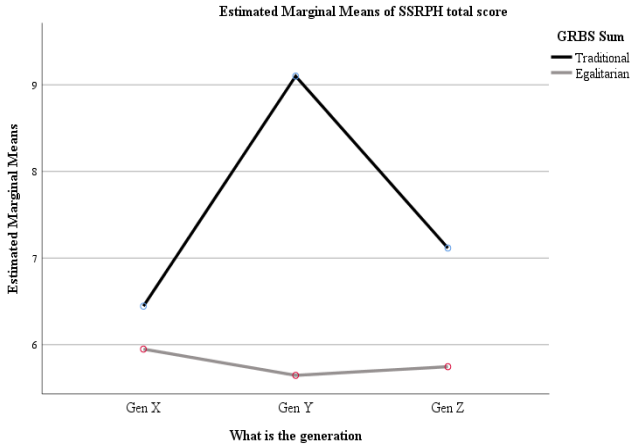

Figure 1: Profile plot of Gender Role Beliefs Scale (GRBS) and generation on Stigma Scale for Receiving Psychological Help (SSRPH)

Discussion

This study found that women who endorsed traditional gender role beliefs reported significantly higher levels of mental health stigma, consistent with previous research highlighting how cultural expectations of emotional strength and caregiving contribute to internalized stigma (Chandradasa & Rathnayake, 2018; Marecek, 2006). This aligns with the notion that women who internalize traditional caregiving roles may view psychological help-seeking as incompatible with their expected identity, especially in cultures like Sri Lanka that prioritize female resilience and silence around distress (Samarasekare et al., 2012). Generational differences, however, did not significantly predict stigma, suggesting that age alone is insufficient to shift deep-rooted beliefs (Pescosolido et al., 2020). This finding contradicts emerging global trends that suggest younger generations are becoming more accepting of mental health services (Pescosolido et al., 2020). One possible explanation is that despite growing awareness campaigns, Sri Lankan youth may continue to face strong cultural and familial pressures that discourage emotional openness and help-seeking (Minas et al., 2017).

The low Partial η^2 value (.054) implies that other unmeasured factors, such as religious values or personality traits, likely influence stigma. For instance, deeply held spiritual beliefs about karma or moral failings may shape stigma independently of generational views, as discussed in the introduction (Minas et al., 2017). Moreover, this reinforces the idea that mental health stigma is not only cognitive but embedded within social rituals, gender ideologies, and collective norms**.** Despite growing awareness, stigma remains deeply embedded in social expectations, institutional practices, and everyday interactions. These findings

highlight that education alone is insufficient; meaningful change demands culturally grounded mental health literacy, safe spaces where women feel understood, and systemic efforts that reduce entrenched barriers to care (Lucksted & Drapalski, 2015). The findings also suggest that gender role beliefs may serve as a more stable and powerful predictor of stigma than age-based categorizations. As such, efforts to shift stigma must directly address the ideologies and norms that shape women's roles in society, rather than assuming that generational turnover will naturally reduce stigma.

This study used validated instruments (Brown & Gladstone, 2012), met power requirements, and applied a factorial design with strong ethical procedures (Kang & Hwang, 2023). However, overrepresentation of Generation Z, convenience sampling, and ethnic homogeneity may have limited generalizability. Bias from self-reports and the cross-sectional design further constrain conclusions. Future studies should adopt stratified sampling to improve diversity and use qualitative methods to capture lived experiences. Rather than relying solely on awareness campaigns, interventions should be developed in collaboration with community leaders and traditional healers to ensure they are contextually grounded and sustainable (Samarasekare et al., 2012).

Conclusion

Traditional gender role beliefs were significantly associated with higher mental health stigma among Sri Lankan women, highlighting belief systems as more influential than age. Addressing stigma, therefore, requires more than awareness; it calls for targeted, culturally grounded interventions that challenge entrenched norms and foster psychological empowerment. By shedding light on the social roots of stigma, this study contributes to ongoing efforts to build more inclusive, equitable mental health systems and supports the well-being of women in culturally conservative settings.

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