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Shivani Seth
"Who do I Reach Out to?": A
Qualitative Study of Help Seeking
Behaviors, Treatment Preferences
and Community Supports Among
South Asian Americans

ABSTRACT

The purpose of this thesis is to discuss the utilization of community resources by South Asian Americans within the context of help-seeking behaviors by members of this broad community and how helping professionals involved with this diverse group can better serve and understand the needs of community members. This thesis includes a discussion of several possible modalities that could be used with this population, current empirical articles showing both the gaps within the current research as well as providing support and structure for the qualitative study this thesis was created for. In my project, I interviewed twelve self identified South Asian American participants, five of whom had utilized mental health services and seven of whom had not utilized these services. The coding of transcripts provided six themes: cultural chameleon, isolation, the importance of feeling understood, conflict in or around identity, what does it mean to be South Asian and microaggressions in comments, questions and explanations. Results can be used to point the way towards future research as well as providing helpful information for professionals working with and within this population to provide better care.

**"WHO DO I REACH OUT TO?": A QUALITATIVE STUDY OF HELP SEEKING
BEHAVIORS, TREATMENT PREFERENCES AND COMMUNITY SUPPORTS
AMONG SOUTH ASIAN AMERICANS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2015

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CHAPTER I

Introduction

The purpose of this thesis is to discuss the utilization of community resources by South Asian Americans' within the context of help seeking behaviors by members of this broad community and how helping professionals involved with this diverse group can better serve and understand the needs of community members in need. The need for this particular study is clearly illustrated by gaps in the literature around qualitative study with South Asian Americans, as well as the application of theoretical models that may not be sufficiently culturally sensitive or appropriate to the South Asian diaspora's unique needs.

Though many theoretical models exist as a guide to how to improve practice in a culturally competent manner, very few studies test the efficacy of these methods or discuss the experiences of clients or participants, relying on large, broad brush strokes of data to extrapolate the usefulness of these new modalities. There is also little discussion of the intense diversity within individuals from relatively geographically close locations in the region and the possible histories that may impact their successful treatment. This may be due to difficulties in obtaining data, concerns around stigma within the community, a lack of culturally competent clinicians to undertake the task or an as yet unknown reason.

Therefore, this study aims to provide insight into these areas with first person accounts and point the way towards possible future research, as well as provide helpful information for professionals working with and within this community to providing better care.

CHAPTER II

Literature Review

Introduction

This thesis will include a discussion of several possible modalities that could be used with this population, current empirical articles showing both the gaps within the current research as well as providing support structure for the qualitative study this thesis was created for. This project is of utmost importance considering that South Asians are a rapidly growing minority who have historically underused mental health services (Sue, Cheng, Saad, & Chu 2012; Dupree, Bhakta, & Patel 2013; Loya, Reddy & Hinshaw, 2010). As the social work profession grows with the changing demographics of the American populace, so must its methods change and adapt in order to provide the best possible care. In this way, this thesis will relate not only to social work practice, but also social work policy, and social work program development/intervention. Though this will be a qualitative study, with a small sample size, it will be able to provide some insights into the needs of South Asian Americans and particularly those individuals who are balancing acculturative stress along with the everyday difficulties of modern life (Wadhwani, 2000).

Definitions

Within this project, I plan to use these definitions primarily as participants would self identify as the South Asian sub-continent is intensely diverse and is the site of many migrations, wars, and incursions. Indeed, even the drawing of maps and borders was found to be deeply difficult and at times controversial during the scope of this study.

Therefore, self-identification has been determined to be the most effective form of inclusion for the study. However, within this literature review the term South Asian will mean

any individual from the South Asian subcontinent or with genetic, familial or historic ties to this area. These countries can include, but are not limited to India, Pakistan, Nepal, Bangladesh and Sri Lanka.

Several articles I reference also use the term Indian or Asian Indian but I found these to be confusing within an American context as the term “Indian” may still be used to describe Native American peoples in some circles. I also felt this promoted excluding of individuals who may identify as South Asian but whose roots are primarily in countries other than India or may be from multiple regions. First generation will refer to individuals who are the first link of immigration from their previous native country and are planning to stay in the United States. Second generation will refer to the generation born after immigration has occurred. The age range I have chosen for this study can include both first, second and possibly even third generation immigrants in order to provide rich data for analysis.

Stigma in this thesis will refer both public stigma and self-stigma. Public stigma is defined as "the results of a naive public endorsing the stereotypes of mental illness" and self-stigma, "the consequences of people with mental illness applying stigma to themselves" (Corrigan & Kleinlein, 2005, p.12). Microaggressions will use the following definition. “Racial microaggressions are brief and commonplace daily verbal, behavio[u]ral or environmental indignities, whether intentional or unintentional, that communicate hostile derogatory, or negative racial slights and insults toward people of colo[u]r” (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal & Esquillin, 2007, p. 271)

Article Criterion

The articles I have chosen represent a field of ideas on the many factors affecting South Asian Americans who may seek out therapy. There are issues within many of the articles in the

current field of literature, as they tend to come from a Western based perspective, may have little insight into their own centrist frameworks or may over generalize the South Asian experience. However, the articles chosen have been chosen for the merits they possess that outweigh the flaws they may contain. These articles were chosen after an extensive number had been read and were chosen for their specificity to the population, relevancy, data, and currency of time written. Some articles chosen were chosen because they appeared to be seminal texts within the literature and were referenced frequently in other articles.

Theoretical Sources

The theoretical sources I focused on were primarily as frameworks for new therapeutic practices, as well as content analysis of the current literature. The Pedersen (2009) article discusses the concept of Inclusive Cultural Empathy as a radical force in changing how non-Western relationship dynamics can be understood and worked within in a therapeutic setting. Pedersen calls for a reality check on the current state of cross cultural work, stating “When counseling psychologists have applied the same interpretation to the same behavior regardless of the cultural context, cultural bias has resulted” (p.152). I feel this particular idea to be very important for clinicians seeking to be culturally competent and focused on anti-oppression, as well as those who hope to work with this population.

Pedersen then goes on to list many different indigenous methods of practicing therapy or healing work within Asian cultures and created the tool of the Interpersonal Cultural Grid, as shown below, to help formulate and discover differing expectations within the therapeutic process between therapist and client (Pedersen, 2009). This grid has possible utility in that it encourages both the clinician and the client to examine their current possible cultural biases and

how they might interfere in the treatment. This could be a valuable tool to use early in treatment to facilitate mutual understanding.

The only difficulty with using the Inclusive Cultural Empathy is, again, the tendency to paint in broad strokes concerning the terminology of “Asian American” and a possible exoticizing of non-Western modalities. It would be interesting and very useful if he had chosen to conduct a qualitative or quantitative study, meeting with practitioners of these indigenous health models instead of discussing them in a theoretical manner. However, this grid provides a possible jumping off point for working with South Asian Americans, especially keeping in mind possible traditional medicinal practices or measures of attaining wellness.

The second theoretical framework I focused on was one known as Radical Caring. As the author states, “Radical Caring, I posit, emerges at the conjunction of individual and organizational motivation” (Rudrappa, 2004, p.589). Though Radical Caring focuses on more individual and societal methods of change and work, I think it could also be adapted to work within communities. What is a community if not a complex organization, where the individual meets the group? In this way, Radical caring could be utilized to encourage individuals to work within groups to provide care to each other, similar to the Peer and Recovery models currently used in the US, but within already formed groups dealing with a problem known to the community, such as domestic violence.

However, the method in its current form was unsuccessful in its goals. Rudrappa discusses the failure of the method within the Apna Ghar domestic violence program in Chicago within her piece and I suspect, based her discussion of the implementation of this method, that the central failing of her methodology is based around its focus on individual autonomy. By trying to encourage South Asian American women to adopt Western ideas of the value of

individual autonomy in saving themselves from domestic violence, Rudrappa unknowingly reinforces colonial ideas of the “culture as deficit” (Park, 2005) and pushes these women to a goal that may be fundamentally circumscribed and opposed to their cultural framework. Instead of working within the possible framework that existed, such as encouraging women suffering domestic violence to consolidate together and form a group that helps each other or encouraging them to leave their abusers for themselves and their children and families, this concept focused on a Western value that may have been foreign or even repugnant to the individuals it was trying to serve. This concept's problematic nature is further discussed in my third theoretical source.

However, I feel her ideas on Radical Caring in the education of workers around gender parity within South Asian dynamics is valuable and could be combined with Inclusive Cultural Empathy to provide a social justice aspect to the model. By using the idea of Inclusive Cultural Empathy to inform the Radical Caring model, a culturally sensitive, organization and individual based model could be formed. However, this would require a discussion of mental health issues within the community, a choice that is much impacted by the stigma surrounding mental illness in many South Asian communities.

In the light of issues of gender parity, sexism and various issues around gender roles within many South Asian American communities, my last theoretical source has a special relevance as it is based on the subject of divine feminine power known as Shakti. Shakti is sometimes seen as a manifestation of the Hindu god Shiva, but can also be a manifestation of his consort Paravati (“Shakti,” n.d.). Navsaria and Petersen pose interesting and highly useful concepts for working with individuals of the Hindu faith. Working within a cultural framework that may be more familiar to the client or their family to discuss power, safety and ability seems

to be a greater affirmation of strength and acceptance than requiring Hindu women to reach towards goals that may not feel comfortable or even applicable within their contexts.

The Western notion of “self as object” is alien to Indian women. To impose such objectification and separation of the self into a traditional Hindu woman would be a repressive tactic that robs the woman of her cultural supports. Centering the self in such a manner and then reflecting upon it requires an individualistic philosophy, which based on the responses in Fenton’s study, South Asian women did not display (Navasaria & Petersen, p.167).

While the concept of Shakti could be used with non Hindu South Asian women, the concept may not have the same weight, meaning and effect with those who do not believe in Shakti in their spiritual life or have no experience with it. So this theory may be more limited than some of the others in its generalizability.

Empirical Sources

With these ideas in mind, I transitioned to the empirical literature. I found several factors hampering and interesting. There were a distinctly larger number of theoretical and quantitative versus qualitative studies within the literature, as well as a distinct lack of discussion of the differences among South Asian ethnic, class and religious groups. There was a marked larger number of studies around Asian Indians versus any other ethnic or regional group in this area. (Inman, Devdas, Spektor & Pendse, 2014)

There were also more studies focusing on the clinicians’ experience of working with South Asian clients than on clients’ experiences of therapy. Except in studies focused on acculturative stress, there was little focus on racism, classism, or internalized colonialism within

the empirical literature, which struck me as a grave lacking. The table found within the Inman et al. (2014) article provides a very thorough overview of the current and past literature and illustrates these lackings. I am unsure if these deficits are a result of difficulty accessing and finding community members to ask these questions of, concerns around stigma or some other unknown impediment.

With this in mind, I searched for articles focused on South Asian clinicians as well as articles and books whose general themes could be applied to the population. I chose to investigate personal accounts of South Asian identified clinicians as well as clinicians who have worked extensively with South Asian clients due to the lack of literature focused on first hand accounts or research on South Asian experiences within the American mental health system. The South Asian identified clinician's perspectives around racism and acculturation are especially important, in my opinion, due to their lived experience within the American context.

Stigma.

For example, as stigma is a significant cultural factor for the diagnosis and treatment of mental illness, I have included writings and research around the effects and impacts of stigma on individuals who are coping with difficulties in their life or mental illness. In the South Asian context, stigma can be a grave concern, as the realities of an individual's mental illness may affect the entire family and may impact anything from their ability to hold a job to their ability for the individual and their family members to find a life partner.

Interestingly, a 2007 study found that Indian individuals with a history of psychosis had a better chance of achieving marital success than their counterparts elsewhere. "...we confirm an earlier local finding that marital success after first-break psychosis, is quite favorable for in India:74% for women, 71% for men, compared with elsewhere, 48% for women and 28% for

men." (Hopper, Wanderling, & Narayanan, 2007, p.1). This shows that there may be more complicating factors affecting success or that the experience of South Asian Americans may be more difficult than their counterparts still on the South Asian subcontinent.

The book, *On The Stigma of Mental Illness*, was my primary source for research around the effects of stigma. The text was broadly done and very helpful in identifying many complicating factors within treatment including self-stigma. Within my previous conceptualization of this topic, I had falsely supposed that stigma might not have as great an impact on those who had not disclosed their mental health difficulties. Most of the discussions of stigma I had read prior to this centered on society's stigmatizing attitudes or the effect of communities stigmatizing individuals. However, this text made clear the possible impact self-stigma could have for an individual on their overall quality of life and the repercussions that societal or cultural attitudes may have on an individual without anyone else knowing of their struggles.

Corrigan and Kleinlein, define self-stigma in reference to Corrigan's earlier work and the work of Holmes and River. (1998). By internalizing cultural ideas on the value, worth and flaws of an individual with mental illness, an individual could "accept these notions and experience diminished self-esteem, self-efficacy and confidence in one's future as a result" (Corrigan, 2005, p.25).

Also, if an individual does not feel free to disclose their mental health status, ask for days off when needed or may have concerns taking medication at work, this could impact their overall well-being and health. A good comparison would be not taking a sick day when one has the flu causing the course of illness to be longer. When compared with someone who has a mental illness, the aggravation of the condition could be caused by not taking a some time after being

triggered by a difficult or traumatizing event, having to be in work while one is going through the beginnings of a medication change that makes one more symptomatic, not feeling able to take one's medication at work for fear of coworkers discovering their illness and other possible consequences.

Some might argue that South Asian Americans might benefit from the increasing amount of awareness and knowledge about mental illness within the United States. This may well be true in some areas but around stigma this is not the case. The text, *On the Stigma Of Mental Illness*, cites a study of US Social survey data from 1996 on the subject of stigmatizing attitudes. Phelan, Link, Stueve and Prescolido found that " a probability sample was more likely to endorse stigmatizing attitudes than a similar group from 1956" (as cited in Corrigan, 2005, p.19-20). This increase was directly contrary to what the APA research group were expecting. Indeed, psychoeducation is a vital part of what we do as social workers and is often recommended as a way of battling stigma within families, individuals and communities. Yet, it seems to not have had the intended effect within the US. What could be different about the Indian context that changes the outcomes for severely mentally ill individuals? How could that be applied to treating Indian American individuals and possibly other individuals?

As previously stated, the study of marital success by K. Hopper, J. Wanderling and P. Narayanan found surprisingly that Indian individuals of both genders had significantly better prospects for marriage than counterparts from the US, Japan, Europe and Hong Kong (2007). "At the time of follow up, the rate of marriage for members of the 3 Indian cohorts was 73% (71% male, 74% female): for the combined 'developed' centers, it was 38% (28% male, 48% female) (Hopper et al., 2007, p.6). This may be a manifestation of cultural ideas around marriage, an emphasis on the family unit as a requirement for any care, different social norms

around mental illness or any number of other variables. What is interesting for this study is that this may point to possible difficulties around marriage, and traditional arranged marriages within an American context for South Asian Americans. If it is more difficult for individuals with a known mental illness to marry another in an American context, what else could be different? If an Indian person in the US experienced psychosis but in a different context than their counterparts in India, would their outcomes be different? How might that also relate to individuals immigrating to the United States or growing up as the children of immigrants? Would their mental illness or needs have been handled differently in another context? Is stigma different for them than for their Indian counterparts? How might this play into a person's presentation or choice to disclose? Is the size of a community a mitigating factor? All these are important questions that lead into the need for my study as well as many others investigating stigma as a complicating factor for effective care.

Another mitigating factor within this study was speculated to be "cultural imperatives, specifically the importance of duty (dharma) and presence of children in this largely Hindu society (Hopper et al., 2007, p. 7). Dharma can be defined in many ways and has many meanings, but is a very important concept within the Hindu religion. In this translation, as duty, dharma may contribute to individuals within the community being cared for and allowed full participation in the community as part of the duties of the community, family and culture overall. The caring for mentally ill family members may also fall under the idea of dharma, which could possibly change outcomes for some individuals. Indeed, one of the speculations within the piece is that the presence of extended kin and collectivist ideas of child rearing might account for mediated effects (Hopper et al., 2007, p. 7-8).

Another issue around stigma can be the difficulty in even obtaining treatment when needed. The article by M. Rastogi, R. Natrajan and V. Thomas brings up many salient themes around the factor of immigration, acculturation and mental health treatment. The study focused on two generations of South Asian immigrants, designated younger generation and older generation. Stigma was identified as the most common barrier for individuals in engaging in treatment in this study.

Participants noted that South Asian patients with mental illness are often concerned about being called “crazy,” “mad,” or “insane.” Young South Asian patients often did not feel comfortable discussing their emotional issues with their family even if the parents were well educated for fear of being misunderstood or considered weak. Obtaining family history of psychiatric illness was often challenging because patients did not want to discuss this (Rastogi et al., 2014, p.18).

This, along with other concerns around confidentiality, are a clear sign that this study and all future studies must be careful and conscientious about confidentiality and anonymity, in order to provide participants with a safe space to discuss these issues as well as avoiding or lessening harm to the participants by their participation in this study. It also may point to why more studies around South Asian individuals may not have been done, with these sort of stakes, concerns about confidentiality and possible risk. Further more, it may explain some of why mental health services are historically underutilized by this population.

Several participants spoke of South Asian patients who feared a loss of confidential information. These patients were often not forthcoming with their issues for fear of the information being leaked to other community members,

colleagues, and even future in-laws. This was seen to be more of a problem when the clinician is also South Asian and participates in the same community events as the patient (Rastogi et al., 2014, p. 19).

The *Asian Journal of Psychiatry* Rastogi et al. also article contains within it a very useful table of Do's and Don'ts for working with South Asian clients. Some suggestions seemed apropos to many populations, but the particular cautions around pharmacological intervention due to the lack of literature around South Asian populations and avoiding jargon within a clinical setting seem to be two of the most important suggestions. It may be very useful as a reference tool and resource for teaching new clinicians in order to provide more culturally competent care.

The possible lack of a strong South Asian collective, strains of acculturation, distance from possible assistance from family members, or extended community, differences in the effects of stigma and other concerns may change the outcomes or effects of mental illness on an individual and their family. This may also point the way to important methods of discussion of mental health treatment with the diaspora community as a whole.

Other themes included differences around gender, as female patients were often accompanied by male family members, who were very involved in their treatment and the treatment planning process. Many clinicians discussed having female patients “dropping out of therapy because their spouse did not believe in psychiatric treatment” and were unwilling to pay for their treatment (Rastogi et al., 2014, p.17).

Clinical experiences.

I certainly experienced aspects of this phenomenon with my first South Asian client, whose husband was often present at our meetings and had to be urged to allow us to conduct psychotherapy privately. As the agency I worked for was unwilling to pay for translation, her

husband or her son often did translation. This hampered my ability as a clinician to treat at times, as I was unable to ask questions directly or often noticed that her husband did not wait for her answer but answered the questions for her.

Other factors arose as well that made it difficult to provide effective treatment. Specifically, as both my client and her husband were elder to me, it would be considered rude for me to advise them, as I am a younger woman and, within our similar or shared cultural context, should be more in the position of accepting their advice as they are elders and are presumed to have more knowledge. But part of being a therapist can be to provide advice or ways of changing how one may deal with a situation. The language barrier also made it difficult to accurately determine whether I was getting my meaning across and many words present in English around therapy do not have counterparts in Hindi, the language we primarily used in session.

There are no words in Indian dialects that directly translate to “depression” or “guilt.” Therefore, in articulating mental states, a core expression for many women in this study translated to phrases such as “thinking in my heart” and “my heart kept falling and falling” and “my sorrow has become my illness.” One woman, after her husband left, received news that her sister passed away which “made the illness grow.” Another respondent spoke of the benefit of receiving anti-depressants stating, “My heart grew a little stronger” (Navasaria & Petersen, 2007, p.166).

This quotation may also be referring to a common concept in South Asia of referring to one's physical brain or *dimaag*, as its said in Hindi, versus *maan*, which roughly translates to heart mind. It can also be thought of as an emotional mind (Singh, 2015). Nevertheless, this lack

of vocabulary made even the most simple intervention more complex and requiring some extensive navigation.

Mental health utilization.

One of the strongest pieces of research I found was centered on those Asian Indians who do utilize therapeutic services within a college counseling model, with a control group of non-clinical individuals who had not sought out care for a control group (Wadhvani, 2000). Though the dissertation focuses on Asian Indians, I believe that the information provided within is useful in general for working with South Asians and at least opens the door to flexibility and new ways of thinking about cultural competency.

Within this dissertation, I was able to find data regarding South Asian individuals who had sought out therapeutic intervention. The questionnaires were extensive and ranged on a number of topics. The concept of individuation and the difficulties inherent in not addressing individuation as a cultural bias was one such topic.

It is clear that Grayson's developmental theory was based on Western philosophies. When using this framework, many Asian Indian students would be viewed as *developmentally behind* if cultural differences are not considered, since separation and individuation are not promoted in the Indian culture (Viswanathan, Shah, & Ahad, 1997). On the other hand, it would not be realistic for the Indian family to expect that Asian Indian students would not somewhat individuate when they are in a context in which that is the norm. Although, Asian Indian parents may hope that it would not be the case and do whatever they felt necessary to prevent such individuation, for the survival of family life. Even in Western

cultures, many families have difficulty adjusting to the affects of their children's independence on the family system (Wadhvani, 2000, p.4).

The dissertation points out a crucial possible pitfall for clinicians working with South Asian clients, who may promote concepts of individuation as interventions for their clients without realizing the possible implications, as was discussed in the possible reasons for failure of the Radical Caring model. It also discusses the unique stressors that may be present in South Asian college age students.

For the Asian Indian student, the stressors of college can be exacerbated by pressures of the Indian culture regarding academic expectations, contact with family, and social restrictions with peers. They may face conflict due to the dissonant values of the American and Asian Indian cultures. Ramisetty-Mikler (1993) states that there are considerable differences between the two cultures, including the perception of time, role of religion and philosophy of life, and family structure, which are likely to lead to the need for family role adaptation and conflicts during the acculturation process. Asian Indian students are likely to experience dissonance between the demands of their family (i.e., Asian Indian norms and values) and the environmental pressures to individuate and seek independence (Wadhvani, 2000, p.5).

As previously touched upon, a critical point ethically speaking for this study will be around the importance of confidentiality. Wadhvani (2000) accurately pinpoints some of the major difficulties for this population seeking mental health services.

Certain students who are less acculturated may have particular difficulty seeking services due to the cultural stigma associated with receiving mental health

services. They may also be concerned about issues of confidentiality. For example, they may particularly avoid group level therapy since other members of the group could be from the same, close knit, Indian community. Also, they may feel protective of family privacy and may consider sharing family-related problems with a professional or other member of a support group as betrayal to their family (p.13).

There is far more information within the dissertation than can be explained in this particular thesis, but I hope to continue to mine its rich data for more information as the process continues. To date, it is the only piece of research that I have found that asks who South Asians seek out when they have emotional difficulty, their perceptions of family reactions towards mental health service seeking, ideas around stigma, and preferences within the therapeutic settings.

Content analyses.

Asian American Mental Health: A Call to Action conducts a sweeping content analysis of the current empirical literature, discussing many of the gaps I have mentioned as well as areas for further discovery (Sue, Cheng, Saad, & Chu, 2012). It focuses on the difficulty in evaluating the need for care within the Asian American community, based on the lack of differentiation between ethnic groups, focus on Western dominated practice methods, the complex cultural factors involved for many Asian American groups in even determining that mental health care services are needed instead of physical health care and the dichotomy within Western traditions that separates mind and body in a way that many Asian cultures do not. The article calls for further investigation in the needs of Asian American communities. “In addition, further research is needed that focuses on the establishment of valid measures for Asian Americans and that

addresses cultural considerations in symptom reporting bias and conceptualization of mental disorders” (Sue et al., 2012, p.542).

Inman, Devdas, Spektor and Pendse's (2014) three-decade content analysis specifically on South Asian Americans was also an incredibly useful article in discussing the slew of work that has been done on South Asian Americans.

Although studies addressed several constructs, the top five frequently examined topics in the SA literature included psychological health, interpersonal dynamics, acculturative stress, identity, and domestic violence. Despite a concentrated focus on these areas, the research within each of these subtopics is not only limited but also fragmented, which creates difficulty in making comparisons across studies (Inman et al., 2014, p.4).

The content analysis found a great deal of trends as well, around convenience sampling and snowball sampling being primary methodologies of recruitment and Asian Indians as being the primary participants in many of the studies.

Empirical continued.

All of the articles stressed, with varying intensity, the importance of keeping an open and unassuming mindset in mind when working with Asian American, South Asian or South Asian American clients, particularly around family and community dynamics. The Reavey, Ahmed, and Majumdar article focuses on the difficulty workers faced in discussing sexual assault within South Asian cultures with the many drawing on factors of family, community, honor, shame and a lack of language for mental health problems. The article went into great depths regarding the importance of realizing that the very idea of the individual is a concept that is distinctly Western

and that viewing a South Asian woman particularly as a separate individual from her community, family and environment would lead to distinct difficulties in ongoing treatment.

According to a number of participants, the issue of South Asian women talking about themselves and their experiences was seen to be deeply problematic. They described how many women appear unable to disassociate themselves from their family, their partner, their children and their community. There were instances when participants would state how sexual abuse was bad enough, but if you were South Asian, it was felt that an added layer of difficulty should be acknowledged. According to these professionals, the feelings associated with the abuse did not have any translatable 'language'. Although the therapist in extract 3 concedes that her clients had to be 'persuaded' to think in more individual terms, the benefits in acknowledging the abuse can be far outweighed by the real problems in doing so in the context of familial relationships (2005, p.179).

The Dupree et al. (2013) article also brings up this crucial point. Focusing on family and marriage therapy, the article discusses the importance of extended families, parents and other members of the family and community in the life of a married couple and the importance of working within this larger context when working with South Asian couples and families. "The collectivist nature of Asian Indian American families means that in both traditional and modern marriages, parents and extended family often influence an individual's choice in spouse as well as how the marriage functions" (p.318).

The tendency to view South Asians as a homogenous group rather than acknowledging their diverse heterogeneity is, in my mind, a mistake that leads to improper, ill fitting treatment modalities that rely on uninformed premises and stereotypes. Within the Dupree et al. (2013)

article, this is very well summed up by their reference to another article. “As Bean, Perry, and Bedell (2001) note in their study designed to provide guidelines for working with Hispanic families, our intent is not to perpetuate the myth of sameness or ethnic homogeneity (see Falicov, 1995)” (p.312). Indeed, many Indians may identify with their particular state, region, ethnicity, tribe or religion more than with the general idea of being “South Asian” or “Indian” (Dupree et al., 2013). One participant in a qualitative study stated that

Being Indian to me doesn't mean as much as being Jain. When I think of what it means that I'm Indian, it's my religion. When we were young, we were taught how to live our lives according to Jain principles and that's what I know about being Indian. Otherwise, how can I know what India is, living here (Kallivayalil, 2004, p. 546)?

On the more quantitative side, the Loya et al. article, along with Castillo et al. are the two best articles I was able to locate studying the actual population. The sample size for Castillo, Zahn, and Cano's paper is larger than any other study I had previously found but included a large number of white students. Neither article problematizes the identification of whiteness around South Asian contexts, which is particularly of note within the South Asian context due to the Supreme Court case of *United States vs. Bhagat Singh Thind* and Thind's attempts to be recognized legally as a white individual for the purposes of attaining certain legal rights. (Shah, 1999)

The Castillo et al. article also brings up interesting points on family dynamics and the conflict that can come with acculturation, a difficulty very particular to the 2nd generation experience as well as others. As the family unit is deeply important to many South Asians and acculturative stress could be a reason for seeking therapy, this area received more attention as I

conducted interviews. Again though, this study's limitations clearly illustrate the lack of distinction drawn between Asian American groups and calls for research on specific group experiences to determine the different possible experiences within this larger group.

Das and Kemp's (1997) article, though out of date for inclusion, is included in this literature review largely due to the prevalence of its citation with many of the other articles used. The article draws broad sweeping generalizations around South Asian culture in general and may be an example of outdated literature that needs updating for the current time frame. However, It seems to be a seminal article in the field. One quotation sums up a difficulty that eventually arose in the course of the study and resulted in a substantial change to the methodologies of this thesis.

We don't really say mental health coz that scares a lot of the Asian community, as soon as you put a label of mental health into it, they say oh no I don't need it, I don't need that type of service. We just say anybody who's just feeling down or feeling isolated ... there's no such term as depression in the Asian language (p.183).

Lastly, Kallivayalil's (2004) article ties many of these aspects together in a qualitative style, speaking to young girls in a long interview form about their experiences as 2nd generation individuals, the constant push and pull between two cultures, their difficulties in relating to and accommodating their parents dual desires for them to be "modern" and "traditional" at the same time. This is one of the few articles that discuss the intersections of gender, identity, and religion and South Asian identity.

Future Research

With all of these variables in mind, how could clinicians possibly serve South Asian clients better? Could billing be conducted differently to accommodate gender dynamics or

concerns about confidentiality? Would groups be better if they could be also put forth to client's families as social opportunities or some sort of group activity? How could clinicians respectfully ask families for privacy while they assess a client initially or utilize the family's reports without jeopardizing the client's care or their right to choice? Moreover, how do all these factors affect a client's needs? Once again, this points the way to a need for more research.

Critique of Existing Literature

Beyond these items, the themes I focused on were around the discussion of the issue of the term South Asian, critiques of Western based therapeutic models that focus on individuation instead of collectivist or community based ideas important to many South Asian groups, concerns around the conflicting research reporting both higher rates of mental illness within Asian Americans and lower rates among Asian Americans as a group and finally, ways in which to improve practice to better serve South Asian identified clients.

A good starting place for discussing the critiques of Western based therapeutic models would be in discussing the idea of "Western privilege." This idea is based in the idea that certain ways of life, ways of thinking and ways of being are privileged in our modern world, due to the West's history of colonizing and the increased media representation of Western norms, ideas and events (Ferguson, 2014).

When considering working with South Asian American clients, this idea must be considered. Some of the points made within Ferguson's article are very relevant for clinicians, such as the possibility of being reduced to a "single story by being from a given country," the possible lack of knowledge about a client's "national traditions and cultural norms", the possibility of a client's background being regarded as "backwards" and the very real problem of the South Asian subcontinent being treated as though its "one monolithic country" (Ferguson,

2014). These could be very real pitfalls and traps for therapists in building a therapeutic relationship with South Asian clients.

Even this very research is in some ways compromised by the idea of focusing on "South Asian Americans". It reduces this enormously diverse subcontinent to one name, which may encourage those who read this piece to reduce their diverse and complex clients to a set of Do's and Don'ts. But as in all clinical cases, clients are more complex than their demographics

Overall, though these articles were deeply useful in formulating my methodologies and overall scope for the project, they are difficult to compare to each other, as Inman et al. discusses (2014). However, when taken as pieces of an overall puzzle, they put together a picture of a deeply diverse community, with a great deal of differing needs, experiences and quandaries, that is affected by stigma, acculturation, stress, gender dynamics, racism and many other factors.

CHAPTER III

Methodology

Purpose

The purpose of this study was to conduct interviews and identify common themes for South Asian American individuals around mental health resources and utilization of these resources in order to better understand the context of these clients and improve care for future clients. The definition of what constitutes resources is broad in scope, including but not limited to, self help books, support groups, crisis lines, therapy, psychiatric interventions and other modes of help seeking that are not be covered by this brief description. South Asian Americans were also described in a broad sense, including any self identified South Asians, who had lived within the United States for at least five years. Discussion of mental health stigma was also part of this investigation, as this was hypothesized to be a barrier to South Asian American clients seeking treatment. Stigma in this thesis will refer both public stigma and self-stigma. Public stigma is defined as "the results of a naive public endorsing the stereotypes of mental illness" and self-stigma, "the consequences of people with mental illness applying stigma to themselves" (Corrigan and Kleinlein, 2005, p.12).

Complexities and Changes

However, as will be expanded upon within the discussions section, it became necessary through the course of this study to both change the scope and focus of the overall study in order to both gain sufficient participants and also provide a richer and more complete view of the resources the South Asian American community was choosing to utilize instead of or in addition to mental health resources.

Based on initial recruiting information and community feedback, the wording and description of the study was changed to encompass the idea of community support, or an individual's utilization of natural resources within their community, family, and peer group or outside communities that they engaged with in order to meet various needs during times of difficulty. This was developed in the hopes of speaking to more of the South Asian American experience and the choices made by many individuals to seek supports other than traditional mental health care or resources labeled under the umbrella of mental health care.

Research Question

The overarching question, after these changes were made, was what are the experiences of South Asian Americans around help seeking within both community settings and mental health settings? Additionally, what methods, skills and ways of providing support were deemed most useful, helpful or culturally appropriate by these individuals, to further point to possible application of these methods by community members and mental health professionals and possible development of new theories or methods to provide improved support to this community.

Qualitative methodology was chosen as this seemed to be a gap within the research that was at hand. Very little research with direct interviews of clients or individuals in need was found within the current literature, though it has been increasing in the past ten years (Inman et al., 2014). Qualitative methods were also chosen due to the immense diversity of the subcontinent, the incredibly varied amount of identifications, religions, gender identities, ethnicities and possible sub region identifications. With this many possible variables within any individual, it was deemed wise to utilize a qualitative study in order to allow for the most possible nuance without excluding any participant's experience.

The many complicating factors, possible biases, sample characteristics and other important pieces of the study will be discussed in the following sections.

Sample

The sample population for this study included self identified South Asian Americans, ages 18-40, who had lived within the United States for at least 5 years. The term South Asian meant any individual from the South Asian subcontinent or with genetic, familial or historic ties to this area. This includes but is not limited to India, Pakistan, Bangladesh, Nepal and Sri Lanka.

Within this study, I focused on individuals who sought some type of support, whether from a mental health provider, support group, family member, peer group member or other individual for any issues they may have been having. This ranged from talking to a friend about a problem with a boss to seeking psychiatric medication in order to deal with a diagnosed disorder.

Demographic questions were used to determine eligibility prior to the interview process and informed consent, along with a resource list, were sent to those participants who were participating via Skype.

Recruitment

The study's recruitment utilized non-probability sampling including snowball sampling and convenience sampling in order to recruit participants. The study utilized flyering, the social media network Facebook as well as several South Asian focused websites, Craigslist, Reddit, LinkedIn and emails sent to individuals known to the researcher in the South Asian American community. The researcher's Smith.edu email was utilized for contact in order to preserve anonymity and separation from personal email accounts.

Informed Consent

Prior to any contact, a Human Subjects Review application was submitted and approved by Smith College's School for Social Work Institutional Review Board. Online communication was used primarily for the first contacts with individuals in order to preserve anonymity and security of participant's personal information. After the initial contact, participants were sent two copies of the Informed Consent Agreement, as well as a resource list for their area (for those outside the Greater Cincinnati area) and a self addressed stamped envelope to aid in returning the signed informed consent to the SSW's HSR committee. (See Appendix A for Informed Consent Agreement and Appendix ___ for HSR Approval Letter) Once this document was received, participants were asked 7 questions around demographic criteria. Only the data from the first two questions was retained for demographic purposes.

During the initial contact, participants were encouraged to ask any questions prior to signing the informed consent forms and were asked for any follow up questions prior to the beginning of the formal interview. If the participant had family members or community members who also had questions that they would prefer to have as a part of the initial contact, this would also be allowed in order to provide an atmosphere of safety for the participants, particularly in person. This would only occur with the participant's approval and initiative. I felt that it was vital to provide this opportunity in order to be respectful of community ties as well as the desire to protect individuals within the community from any possible harm.

After the interview and prior to transcription, all participants were assigned a number in order to safeguard their anonymity. The voice recordings were stored on a password-protected device and backed up to a password protected cloud. The transcriptions were stored on a password-protected computer and the identifying information was stored separately from the transcriptions. All other data and recordings will be kept secure for three years as required by

Federal regulations and, after that time, they will be destroyed or continue to be kept secured as long as needed. When no longer needed, all data will be destroyed.

Risk and Benefits of Participation

As confidentiality was closely protected, it was unlikely that community members would discover each other's participation via the study. As the interview occurred in a public location of the interviewee's choice, likely a library or some area with a private meeting room, the likelihood of discovery by an outside observer was unlikely. However, because of snowball sampling, there may have been a certain aspect of risk during the recruitment process. There may have also been a risk of confidentiality being compromised if an individual chooses to bring a supportive individual, family member or friend to their initial appointment. Though this still seems to me to be a vital part of being sensitive to the community's needs, it was a concern as a researcher for how to properly keep confidentiality in this case.

Providing mental health and community based support resources through the document that was given to each participant was intended to mitigate the possible distress participants may have felt. This document would contain information for mental health providers, self help lines, online forums, self help groups and other resources within their geographic area. Self-stigma may also be combated by being a part of the study, as a normalizing of utilization of mental health services and resources may occur.

Data Collection

The data for this study was collected from March 6th, 2015 to April 12th, 2015, using a semi-structured interview, with ten of the interviews conducted via Skype and two conducted in person. There were nine open questions, with one tree of questions for if an individual had utilized mental health resources and another tree for if the person had utilized community

supports. In cases where a participant utilized both methods, the participant was asked both trees of questions, which resulted in the participant answering fourteen open questions. (See Appendix B) The process was designed to take no more than an hour and thirty minutes, including any questions prior to the beginning of the interview around informed consent. Each participant was given or mailed two copies of the informed consent, one to sign and return and one to keep for their records. Once each participant had returned their informed consent, a time was scheduled for the participant to ask any further questions around the informed consent and answer the open-ended questions.

The qualitative data for this study was collected through semi –structured interviews both over the phone and in person. The Voice Memo function within the iPhone 5 system was used to record these interviews. These recordings were saved as voices memos and downloaded into iTunes for easier playback and recording. Each participant was given a number to protect confidentiality, with the names and numbers stored in a separate document on a password protected computer. The recordings were saved to a password protected computer and password protected cloud folder. The interviews were completely transcribed by a paid transcriber and myself. The transcriber signed a confidentiality agreement. The demographic data was labeled along with the number and codes assigned to each participant in an Excel spreadsheet.

The open-ended questions in the interview were designed to elicit personal as well as collective data around the utilization of mental health resources and community supports for each individual. This data would both be based on subjective, emotional experiences of these difficult times, as well as imagined or realized ideas of what could or would improve these scenarios, methods and outcomes. The questions ranged from queries on how the individual identified themselves, interactions within the community, the experience of utilizing a mental

health resource, reasons for not utilizing a mental health resource, desired changes or wishes for what a mental health professional might be like in working with the individual, community involvement and the nature of the community support received and the manner of difficulties they had experienced within their lives.

CHAPTER IV

Findings

The purpose of this study was to analyze and discover the utilization and effectiveness of both mental health interventions and community supports by South Asian Americans in order to deal with difficulties in their lives. In addition, there are suggestions of ways to improve mental health care for South Asian Americans seeking out assistance and speculate on possible alternative intervention strategies that could be developed that fit with values, particular struggles and the strengths of this diverse group.

This chapter contains findings based on 12 interviews of South Asian self-identified or nominally self-identified individuals, living within the United States for more than five years and who identified themselves as either individuals who had utilized mental health interventions or individuals who sought out community support during times of difficulty. Interviews were conducted via Skype or in person, recorded, fully transcribed and then coded using thematic analysis. Demographic information was collected in a brief questionnaire prior to the interview. The interview portion focused on the participants' utilization of various services or community supports, experiences with these interventions, and thoughts on possible improvement of these supports.

For several reasons, only limited demographic data were collected. Participants were asked to answer questions on their regional affiliation within South Asia, and the generation of immigrant they defined themselves as. The main reasons for this were due to a concern for keeping the proceedings very confidential and very disguised due to the concerns often expressed within this community around confidentiality and stigma and especially with the need to use snowball sampling and convenience sampling. Another reason revolved around the

relatively unexplored nature of this diverse group's interactions with the American immigration experience. Analysis of the many demographic variables may have been interesting but detracted from the focus of the study, which was based around personal experiences by these individuals and not around making possible generalizations or conclusions based on or reflecting their demographic designations. Therefore, only the generational status and region of family origin were asked for and retained as identifying data.

Within the recruitment process, there were only two individuals who came to participate in the study without any community link or introduction by a trusted individual. Indeed, this may point to the very reason that there was very little research on this demographic group. The difficulty of recruitment may be in creating trust within the community sufficient to allow for studies of this kind. Even one of those two stated that she had been told about this study by her family, but we could not determine how the chain of information had been created.

Due to the stigma and difficulties around confidentiality discussed previously, there were concerns about the initial possibility of gathering any data or recruiting enough participants. While the study was successful in gathering sufficient participants, the methods used affect the overall data.

Three of the participants of this study were recruited under the initial vision of this project, and identified themselves as South Asian Americans who had utilized mental health services and wished to share their experiences on this topic. The other nine participants were recruited under the revised study, after I received feedback on potential participants lack of comfort around discussing mental health. This discomfort was seen and reported to me by family members, friends and colleagues during their attempts to discuss the study with their

communities. Of these nine, an additional three participants had utilized mental health services at different points in their lives, but also community resources.

With this in mind, as well as what was found in the process of building a literature review, the wording and scope of the study was changed to one centered around community support so that the focus could shift to understanding what South Asian Americans may be doing instead of seeking out traditional mental health workers or possibly in addition to doing so. Please keep this in mind while looking over the findings, as it did affect the overall picture.

Cultural Chameleon

While the above wording may seem odd, it seemed the best to describe a particular sort of phenomenon noted in nine of the twelve participants. Notably, each of these nine described at least one, if not many instances of shifting or emphasizing a particular part of themselves to blend in, work with or unconsciously adapt to a particular group of people. It could be something as small as emphasizing one's identity as Asian when applying for jobs or scholarships, as 2 participants discussed doing or as explicit as trying to be "more or less" of one's South Asian self based on the composition and atmosphere of a group.

it was also a dichotomy, honestly, I had my Indian friends and I had my, white friends, not that they were all white, but just, the non-Indian friends, and there was definitely like a group of Indian kids that, I don't remember what the association was called, but be involved in, I think I it was like the--- but do the dances that they had, we had cultural events like twice a year, and, you know, the more I would practice dances with them, the closer I would be with them, so it felt like I was two different people. And depending on what I was doing activity

wise with either group, I was either more Indian or less Indian, depending on what I was doing (Participant 3).

Within this code, an action could be an act of shifting what is emphasized within one's identity in accordance with the environment and people within in, much like a chameleon shifts its skin color in order to protectively adapt to its surroundings. However, importantly, this does not make the people change themselves, just as the chameleon is still a chameleon, but rather how they may be perceived.

Many participants also spoke of feeling as though they were two selves. Sometimes, this seemed to be based around pain, other times around practicality.

I just want to be able to be the same person whether I am at work or school, or in front of my friends or my family, people I've never met before, but I always seem to put on this showman's face for interviews, for jobs, at work, in public (Participant 5).

Sometimes, it appeared to be based in both.

I was exposed to a lot of people, a lot of people from different backgrounds, cultures, so I guess, so they were like, when we used to have potluck, I used to make something and they, even, didn't attempt to try it, you know, so I felt a little awkward at that time, but then I realized, then I just started getting fruits or ice cream or something like that (Participant 8).

One participant identified this skill as a vital skill set in his previous work.

I was this child of two worlds. I grew up, at that point, even in my mid twenties, I had the skill-set of being able to connect with Americans and Caucasians and at the same time, in Chicago, I was, when I was selling, I could turn and switch and

all of a sudden connect with people who at the time, had a lot more money to buy bigger houses and that kind of thing, so I took that tool to my advantage. I'm a child of two worlds, I can excel in two worlds and my father used to say, it's an old saying, the translation in English is roughly: You can't have one foot in each boat. You have to go one-way or the other, right? You have to jump in one boat and stick on it... and I was like, f that, I'm going to be on two boats" (Participant 10).

One participant discussed the idea of trying to integrate or negotiate with multiple facets of identity.

the more I started identifying the fact that I did not identify as just American, like, the more like I felt like I had to negotiate, the more I realized I had to negotiate my relationship with people, like, my identity and how I interact with people and a way to maintain both" (Participant 12).

As an individual who had utilized this same technique in my own life and not seen it used by others, this particular code drew me in significantly, particularly the idea of being in two boats. I had previously articulated this to myself as the idea of having a foot in two worlds and being pulled apart. It was deeply validating but also very intriguing to see so many different variants of the same theme in my participants.

Isolation (Taking Many Forms)

Seven of the twelve participants spoke about isolation, four of them extensively within their interviews. All four had sought out treatment from a mental health provider and utilized these services because they felt their family or community was not sufficient in some way to assist them.

there were no other Indian people, or Indian kids whose parents divorced in my community...who do I reach out to? My brother and sister? Ok, but I mean, they're my family, it's nice but it's also like, I want to have that shared experience with someone else outside of my family " (Participant 1).

Domestic violence, which has been discussed in many previous South Asian studies (Inman, 2014) was also an aspect of isolation for one participant.

being in that relationship, losing my friends, it was like emotionally and physically abusive, and um, I lost a lot of my friends, created this huge gap between my parents, you know and between me and my brother and stuff, where I was really isolated, and, my last year of college is when I was able to get away from him with help from friends because they recognized what was going on, and they were like, "no, it's time to stop," and one day I woke up and I was like... I'm done (Participant 2).

Transition after immigration was where this manifested for another participant.

So, a lot of things, like, no one sat next to me in school, in the deli, cafeteria. I didn't know how to use a locker or nothing. It's hard... so many small things and I started observing things like how different it is (Participant 4).

Differences around religious group's methods of interacting between sexes created an intense feeling of isolation for one Muslim identified participant.

for the first two years that I went to jumma at school, umm, no one said anything to me once, like I did not receive a single salaam alai kuum, I didn't receive like any sort of like, real acknowledgement until actually I was um, at the beginning of last semester I was just feeling like super lonely and then I went to jumma and I

started sobbing in the middle of jumma, and I was like, “ I can’t take this, literally people ignoring the fact that I exist (Participant 12).

I kept trying to find out a way to find a sort of similar community and if the MSA wasn’t working out, so I tried to do individual friends...there are just not enough Muslims in Americ---not America, in, um, _____ University to do that with, and I tried to do that with non Muslims and I found out they just didn’t get it, like that common ground that I felt like we had, didn’t exist...like they were like Christian so we still have this common ground of faith...it was just...it wasn’t the same and you know, they felt like every time I wanted to talk about religion, I wanted to talk about the Jesus thing, and I was like, “no can’t I just talk about religion and faith and spirituality without talking about our differences? Can’t I want to talk about our similarities?” But you know, that’s not what happened" (Participant 12). I’ve always sort of been, inherently, I hate to use the term lone wolf, it gets used a lot, but that’s me, I’ve always just been, kind of dealt with it on my own, you know, bear the burden on my own, um, with exception of one person (Participant 10).

One participant identified this isolation as detachment that had existed for much of her life, starting after she attended boarding school in India while her parents were abroad.

I mean I was distanced from my parents at that time, there was a sense of detachment and that detachment has always stayed with me, it takes me a while to, not, I can come across as an extremely warm person, hugging and all that, but at the same time I am also a person who can walk away very quickly (Participant 7).

One individual identified a sense of feeling as though he wanted to be part of a group, but unable or uncertain about attending.

eh it's a good idea I didn't get into any major religions, but at the same time I did feel kind of left out when friends would go off and do some kind of religious thing and they would be surrounded by community and I felt like I could be part of that if I wanted to, but I just feel like it would be disingenuous to do so, so here I am, I have all of the instincts to want to be part of that group, but I just can't commit myself and now I'm back to being separate from others (Participant 5).

Though the isolation could be in multiple aspects of life, it seemed to be an important factor in the decision to utilize a mental health worker, versus a community member or family member. For some individuals, it seemed to be a burden and for others, it seemed to have become a way of life or something that felt comfortable eventually.

The Importance of Feeling Understood (by the world and by your community)

All participants discussed in some way, their desire to be understood or at least not misunderstood. Some identified it as a key criterion for any work with another person on their difficulties. Others discussed the pain of being misunderstood or made fun of for their lack of understanding of social mores. Shared experience was a sub theme of this category, as was expert knowledge, active listening and a sense of collaboration. Active listening was especially identified as a helpful component of helping someone feel understood, listened to and what might be effective with mental health practitioners they either had worked with or would consider working with.

One participant articulated the work she had done with a family member discussing unhealthy relationships and how her family member's shared experience had made her a more valuable resource, as well as easier to talk to.

because she's been through a lot in her own relationships with her own husband, there were a lot of difficulties that she faced, and because she opened up to me, she was one of the first people to treat me as an adult, and told me, told me about the difficulties that she faced, and so it was like, ok, she's been through this, and now like, her relationship is working, she must have done something right, and I feel comfortable you know, going to her about it, whereas my mom has never opened up to me, we've never had that open line of communication, so I don't feel comfortable going to her (Participant 2).

Another participant discussed the value of expert knowledge in her work with a school guidance counselor shortly after immigration.

She was amazing and she was just very, she was just amazing. She didn't have to do what she did and I just went there to basically ask, who do I apply to? It wasn't anything related to this topic—like oh, I need help. I need kind of counseling. I didn't go to see her with that intention; but it just came out. We just started talking and she was just a good listener and helped me out. So yeah, and that helped me out to write lots of essays. I wrote about this experience of mine a lot of my essays and I got scholarships due to it so I was like—oh wow, I didn't know I could do this (Participant 4).

One participant discussed his frustrations at the lack of progress he felt he had made in counseling and a desire for an expert to tell him how to change things.

I feel like the same thing was with counseling, sometimes I would talk to some people, with counselors and it was like, “well gee, it sounds like you have a really good handle on this, what do you want to achieve?” and it was like...”I just want to feel better, I want to feel happier about the person I am, and not the person I think I’m supposed to be...” and they are like... “well why don’t you just do that...?” and it was like...”well...you know...it feels so stuck...” that’s why I use the car analogy, because I couldn’t figure out how to explain it to them without going through my life history every single time or my life story every single time we talked (Participant 5).

The same participant discussed his frustrations at trying to utilize his community, but feeling a lack of understanding in their support. He also discussed the ambivalence he felt in working with a mental health worker.

I tried to talk to some friends, but I realized pretty quickly that their limitations are my limitations, they couldn’t empathize or sympathize the way I could, which I think is good and bad, because in some ways I didn’t really want to be around, someone who was just like me, which was a weird thing to have to deal with growing up. By the time I got to high school I did try to start to look for help, but it kind of came in the form of go behind closed doors, talk about it with somebody who you’ve never met before and who doesn’t really seem to have a connection to you...I met with this school counselor who I had never seen before, he was kind of a private counselor or therapist who the school had, in order to, just help someone who needed to talk it out, but I was like... “gee, I would rather talk about it with my teachers or my advisor than with some stranger...” you know,

granted I understood that he might not feel uncomfortable or totally understand how to help out (Participant 5).

One participant, who had never utilized mental health services, described her relationship with an older woman who lived in her apartment building and served as a positive influence for her.

At that time when I was still getting to know myself or finding more things about myself and she was there somewhere in the picture, and you have questions, you go ahead and you would want to share, because, with knowing yourself, I don't know how many people do that, but there is a certain kind of energy that comes from within, it's very hard to explain, it's something that just is and you literally have to go through the experience to just know. It's very experiential sort of thing, but I had that energy within me and I would be burning with questions, and I think because she has been through a lot of crap in her life, she has been through a lot of psychiatrists and things like that, and there was one person she never mentioned, who had been there, who answered a lot of things for her in a lot of ways, so I would be burning with questions, and I would go ahead and ask her about this and that, and she would kind of give it a perspective or give it a shape, of this is what it is, and you would take that back and you would think on it a little more, sort of thing, and you keep going deeper within, within, within, and sometimes, I would be telling her things, and because, you just, you just learn a lot if you actually get more aware of yourself (Participant 7).

Shared experience was a frequently cited example of a way participants felt they were understood, a key asset in a mental health worker or community support person and a key stumbling block at times for discussing their problems with others.

my cousins knew exactly where I was coming from so I didn't have to explain to them...and even with my brother or anyone else in my family—I didn't have to explain my identity to them because they knew where I was coming from (Participant 6).

it's really um, you feel, they listen to you and uh, they throw at you some guidance and I guess since we are of the same age and most of them have gone through the same things that I have gone through, so, they uh, they are so kind of guide you, I mean they know where I am coming from and I know where they are coming from, so the guidance in talking to them, the kind of support you get, you feel relaxed, and I guess the guidance they provide is relevant to you, so, so not just you know, typical thing (Participant 8).

Lastly, one participant discussed the difficulties possibly inherent in going into therapy.

I think making that choice, right for anyone, for a person to go to therapy is kind of a big choice unless you grow up in a house where people are very open about these things, um, and there's probably not that many families that are like that, and I think it's kind of a big choice, and when you go in and you're in a bit of a vulnerable position, right, and you're unloading all of these things that are very personal and private, in some cases, to someone who is a complete stranger, um, so then to feel like you're judged or something's not jiving, I mean, um, I think based on my own experiences, can cause some sense of anxieties maybe, or more

than anxiety, because you've just shoved all this very personal stuff on someone and you're like... "that was useless, this person doesn't understand at all, this isn't helping me..." (Participant 11).

Conflict In Identity (Across a Spectrum)

Eight of the twelve participants described various struggles around articulating, forming and maintaining their various identities. Two individuals discussed the fact that they did not identify at this time as anything other than a human being and one stated that he felt those identifications were part of the problems within the world today.

That is a big problem in today's society. Why do you think the Islamic militant of terrorist want to kill any other religion? Because he gets identified with it. That he is identifying himself as a Muslim or an Islamic person, and just as a human being, he will not do those acts. The root cause is identification. Why do you think any soldier of any country is ready to kill another pers, human being (Participant 9).

One participant talked about the difficulty of identification around looking or sounding a specific way. This particular quote also cross-references with the code of Cultural Chameleon because of her discussion of changing depending on the group.

It's like, I know I'm not really, I don't look American, I don't sound Indian, so, it's just this constant struggle, like where do I really fit in, and I think it's just, I'm always going to be a little bit off from completely fitting in. Um I can blend in and pretend to be part of different groups like, I've been, um, mistaken for other racial identities, or, um, nationalities and I'm just like... "oh, ok, that's cool," but then, it doesn't really bother me, but difficulties, I can't really be my true self, I

guess that's pretty difficult, I don't really know who I am sometimes, because I feel like depending on who I am around, I'm a certain way (Participant 1).

One participant identified frustration with feeling unable to question traditions within her religious context and led her to move away from her family's religious background and cultural background.

Our religious group, we used to meet every frickin Sunday morning, and I used to, my job was the rally the kids and keep them all together in the Sunday school, create a curriculum and keep them all, you know, learning about Hinduism, learning about the sacraments of Hinduism, learning about morals and values and whatever, and I was looking more and more at what I was being provided and the curriculum I was being asked to teach these kids, I started questioning the religion and being like, "well why do we do these things?" asking "why this, why that," or "why are we following this thing that is so outdated, so from back-then, it has no aspect in modern life, why are we still doing this crap?" And um, my mom was like, "you don't question, you just do," and I had a hard time with that, and I was like, "no I don't want to just do," they never actually answered the why so I started pushing away from the religion, I was like, "this isn't how I want to live my life, I don't want to be told what to do," I want to figure it out for myself, so as I went through high school and college I just sort of pushed away from the religion, because if you can't answer my questions, I'm not going to follow, you know, and as Indian girls, we are always "do what you're told," and I hated that, and so that was, that was a huge part of my identity, when I was little I did what I was told, I was a good girl because I did what I was told, and then as I started

getting into my teenage years, and asking the why questions, um, is when I really started to move away from that identity and create a new one of being the rebel and being, you know, asking the why questions, asking the tough questions, stepping away from what I know (Participant 2).

One participant identified shifts that came with age, and the urge to distance herself from her cultural in her adolescence.

I don't think that I felt boxed in by my identity, maybe I did later, when I was in high school, I did probably. The whole Indian, thing, I felt like, I didn't appreciate it too much, I think at the times, when I didn't appreciate, because I felt like it wasn't normal, or what all the other kids were like, it made me different, it meant that I didn't have friends...that I knew from Sunday School that also went to school with me, so I was also friends with them outside of school...um I think it depends kind of where in my timeline you say it, because I think, being older, I can embrace all of that, whereas, when I was younger, I kind of couldn't (Participant 3).

One participant discussed the idea of identifying as something that felt divisive to them, particularly around religion and background.

I like to be outside the whole thing, because I think, anywhere in my mind, the minute someone talks from the aspect of religion, for the most part, because that's where the whole crap is happening these days, the minute that my mind says this is something that divides, I steer away from it, I don't like to...I like to see everybody as a being, rather than from a certain place. But yes, culture wise, Indian (Participant 7).

One participant discussed the pressure she felt to identify as Indian from her grandmother and her grandmother's experience of isolation.

she's always very confident that, um, my identity and my relationship with her was like, enough. I don't know, I don't even know, I think she has dealt with being isolated a lot. She moved from India, she moved into an area that had almost no Muslims, almost no Indians, um, and like her husband was working a lot, and, so I think she dealt with being very isolated and the way that she dealt with it is not the same way I can deal with it, but like the way she dealt with it, was like by calling family and like, she had this very strong, like lots of Indian family, some of which had moved to the states, some of which hadn't that she could talk to, um, and then, that was the way she overcame that, by talking to them, and I think she felt that by me talking to her, that was enough to solve my issues... (Participant 12).

What Does It Mean to Be South Asian?

Ten out of twelve participants discussed themes around what it meant to be Indian, Bengali or generally South Asian. Sub themes included forces from within the community, outside of the community and the necessity of defining oneself for another's understanding and curiosity. These also cross-reference with certain quotes from Microaggressions in Comments, Questions, Explanations.

Some identified anxiety or difficulty in explaining themselves as a South Asian person to others.

I think when I'm put on the spot and asked, "oh what does it mean to be Indian," that like, stresses me out, because I'm like... "why am I even... why am I even –

why is this person even talking to me?! Why am I even entertaining the question?" Because I don't have...there's no standard, and that's true with all races, all religions, there's no standard and I think that I just feel pressured to give a really good answer and that increases my anxiety (Participant 1).

One of these participants discussed the complexity of even answering questions about where she is ethnically from.

I am Indian so I guess I would fall into that sort of group as far as ethnicity goes, but I guess it's kind of hard to identify myself as an Indian, because even though my roots are in India, my ancestors were taken as slaves to Fiji Islands, so I identify myself as Indo-Fijian, because we've been there for so many generations that we've kind of lost our roots in India, and trying to find that has been difficult, but, I'm Indian, but I grew up in Fiji for so long, so Indians, from Indian don't even acknowledge that we even exist, so when I tell people "Oh I'm Indian," they're like, "Oh! Where in India are you from?" and I'm like... "Oh, I'm actually not," you know, like I was born and raised somewhere else. Indians in America, I guess, you know, American Indian or whatever...(Participant 2).

Others defined feeling boxed in by the expectations of others or by definitions of "Indianness" imposed by others.

I feel like that defines, to be a person that's asking, they're asking me what my ethnicity is, because they look at me, and they don't automatically think, "oh she's an American," or, you know, whatever, they're just trying to dig deeper to see where I'm from, and what being Indian means to me, I mean there is a culture that comes with it, there's, so many languages, it's not really one language,

there's food—I think people identify with Indian food, so they're like, "oh I love Indian food!" that's one of the first things they go to, but like, there's music, there's movies, there's dancing, there's a lot of things, that I identify to being Indian, but I sometimes also detach myself from, because I also don't watch Bollywood movies, but that doesn't mean I'm not Indian (Participant 3).

One participant identified the difficulty of accepting or claiming an identity and the isolation that continued even afterwards. This is cross-referenced with the code Isolation.

but it also has been very interesting how even not identifying myself is a way for people to kind of go, "oh my gosh, you don't even know where you come from? It's like, I know where I come from and I know a pretty decent amount of my family's history, but you know, not to the extent that I'd like to---but I think that it's made me very aware of how questions I've had, questions I've been seeking answers to, and questions that just go unanswered have been kind of haunting me for a long time and I just didn't really have time to process it growing up--- I felt like everything was just a whirlwind and I just had to put myself into those categories for the sake of convenience rather than for any kind of growing or developmental purpose. So, right now, after all of that, I still identify myself as Indian American but I see myself as still set apart from other Indian Americans or even Indian Canadians I've met living in _____ who have felt like, you know, we had a similar childhood but why is it that we just can't connect or why is there this um, I don't know, some sort of reticence on my part to seek them out or to join professional groups now that I've been working for so many years. Um, so it's sort of weird because I still feel Indian American but I feel it in a very private

way, like when I go out into the world, I'll leave it up to whoever I am talking to to decide what they think I identify as, but I won't usually bring it up unless someone else brings it up. (Participant 5).

This participant discussed the process of coming to their identification over time, with help and the positive emotions this brought on.

Um, yeah, I think in certain respects, yeah I would say. I mean, because they identify themselves as Indian as well. That made me realize that I don't have to change my core identity just because I speak another language or I've adapted to a different culture... that I can still identify myself as something else, even though I've grown up through most of my life in one country (Participant 6).

I always thought I was too Americanized; that there was no way back for me to find my way back to my culture... and as I've gotten older, I've realized that my core, I've always been a Bengali oldest, eldest son in the family and inherently, that nurture, that caring, that sense of responsibility is something that's always been inherent in me... I just never recognized it so as I've gotten older, I've gotten much better about recognizing it—whether it be with my brothers or even just extended family, or my wife, my father and mother in law now—my nieces and nephews—that concept, that you're a family oriented kid; that never occurred to me until all of a sudden, I went into this world of marriage (Participant 10).

These participants described the burdens or difficulties that came from within their communities.

Oh yea, it's kind of crazy, it's like, you know, if people, in at least, in my community, think, or even Indians, Indians for example, you are born to get

married, that's your aim. And if, parents think that if you get married then their job is kind of done. Ok, they got you settled down. So it's like a lot of pressure all the time, when you talk to anybody for that matter. Here there's not, because I don't know so many people here. But still like people push you, you know, I mean I understand their point of view, they want, uh, they are kind of telling me getting married, settling down would be good for me, but I, and you will be happy, the common thing I hear from Indians---but I'm already happy so, you can't define happiness, like, boom, once you get married you'll be happy. I mean, what, I foresee so many problems out of marriage too, right? So that is quite, um, sometimes, yea, that is quite, sometimes, irritating or, kind of, you know. People don't understand and every time you meet it's the same questions. Kind of same discussion comes. It's difficult even talking to parents, it's difficult. And that, like, parents raise pressure from their relatives, so that makes things difficult sometimes. And nowadays it's so, weird, uh, that people, gossip about you, "hey why this guy not getting married, is there a problem, is he gay, or what," and you know, some things you hear, not, they don't talk to your own face, but something you hear from somebody else. Then I feel bad about it. I don't know why these people think like that (Participant 8).

Issues of immigration, class and expectation played a role in pushback from within communities.

that's where being Indian comes a little bit into play, we're kind of conditioned in the community to feel like, like "what is your problem?" you know like, "it can't be that bad, you have food and clothes, your parents provide all these things for

you, so really what could be the problem?” um, I think that those expectations though also, can, make you, I don’t know, make you feel like, there’s thing that you should do or ways that you should be (Participant 11).

Microaggressions in Comments, Questions, Explanations

Lastly, ten of the twelve participants described and remembered micro aggressive comments, questions asked of them or things they had felt obligated to explain over the years around their identity, South Asian heritage or background. Some of these comments could definitely be seen as the result of prejudice and some were actively hostile. Many of them were distressing to participants. Again, the definition used in this thesis for microaggressions is “Racial microaggressions are brief and commonplace daily verbal, behavio[u]ral or environmental indignities, whether intentional or unintentional, that communicate hostile derogatory, or negative racial slights and insults toward people of colo[u]r” (Sue et al., 2007, p. 271).

people asking me, “well what’s Hinduism,” and it’s like...look it up, google it! What do you what me to tell you?! Because then whatever I tell them is like...the standard...and so then people are like, “well, {her name} has told me this and so everybody...” and it’s like...no, everyone doesn’t do that! Just like, just like that, a lot of, ignorance and stupidity, being lashed out at me, and I’m like, no, I just want to be Christian and white because then I don’t have to explain stuff.
(Participant 1)

because they’re like, “how did you end up in Fiji?” and I’m like... “well, here’s the story...” there’s no short way to explain it, you know, it’s just like, oh well my ancestors were taken as slaves, and people are like... “oh my god that’s

terrible,” and I’m like... “I guess. I don’t know, I wasn’t alive for it,” you know.
(Participant 2)

Some described the struggle of fitting in during high school or having assumptions made about them based on being from India.

in high school, I think I tried really hard, I remember my friends, when we would go out and they would be like “oh you smell like your house,” which I never took as a compliment, and they probably didn’t mean it as an insult, but you know, you’re in high school, you’re sixteen, seventeen, you’re sensitive about everything, yea I’m sure I wanted to be white, or, not Indian, you know. Like, I’m sure I fought that and tried really hard to be what I thought was cool (Participant 3).

So my uncle and I went to the principal's office, whom I got an appointment after a week there, and she was like, "oh, so she can read English" and I'm like, "what do you mean read English"? Throughout my life, I was in an English reading school, and I was talking to her in English... and so it's just—the way, the attitude, the tone, the way they were talking... the way they were disrespectful to my uncle too... and just like, you know, what is this? And finally my uncle had to write a notarized letter to the school district saying that, hey, this is what is going on. I don't think my niece has to go through this... and she's ready to take an exam (Participant 4).

One person articulated well the difficulties of therapy with a therapist who didn't know much about the South Asian experience. "it felt awkward because I was basically explaining myself to them, like I was explaining my entire story to them, basically" (Participant 6).

Another individual faced a similar experience in a therapeutic relationship and never returned to that therapist due to this interaction.

I was trying to express all these things, about having thought about all these things my entire life and how they were on board with what my parents had wanted for me my whole life, and then not being on board with those things or those expectations and all of the things that go with it, you know. And I just felt like, super judgmental of my parents and kind of of their expectations of me, and it turned me off, I never wanted to go back again (Participant 11).

Another individual discussed the negative experience of a family member in therapy and the assumptions made about her family member's needs.

You have to find someone who's like willing to even try to understand and that's so hard to find someone who's willing to do that. And you know, honestly I feel like, therapists are kind of like trained to do that, so that's like kind of good but, umm, my sister went to therapy and she had a totally different experience where her therapist, like didn't even think about cultural differences and everything like that. And she like came from a really Western, like sort of view and she was like, well, like all her therapist wanted to talk about was like, sexual tension and she's not like "that's not what I wanna talk about! I came to you because-" My sister got really low and she started self-harming and she's like " I came to you because I'm self-harming, not because I have sexual tension" (Participant 12).

One participant discussed feeling isolated and misunderstood at her current job.

I'm working with four other RAS and an RB and every time, like every time I butt up with them, I'm basically told "sorry, you need to change..." and "sorry

you need to change the way you are doing things...” and it is never the other way around, and it’s like, why can’t they meet me half way, why is it always...and it’s very frustrating...just because they are the majority culture doesn’t mean they are a better culture, their way of doing things is inherently right, you know? For group projects, I like, when I’m working with someone I like a lot of communication, I like to know what they are doing and when they are doing it, and especially when I, when I know that they are not the most reliable of people, which a couple members of my RA team are not, as we were talking about group work style, and the way that we talked about needing a lot of communication was seen as a weakness. I was like...that’s not a weakness, and like, I went along with it because it was everyone in the room saying it was something I have to overcome, and it wasn’t until a week or two later that I was like.... “Wait a minute, that’s not something I should be ashamed of, that I need a lot of communication, in fact that has a valid role in any amount of work, because right now we are not communicating like, nearly enough and stuff isn’t getting done, you know?” (Participant 12).

One individual was able to identify themes of very specific and targeted racism against him and his South Asian coworkers after 9/11.

So that time, there was, job market was not doing well, quite well in US and also because of 9/11 there were some, uh, too much stress in the country at that time, so I had to face comments like, um, like people, when we used to eat together during lunch time, me and my friends, and people used to pass comments like, “they are taking our jobs,” or “why do you have to work here, you can go back,”

and something like that. And uh, it was, it was, like kind of frightening, kind of too, because you don't know what they will do to you. At the same time it was quite depressing, sometimes like, uh, frightening, uh, so yea, that kind of, difficulty I faced here (Participant 8).

Summary

These findings point to some clear themes within the community that would benefit from further analysis and may point to further reasons, beyond stigma, on why South Asian American individuals do not usually seek out mental health treatment. In addition, it also points to some of the techniques or valued methods that South Asian individuals enjoyed within the relationships they did seek out, including therapists, guidance counselors, teachers, peers and family members.

CHAPTER V

Discussion

Personal Experience

The purpose of a discussions chapter is to discuss what the meanings of one's findings are. But I wish to articulate several caveats to utilizing these findings. One, a researcher in a qualitative study cannot help but be informed by their personal experience in their interpretation of data. Two, I am aware of the mindset I had coming into this study and my own biases. Three, I identify some of the experiences by names that I find accurate, but understand that the participants might not identify them in this way.

Many of the codes had a lot of relevance and difficulty for me personally. Growing up as one of only a few South Asian Americans in my community, I often felt that I either didn't fit sufficiently into the idea of what being a South Asian person or too Americanized to be "truly" South Asian. I nearly didn't attempt this thesis process as a result and often felt cautious about the idea of interpreting these results, for fear of somehow missing something for these reasons.

For example, microaggressions and racism seem to be glaringly obvious to me in many of the narratives described. Anti-Islamic sentiment also seems to be obvious in several cases. And yet, my own internal processes on these topics and my own experiences of racism also inevitably bias my interpretation. It has never been so clear to me how difficult it is as a researcher to not impose one's voice or thoughts on a researched population than this particular study, undertaken to discuss the needs of a community I am inextricably linked to.

But there are also important themes found within this research that I think can be put forth as possible guideposts or useful beginnings for clinicians. There are themes here, even if they are also themes that mean something powerful to me. So, I put forth this disclaimer to note

that, due to the lack of research, the immense diversity of the subcontinent, diversity of immigration experiences and the lack of discussion within this thesis of such important matters as gender dynamics, shadism, the impact of colonialism on South Asian populations and many other important factors, the reader should take these recommendations with a critical mind, in order to avoid over generalization of the needs and experiences of South Asian American individuals and communities.

Elaboration of Findings

As this study was not based around a single hypothetical question, but rather around establishing a possible baseline or endeavoring to discover the needs of this particular community around mental and community health care, the discussion presented in this chapter will show the depth and breadth of opinions, diversity and needs within this community and hopefully point the way to future, more extensive studies to further identify the needs and best modalities used to work with this particular community. In addition, the expressed preferences for treatment and the role of the therapist within the treatment setting may be useful to current and future clinicians in providing guideposts of where to begin treatment with a South Asian American individual.

These findings also correlate with a previous study around help seeking attitudes and behaviors and mental illness, which provides an interesting compare and contrast to this study and helps provide a basis for further research, beyond help seeking attitudes, to be conducted.

The majority of the respondents preferred to seek help from friends and family members both for their emotional problems or when concerned about the mental wellbeing of another family member. Participants who chose to see mental health professionals preferred non-Asians over Asians. Responses to ‘barriers on

accessing treatment' included lack of culturally sensitive providers, trust issues, stigma, dislike of medications, and treatment not having been effective in the past.

(Rao & Jayaram, 2011, p.1)

One surprising finding is that the discussion of stigma or the palpable effects of stigma were only discussed by a few participants, at least explicitly. More analysis may be needed to find the more implicit discussion of stigma or additional questions may need to be added in order to determine these individuals' experience of stigma. Also worthy of consideration is the possible difference that may have been made by the study being conducted by a South Asian American, versus an individual from another ethnic or racial category.

More individuals seemed to discuss difficulties around microaggressions around their identity, not their mental health status. Most participants stated that they would not utilize mental health workers, but not from an explicit fear of what their community might say. However, any participant that utilized a mental health worker was strategic in who they chose to notify of this fact and often had specific family members who were told and others who were not. Also, those who had not utilized a mental health worker stated that if they had chosen to do so, they would have followed this strategic pattern as well, choosing those they disclosed to with care to their reactions. This may be more of an implicit avoidance of stigma or way of coping with that reality. It is possible that the individuals who responded to this study were unconcerned with stigma and felt comfortable being part of this study as a result or that my own lens on the subject of stigma may have interfered with the ability to notice and understand this experience of stigma.

Also, guidance counselors were seen, by several participants, as a helpful individual who was not a family member that they could derive support from. This seemed to differ categorically from attitudes towards a mental health professional. Mental health professionals seemed to

require individuals within this community to be in some manner of psychological crisis to see and utilize without feeling it to be an inappropriate or overly concerned action. Guidance counseling may be an effective way to assist this community in a way that feels comfortable and appropriate, while also assessing for possible further needs.

Code elaboration.

The six codes, though providing a certain amount of overlap at times, are valuable in being distinct from each other in several ways. Though at times I considered integrating them or creating sub categories, I feel each one has its value as a separate category, because they speak to particular aspects of what the participants shared.

Cultural Chameleon.

The first, Cultural Chameleon, was a term developed based around the shifting, changing, choice of emphasizing one part over the other that was articulated by many of the participants. While this phenomenon varied in its intensity, some individuals described having entire aspects of their identity or life separated based on whether the person they were speaking to was someone they felt would understand or be able to understand a given part of their identity. While I am not saying that this is something that only South Asian individuals do (indeed, I suspect this is a coping skill used by many in their lives), I do feel the need to point out its possible impact on the personal experience of immigration. Most of the participants pointed to this phenomenon occurring most when they were with in groups that were either entirely South Asian or entirely not South Asian minus themselves.

The only two individuals who did not identify with this code noted that they had immigrated to the US as adults, after their schooling was completed. They described no pressure to integrate or assimilate and both individuals also discussed their desire to shed themselves of

their identities and the feeling of being "boxed in" by labeling themselves. Both also identified as having an internal spiritual practice that was important to them.

This code may also be linked to the concept of acculturative stress and various coping mechanisms or reactions to acculturative stress. Acculturative stress and mental health are topics commonly studied around the South Asian community and were elaborated upon in the literature review for this reason.

Isolation.

Isolation was a theme and a code but also in four cases, an apparent cause of why the individuals chose to seek out mental health treatment. This isolation occurred in both South Asian communities and non South Asian communities for participants. Several participants identified that there were particular issues that they did not feel comfortable raising with their families or extended family or even members of the South Asian community. One individual identified divorce as a difficult and isolating experience to undergo within the community and the subsequent isolation she faced outside of her family. Others were concerned about being a burden upon family members, who were dealing with their own struggles and choosing to go to outside providers in order to avoid burdening their community. This isolation may be somewhat influenced by the immigration experience but may also be related to the experience of being a minority after previous experience living in an area where one was the majority ethnic group. Several individuals identified the difficulty of adapting to different social mores and the isolation of being seen as different.

What does it mean to be South Asian?.

One code that has a great deal of complexity and breadth to it is the code what does it mean to be South Asian. This code covered a wide span of experiences, but centered around the

concept of what makes a person South Asian, how does a South Asian person present themselves, look, talk, sound, interact with the world, etc. Because the study focused on individuals who identify as South Asian American, this may have drawn a particular group of individuals who were pondering this concept, but it also seemed to stir a great deal of anxiety in some of the participants. Several were concerned that they were not "South Asian enough" for the study and discussed ways in which they felt they were not South Asian, such as hair texture, voice, lack of accent, lack of exposure to specific cultural milestones and a lack of knowledge around topics particular to their family or ethnic background.

Conflict in identity (and crossovers).

This code linked closely to the code, Conflict in Identity, as well as Cultural Chameleon. Some of the individuals discussed feeling pulled between different parts of their identity and emphasizing them, within the code Cultural Chameleon, but also felt conflict and negative feelings around being able to be their whole selves within public spaces. Some felt conflicted about the idea of being able to claim a South Asian identity or as though their Americanness negated somehow their South Asian identity or that identity was a box that somehow was damaging towards them. Identity didn't seem to be a simple idea for many of the participants and that is why it became its own code, despite its crossovers with other codes.

Some discussed holding on to pieces or aspects of their South Asian or South Asian linked identities, which could include religious, gender, ethnic or personal identities. One spoke about colonialism and the idea of the name Hindu being given by outsiders. (Participant 9) The very holding of a labeled identity was complicated for two individuals. Many spoke about the difficulty of finding an appropriate label on forms or one that felt as though it fit. For future service providers, this may be of note for documentation.

The importance of being understood (or how to listen so that they can talk).

Lastly, we come to what I view as the most important code for possible service providers. All of the participants were included within this code, to varying degrees. Some spoke about feeling understood by a family member or a friend or a cousin and how much that meant to them when they were having difficulties. Some spoke about the connection they had with service providers of many types when they listened to what they had to say and didn't make assumptions about their life. Some spoke about frustrations in their current work or life, with professionals and support networks, in feeling misunderstood, judged, unable to share themselves or not listened. Many discussed the value of shared experience, expert knowledge, feeling actively listened to, not having someone make assumptions about their background, but also their desire to not feel like everything had to be explained. Many discussed their preference of utilizing community members or members of their support network simply because of their accrued understanding of their experience. Some stated that if they could find a service provider who was attentive, open minded to their experience, willing to collaborate and share themselves as well, they would be interested or able to work with this person. Only a few stated they would never utilize a mental health practitioner and each had their own reasons that were individual to their experience.

Suggestions for Service Providers

While some of the suggestions I present may seem overly simplistic, this comes from the hope of synthesizing all of the participants' remarks into easily achievable and understandable goals. It also comes from the hope of not generalizing the experience of these individuals and from the very real experiences of being misunderstood or having assumptions made about their culture, lives, identities and other aspects of their lives.

Ideas such as providing space and time for an individual to explain their cultural context in a way that feels useful and non oppressive to them, actively listening to an individual and validating moments of shared experience may seem basic. But for a population that has been at times exoticized, colonized, misunderstood, scorned and held up as a "model minority", this act appears to be profoundly important and lacking in their current interactions with service providers. Also, learning something about South Asian culture, without assuming that it is monolithic, universal and generalizable, could be valuable for an individual working with this population. Creating more sensitive forms that include the possibility of many different identities beyond the monolithic Asian-American or Pacific Islander could also be valuable and validating for this population.

However, my primary suggestion revolves around the idea of cultural bias. Clinicians, as discussed previously in the literature review, must also be cautious about their own possible cultural biases and check their own interpretations in order to make sure that they are not imposing these biases on individuals who may have different cultural norms. In my mind, this checking of one's interpretations is crucial in order to operate in a way that does not perpetuate oppressive forces or centrist notions that are not helpful or appropriate for a given individual or group. This particular difficulty is, in my mind, the most possibly damaging to this population and many others, because of its ability to pathologize or otherize different mores, norms and ways of minority cultures within the United States that could lead to great harm within many communities.

Focusing on independence and individuation or distancing from the family unit for an individual who may be based in a collectivist or community oriented background with a focus on the family as an integral part of society because one's own background emphasized individuation

above these ideas would be a possible example of operating from a cultural bias that would be applicable to this particular group.

However, on the other hand, one must not assume that because one is dealing with an individual who identifies as South Asian or by a regional designation within that subcontinent, that they have a collectivist upbringing or tend towards the communal, as this would be overgeneralizing the experience and the many differing ideas and experiences present within both the South Asian community and the South Asian diaspora. In order to avoid cultural bias, a therapist must, in my opinion, undergo the process of learning what the individual's upbringing, values and life have led them to, without overlaying their own experiences or underplaying the differences or similarities between the clinician and client. By allowing the individual to identify themselves without assumption and giving them the opportunity to explain their context, one may avoid the possibility of assuming one's understanding of their cultural experience. This particular aspect is one of the things I felt most represented by the current data, another significant part of the reasons South Asian American individuals do not utilize mental health workers, and something that a mental health worker can do partially on their own time for their own education.

Limitations

The study has a number of limitations. Firstly, as with many studies around the South Asian population, almost all of its participants identified their ethnic origin as Indian, rather than any other region of South Asia. One individual identified as Bengali. Though the regions within India were diverse, this limits the generalizability of the study, as well as being less useful for discussing the possible other regional differences that may exist for individuals who identify as

South Asian but come from regions such as Nepal, Bangladesh, Sri Lanka and other regions of South Asia.

Another limitation is the relative small number of participants, which were twelve. Though a good beginning, this small number limits the generalizability of the study. However, the depth and breadth of the study will hopefully provide useful guideposts in order to facilitate further and more extensive and focused studies.

The study also only selected individuals from the ages of 18-40, so elderly populations and children were not utilized. There was also no flyers posted in a language besides English, which may have resulted in selection by individuals who could easily read English, who are likely more educated and possibly wealthier than other participants, due to the class distinctions that occur between English medium schools and regional language schools in India.

Lastly, the Western concept of identity was used to create and discuss several of the initial methodology questions. However, many of the participants did not subscribe to this notion, understand this concept or find it useful or meaningful in their lives. Several described the idea of feeling as though parts of themselves were cut off by having to choose a labeled identity. One participant discussed his decision to describe himself as "other" on formal documents, because of the difficulty of ascribing to an identity as South Asian, Asian American or Pacific Islander, feeling that none of the categories accurately described his situation. Due to my own bias, including my acceptance and utilization of the concept of identity within my own life, I had no idea that individuals would so little utilize or even understand the need for such a concept in their lives. Indeed, one individual described identity as "a big problem in today's situation" and espoused the idea of ridding oneself of identity as a necessary act for individuals. This difficulty with the concept of identity differed between generations and relative immigration

ages, tending to be easier to comprehend for 2nd generation individuals or individuals who had immigrated to the United States at a relatively young age, such as 7.

Conclusion

In conclusion, this study points the way towards new possible research around other effective methodologies, theoretical approaches and ways to engage the South Asian American community in mental health care. However, it also points to key current failings within the field as a whole to address this minority population in a culturally competent, culturally unbiased way. As the United States continues to change, grow and become more diverse, more mental health workers will be called to diversify their knowledge, find more applicable methods to every population and become more flexible in their approaches. I hope that this thesis provides some basic suggestions that can be of use to future and current workers.

References

- Abbassi, A., & Singh, R. N. (2006). Assertiveness in Marital Relationships Among Asian Indians in the United States. *The Family Journal*, 14(4), 392–399. <http://doi.org/10.1177/1066480706290961>
- Abraham, K. V. (1993). *A psycho-social view of Asian Indians in the United States of America* (Psy.D.). Miami Institute of Psychology of the Caribbean Center for Advanced Studies, United States -- Florida. Retrieved from <http://search.proquest.com/docview/304117546/abstract?accountid=13911>
- Abkutsu, P. D., & Abhari, B. (2014). Adjustment disorders in Asians and Asian Americans. *Asian Journal of Psychiatry*, 7, 68–70. <http://doi.org/10.1016/j.ajp.2013.12.002>
- Aselton, P. (2012). Sources of Stress and Coping in American College Students Who Have Been Diagnosed With Depression. *Journal of Child & Adolescent Psychiatric Nursing*, 25(3), 119–123. <http://doi.org/10.1111/j.1744-6171.2012.00341.x>
- Castillo, L. G., Zahn, M. P., & Cano, M. A. (2012). Predictors of Familial Acculturative Stress in Asian American College Students. *Journal of College Counseling*, 15(1), 52–64.
- Corrigan, P. (2004). How Stigma Interferes With Mental Health Care. *American Psychologist*, 59(7), 614–625. <http://doi.org/10.1037/0003-066X.59.7.614>
- Corrigan, P. W. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice*, 5(2), 201–222. [http://doi.org/10.1016/S1077-7229\(98\)80006-0](http://doi.org/10.1016/S1077-7229(98)80006-0)
- Corrigan, P. W. (Ed.). (2005). *On the stigma of mental illness: practical strategies for research and social change* (1st ed). Washington, DC: American Psychological Association.
- Das, A. K., & Kemp, S. F. (1997). Between Two Worlds: Counseling South Asian Americans. *Journal of Multicultural Counseling and Development*, 25(1), 23–33. <http://doi.org/10.1002/j.2161-1912.1997.tb00313.x>
- DuPree, W. J., Bhakta, K. A., Patel, P. S., & DuPree, D. G. (2013). Developing Culturally Competent Marriage and Family Therapists: Guidelines for Working With Asian Indian American Couples. *American Journal of Family Therapy*, 41(4), 311–329. <http://doi.org/10.1080/01926187.2012.698213>
- Ferguson, Sian. (n.d.). 25+ examples of Western Privilege. Retrieved from <http://everydayfeminism.com/2014/09/examples-western-privilege/>

- Hoge, E. A., Tamrakar, S. M., Christian, K. M. B., Mahara, N., Nepal, M. K., Pollack, M. H., & Simon, N. M. (2006). Cross-Cultural Differences in Somatic Presentation in Patients With Generalized Anxiety Disorder. *Journal of Nervous*, *194*(12), 962–966. <http://doi.org/10.1097/01.nmd.0000243813.59385.75>
- Holmes, E. P., & River, L. P. (1998). Individual strategies for coping with the stigma of severe mental illness. *Cognitive and Behavioral Practice*, *5*(2), 231–239. [http://doi.org/10.1016/S1077-7229\(98\)80008-4](http://doi.org/10.1016/S1077-7229(98)80008-4)
- Hopper, K., Wanderling, J., & Narayanan, P. (2007). To have and to hold: A cross-cultural inquiry into marital prospects after psychosis. *Global Public Health*, *2*(3), 257–280. <http://doi.org/10.1080/17441690600855778>
- Inman, A. G., Devdas, L., Spektor, V., & Pendse, A. (2014). Psychological Research on South Asian Americans: A Three-Decade Content Analysis. *Asian American Journal of Psychology*. <http://doi.org/10.1037/a0035633>
- Kallivayalil, D. (2004). Gender and Cultural Socialization in Indian Immigrant Families in the United States. *Feminism & Psychology*, *14*(4), 535–559. <http://doi.org/10.1177/0959353504046871>
- Kanukollu, S. N., & Mahalingam, R. (2011). The idealized cultural identities model on help-seeking and child sexual abuse: a conceptual model for contextualizing perceptions and experiences of South Asian Americans. *Journal of Child Sexual Abuse*, *20*(2), 218–243. <http://doi.org/10.1080/10538712.2011.556571>
- Karasz, A., Dempsey, K., & Fallek, R. (2007). Cultural Differences in the Experience of Everyday Symptoms: A Comparative Study of South Asian and European American Women. *Culture, Medicine & Psychiatry*, *31*(4), 473–497. <http://doi.org/10.1007/s11013-007-9066-y>
- Karasz, A., Patel, V., Kabita, M., & Shimu, P. (2013). “Tension” in South Asian Women: Developing a Measure of Common Mental Disorder Using Participatory Methods. *Progress in Community Health Partnerships: Research, Education, and Action*, *7*(4), 429–441. <http://doi.org/10.1353/cpr.2013.0046>
- Lasalvia, A., Zoppei, S., Van Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K., ... Thornicroft, G. (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *The Lancet*, *381*(9860), 55–62. [http://doi.org/10.1016/S0140-6736\(12\)61379-8](http://doi.org/10.1016/S0140-6736(12)61379-8)
- Loya, F., Reddy, R., & Hinshaw, S. P. (2010). Mental illness stigma as a mediator of differences in Caucasian and South Asian college students’ attitudes toward psychological counseling. *Journal of Counseling Psychology*, *57*(4), 484–490. <http://doi.org/10.1037/a0021113>
- Makar, A. B., McMartin, K. E., Palese, M., & Tephly, T. R. (1975). Formate assay in body fluids: application in methanol poisoning. *Biochemical Medicine*, *13*(2), 117–126.

- Navsaria, N., & Petersen, S. (2007). Finding a voice in Shakti: A therapeutic approach for Hindu Indian women. *Women & Therapy, 30*(3-4), 161–175.
- Nunley, M. R. (1992). *The mind doctors' dharma: On the social construction of hospital psychiatry in eastern Uttar Pradesh, India* (Ph.D.). University of California, San Francisco, United States -- California. Retrieved from <http://search.proquest.com.libproxy.smith.edu:2048/docview/304006759/abstract?accountid=13911>
- Park, Y. (2005). Culture as Deficit: A Critical Discourse Analysis of the Concept of Culture Incontemporary Social Work Discourse. *Journal of Sociology & Social Welfare, 32*(3), 11–33.
- Pedersen, P. (2009). Inclusive cultural empathy: A relationship-centered alternative to individualism. *South African Journal of Psychology, 39*(2), 143–156.
- Pescosolido, B. A., Medina, T. R., Martin, J. K., & Long, J. s. (2013). The “Backbone” of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness. *American Journal of Public Health, 103*(5), 853–860. <http://doi.org/10.2105/AJPH.2012.301147>
- Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to be Feared? *Journal of Health and Social Behavior, (2)*, 188.
- Rao, V., Goga, J., Inscore, A., Kosi, R., Khushalani, S., Rastogi, P., ... Jayaram, G. (2011). Attitudes towards mental illness and help-seeking behaviors among South Asian Americans: Results of a pilot study. *Asian Journal of Psychiatry, 4*(1), 76. <http://doi.org/10.1016/j.ajp.2010.09.007>
- Rastogi, M., Natrajan, R., & Thomas, V. (2005). On Becoming a Profession: The Growth of Marriage and Family Therapy in India. *Contemporary Family Therapy: An International Journal, 27*(4), 453–471. <http://doi.org/10.1007/s10591-005-8233-y>
- Rastogi, P., Khushalani, S., Dhawan, S., Goga, J., Hemanth, N., Kosi, R., ... Rao, V. (2014). Understanding clinician perception of common presentations in South Asians seeking mental health treatment and determining barriers and facilitators to treatment. *Asian Journal of Psychiatry, 7*, 15–21. <http://doi.org/10.1016/j.ajp.2013.09.005>
- Reavey, P., Ahmed, B., & Majumdar, A. (2006). “How can we help when she won’t tell us what’s wrong?” Professionals working with South Asian women who have experienced sexual abuse. *Journal of Community & Applied Social Psychology, 16*(3), 171–188. <http://doi.org/10.1002/casp.856>
- Rudrappa, S. (2004). Radical Caring in an Ethnic Shelter South Asian American Women Workers at Apna Ghar, Chicago. *Gender & Society, 18*(5), 588–609. <http://doi.org/10.1177/0891243204268131>

- Salmon, R., & Salmon, S. (1977). The causes of heroin addiction-- a review of the literature. Part II. *The International Journal of the Addictions*, 12(7), 937–951.
- Shah, H. (1999). Race, Nation, and Citizenship: Asian Indians and the Idea of Whiteness in the U.S. Press, 1906-1923. *Howard Journal of Communications*, 10(4), 249–267. <http://doi.org/10.1080/106461799246744>
- Shakti. (n.d.). Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/Shakti
- Singh, M. (n.d.). Why Cambodians Never Get “Depressed.” Retrieved May 28, 2015, from <http://www.npr.org/sections/goatsandsoda/2015/02/02/382905977/why-cambodians-never-get-depressed>
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, 62(4), 271–286. <http://doi.org/10.1037/0003-066X.62.4.271>
- Sue, S., Cheng, J. K. Y., Saad, C. S., & Chu, J. P. (2012). Asian American Mental Health: A Call to Action. *American Psychologist*, 67(7), 532–544.
- Wadhvani, S. M. (2000). *An assessment of the concerns and service needs of Asian Indian college students* (Psy.D.). Rutgers The State University of New Jersey - New Brunswick, United States -- New Jersey. Retrieved from <http://search.proquest.com/docview/230786331/abstract?accountid=13911>

Appendix A



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 5, 2014

Shivani Seth

Dear Shivani,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Debra Hull, Research Advisor

Appendix B

RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

**«Working title: South Asian Americans and Mental Health»
Shivani Seth
Debra Hull**

.....

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. Adding in the possibility of conducting interviews via Skype.
2. Informed consent will be mailed to participants with an additional self-addressed stamped envelope for Smith College's HSR department, so as to expedite the informed consent process. These addresses will be stored on a secure document on a private computer and treated as sensitive information, along with any other contact information.
3. The interview will take place as previously discussed, but with two skype sessions in the case of a skype interview, (compared to 2 in person sessions) conducted in a private home with no other individuals present at the time of the interview. The interviewer will ask that the interviewee conduct their half of the conversation from a private home or space with no other individuals present.
4. The interviewer will utilize head phones to protect confidentiality.
5. An alternate resource list will be provided within the mailed informed consent sent to each interviewee. After each skype interviewee's location is determined, a resource list tailored to their locality will be created that will also include all of the online resources listed for in person interviews.

.....

SS I understand that these proposed changes in protocol will be reviewed by the Committee.
 SS I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
 SS I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: Shivani Seth

Name of Researcher (PLEASE PRINT): Shivani Seth **Date:** 12-16-14

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

******Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes***



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 17, 2014

Shivani Seth

Dear Shivani,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Debra Hull, Research Advisor

RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

**«Working title: South Asian Americans and Community Supports»
Shivani Seth
Debra Hull**

.....

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. I plan to change my flyer after several talks with community members. I was previously using a map of the region as an image but was told that some individuals or groups may find the map offensive due to where certain borders between India and Pakistan are drawn.
2. I was also concerned about the wordiness of the initial flyer and the use of the words "mental health". After some conversations, I have discovered that some South Asian individuals seem to clam up or have a negative reaction to the phrase. With this in mind, I plan to use the term "community support(s)" instead and see if this may impact my recruitment.
3. I will also be changing my facebook flyer in accordance with this flyer, using the same language and folder but in a facebook format. The only difference will be in the spacing of the sentences as Facebook uses a more condensed format.
4. I would also like to utilize LinkedIn to see if I can gain more respondents that way.
5. I am changing the working title of my study to the one above.
6. I will be replacing all instances of the phrase "mental health" within my study with the phrase "community supports" in order to better identify the various types of supports individuals may be using outside of the traditional mental health field.
7. My informed consent will have these changes within it as well.

.....

__ss__ I understand that these proposed changes in protocol will be reviewed by the Committee.
 __ss__ I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
 __ss__ I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: Shivani Seth

Name of Researcher (PLEASE PRINT): Shivani Seth **Date:**
 1/24/15

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.*

.....



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 6, 2015

Shivani Seth

Dear Shivani,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Debra Hull, Research Advisor

RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

«Working title: South Asian Americans and Community Supports»

**Shivani Seth
Debra Hull**

.....

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. I plan to add the following questions as an alternate path within the questions for my methodology. As I changed the focus of the research from the narrow mental health to the broader community support, in an effort to address cultural issues of stigma, some of my interviewees may not have answers for some of the previous questions. As some individuals may not have sought out mental health services, these questions will be offered as an alternate path within the methodology so as to ask questions about the supports they did seek. They replace the numbers in front of them, and the first 3 questions of my methodology stay the same.

- 4. Who in your community did you feel comfortable getting support from?
 - a. What about that person helped you feel comfortable?

5. How did their assistance impact your difficulties?

- a. Was it helpful or not?
- b. What do you think made it helpful or not?

6. Did others in your community seek this supportive person/group out?

7. How did other react to you reaching out for support?

8. How do you feel you were impacted by this interaction?

- a. Did you feel your identity was impacted or addressed in any way?

9. Is there anything else you'd like to share with me? Have we missed any important experiences along the way?

[DESCRIBE ALL PROTOCOL CHANGES BEING PROPOSED IN NUMERIC SEQUENCE; BE BRIEF AND SPECIFIC]

.....

__ss__ I understand that these proposed changes in protocol will be reviewed by the Committee.

__ss__ I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.

__ss__ I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: Shivani Seth

Name of Researcher (PLEASE PRINT): Shivani Seth **Date:** 3/11/15

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

******Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.***

.....

RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

**«Working title: South Asian Americans and Community Support»
Shivani Seth
Debra Hull**

.....

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

- 1. I will be using a paid transcriber who has signed a confidentiality agreement to transcribe most or all of my interviews.

.....

__ss__ I understand that these proposed changes in protocol will be reviewed by the Committee.
__ss__ I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
__ss__ I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: _____ **Shivani Seth**_____

Name of Researcher (PLEASE PRINT): _____ **Shivani Seth**_____ **Date:**
_____ **3/11/15**_____

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

*****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.**

.....



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 12, 2015

Shivani Seth

Dear Shivani,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

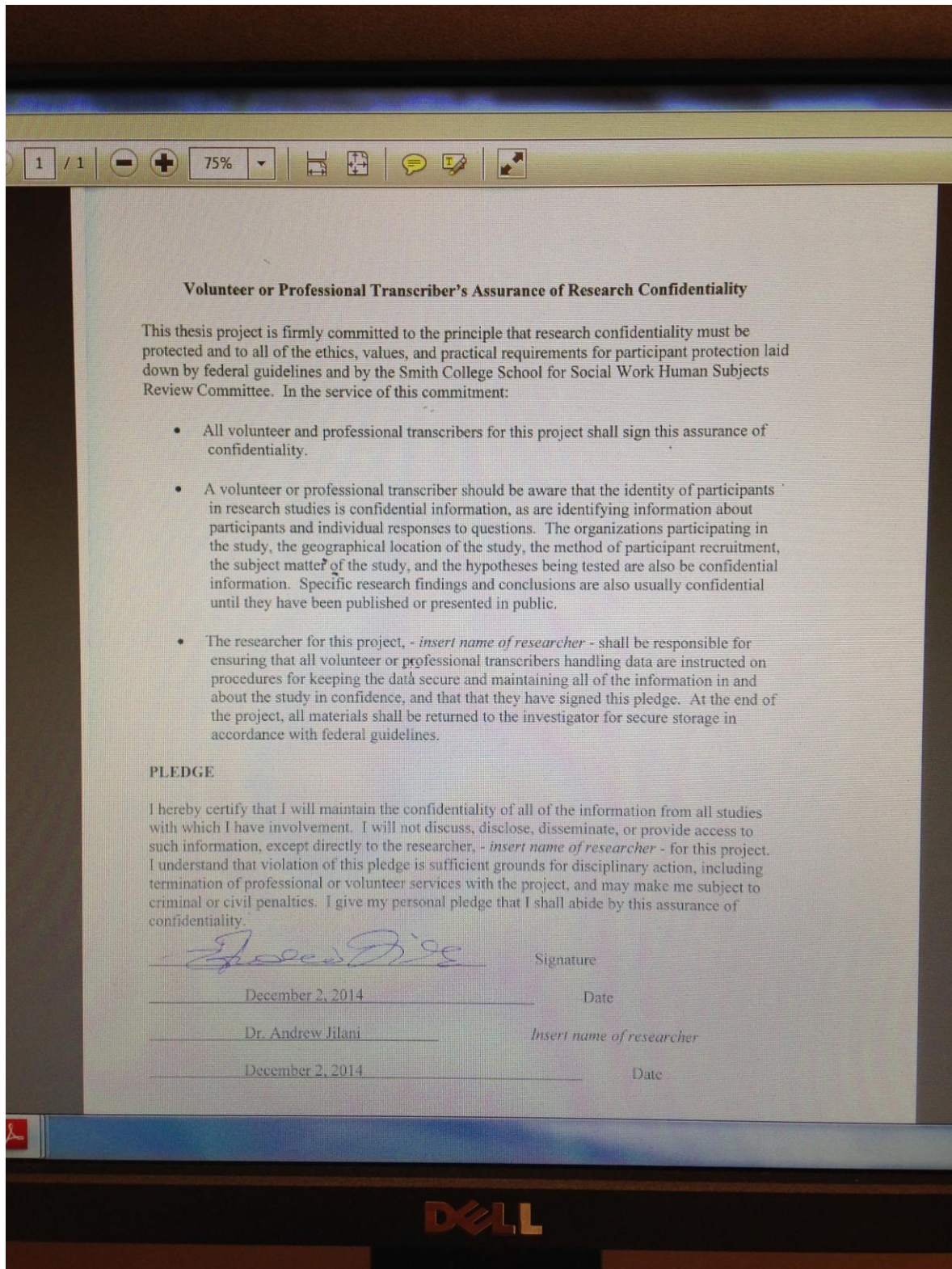
Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Debra Hull, Research Advisor

Appendix C



Appendix E

Attention South Asian Individuals!

Have you ever felt like you needed support? Did you feel like you had someone or somewhere to turn to?

You could be part of my Master's thesis study to help better serve South Asian individuals reaching out for supports in their community!



Who: South Asian individuals, ages 18-40, who have lived in the United States for at least 5 years and have experienced some form of difficulty in their life that lead them to seek outside support.

How: Participants will have an initial contact with the researcher to determine eligibility and answer any questions. Eligible participants will be offered an interview, either over Skype or in person. There are no monetary benefits to participating but refreshments will be served to in person participants. More information on this process is available for interested persons.

Please contact Shivani Seth, at sseth@smith.edu for more information.



Appendix F

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: The effects of mental health stigma and issues of cultural competency on the treatment of South Asian adults

Investigator(s): Shivani Seth, Smith College, School for Social Work, XXX-XXX-XXXX

(List Name, Department, Telephone number for each Researcher)

.....

Introduction

- You are being asked to be in a research study of [*South Asian American Mental Health in the United States*].
- You were selected as a possible participant because [*of your status as a 2nd generation South Asian immigrant, with some level of experience with mental health supports of all varieties.*].
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to find out what impacts or drives South Asian individuals to seek out therapy, support groups, hotlines and other services and how the mental health community could improve those services for South Asians as a whole.
- This study is being conducted as a research requirement for my master’s thesis in Social Work.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: You will meet with me for one hour approximately and answer 9 or more questions around the subject of South Asian mental health and your experiences with support services.]

Risks/Discomforts of Being in this Study

- The study has the following risks. First, there is a small risk of feelings arising after the interview that will need processing in some manner, either with friends and family or a trusted professional.. Second, there is a small risk of confidentiality being compromised due to the recruiting methods of this study, through social media and flyering.

- These services are accessible via phone or online. NeuroTalk is an online free support group network for asking questions and getting support, as anonymously as need be. Membership is required but if need be, participants could create a new email in order to access the services. Mental Health America's crisis hotline is also listed below, as well as RAINN and the National Help Line for Substance Abuse. If you feel your concern falls outside these parameters, feel free to search online for other resources as there are many. You can also create a private window in which in no history will be kept if you wish to stay more confidential.
-
-
- <http://neurotalk.psychcentral.com/>
Mental Health America 1-800-273-TALK
- RAINN 1-800-656-HOPE
- National Help Line for Substance Abuse (800) 262-2463
-

Benefits of Being in the Study

- The benefits of participation are [*gaining insight into why or why participants have not reached out to mental health supports, being able to talk about issues that matter to them in a safe environment and possibly gaining an increased comfort in speaking to mental health professionals.*].
- The benefits to social work/society are: [*expanding the amount and breadth of research on the concerns and personal experiences of South Asian Americans within mental health care, as well as providing possible guideposts for future research in order to improve supportive services and care for South Asians. More direct knowledge, instead of theoretical hypotheses will be valuable in providing new ideas and hopefully expanding on previous theories of how to effectively treat this complex and diverse population.*].

Confidentiality

- Your participation will be kept confidential. (Your data will be stored on a tape and on a secure computer, where it will be designated by a number. Identifying information will be kept in a separate document on the same computer, but will not include your name. The only identifying information that will be kept will be that which you choose to share with me during the course of the interview, centered around ethnic, religious or other identities. Our meetings will take place first in a public space of your choosing and second, in a private space that will be mutually agreed upon. This space will be reserved ahead of time if possible, for our use and the interview will not occur unless it is a private space, with no other individuals present. If you choose to bring someone along to ensure your safety, that is acceptable. Audio recordings will be made, which only I and a transcriber will have access to. They will not be used for any purpose other than this study. After the study is completed and the data has been analyzed, they will be erased.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

You may receive a 5 \$ gift card and a purchase of a beverage for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by [April 2nd, 2015.]. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, [Shivani Seth] at [sseth@smith.edu] or by telephone at [XXX-XXX-XXXX]. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. *[If indicated, include this: You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study]*

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____

Date: _____

Signature of Researcher(s): _____

Date: _____

Appendix G

Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

.....

Title of Study: South Asian Americans' Utilization of Community Resources

Investigator(s): Shivani Seth, Smith College, School for Social Work, XXX-XXX-XXXX

(List Name, Department, Telephone number for each Researcher)

.....

Introduction

- You are being asked to be in a research study of [*South Asian American help seeking in the United States*].
- You were selected as a possible participant because [*of your status as a South Asian American, with some level of experience with community supports of all varieties.*].
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to find out what impacts or drives South Asian individuals to seek out therapy, support groups, hotlines and other services and how the broader community could improve those services for South Asians as a whole.
- This study is being conducted as a research requirement for my master's thesis in Social Work.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: You will meet with me for one hour approximately and answer 9 or more questions around the subject of South Asian mental health and your experiences with support services.]

Risks/Discomforts of Being in this Study

- The study has the following risks. First, there is a small risk of feelings arising after the interview that will need processing in some manner, either with friends and family or a trusted professional. Second, there is a small risk of confidentiality being compromised due to the recruiting methods of this study, through social media and flyering.
- These services are accessible via phone or online. NeuroTalk is an online free support group network for asking questions and getting support, as anonymously as need be. Membership is required but if need be, participants could create a new email in order to access the services. Mental Health

America's crisis hotline is also listed below, as well as RAINN and the National Help Line for Substance Abuse. If you feel your concern falls outside these parameters, feel free to search online for other resources as there are many. You can also create a private window in which in no history will be kept if you wish to stay more confidential.

-
-
- <http://neurotalk.psychcentral.com/>
Mental Health America 1-800-273-TALK
- RAINN 1-800-656-HOPE
- National Help Line for Substance Abuse (800) 262-2463
-

Benefits of Being in the Study

- The benefits of participation are [*gaining insight into why or why participants have not reached out to mental health supports, being able to talk about issues that matter to them in a safe environment and possibly gaining an increased comfort in speaking to mental health professionals.*].
- The benefits to social work/society are: [*expanding the amount and breadth of research on the concerns and personal experiences of South Asian Americans receiving outside community support, as well as providing possible guideposts for future research in order to improve supportive services and care for South Asians. More direct knowledge, instead of theoretical hypotheses will be valuable in providing new ideas and hopefully expanding on previous theories of how to effectively assist this complex and diverse population.*].

Confidentiality

- Your participation will be kept confidential. (Your data will be stored on a tape and on a secure computer, where it will be designated by a number. Identifying information will be kept in a separate document on the same computer, but will not include your name. The only identifying information that will be kept will be that which you choose to share with me during the course of the interview, centered around ethnic, religious or other identities. Our meetings will take place first in a public space of your choosing and second, in a private space that will be mutually agreed upon. This space will be reserved ahead of time if possible, for our use and the interview will not occur unless it is a private space, with no other individuals present. If you choose to bring someone along to ensure your safety, that is acceptable. Audio recordings will be made, which only I and a transcriber will have access to. They will not be used for any purpose other than this study. After the study is completed and the data has been analyzed, they will be erased.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

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question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by [April 2nd, 2015.]. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, [Shivani Seth] at [sseth@smith.edu] or by telephone at [XXX-XXX-XXXX]. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

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.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____

Date: _____

Signature of Researcher(s): _____

Date: _____

Appendix H

Interview Questions

1. How do you identify yourself?
 - a. Do you identify as being from a certain region, ethnic background or other identifying group?
 - b. Do you identify as a religious person or as part of a particular religious group?
 - c. Are there any other aspects of your identity that you feel are important to discuss?
2. What do these identifications mean to you?
 - a. Has this identification changed over time?
3. Have you ever had difficulties in your life? Do you mind sharing those with me?
 - a. If so, when those difficulties occurred, did you consult with anyone?
 - b. Did you contact anyone outside your network of support? If so, who? **(SEE BELOW IF ANSWER IS NO)**
 - c. How do you feel that interaction went?
4. What has been your experience with mental health professionals and the services they provide?
 - a. How was that experience for you?
5. How did you feel your network would react to your seeking out mental health or guidance services?
 - a. Were there different levels or types of reactions? Did you have particular individuals you chose to tell over others?
6. Did you continue to use these services?
 - c. Why or why not?
7. What would you have liked to change, if anything, about the experience?
8. How do you think your identity was impacted by this interaction?
 - a. Did you feel that your identities were appropriately addressed?
 - b. If so, how or how not?
9. Is there anything else you'd like to share with me? Have we missed any important experiences along the way?

Community support tree

4. Who in your community did you feel comfortable getting support from?
 - a. What about that person helped you feel comfortable?
5. How did their assistance impact your difficulties?
 - a. Was it helpful or not?
 - b. What do you think made it helpful or not?
6. Did others in your community seek this supportive person/group out?
7. How did other react to you reaching out for support?
8. How do you feel you were impacted by this interaction?
9. Same as above.