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Stigma vs. Support: Factors that Affect Mental Health Treatment-Seeking Behaviors in Middle-Aged Immigrant South Asian American Women

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B.S. Biological Sciences
University of California, Irvine
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Abstract

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By Mirza Oishee Shemontee

Introduction: South Asian Americans are a growing demographic, rising from 3.5 million in 2010 to 5.7 million in 2019. Although often viewed as part of the "model minority," this community experiences significant unique stressors, such as acculturative stress, that indicate the possibility of high rates of mental distress. However, data on the prevalence of mental health disorders in this population is outdated and often only available as disaggregated data for all Asian Americans. Studies on the South Asian diaspora in other countries suggest that middle aged women, in particular, are especially at risk for mental health distress. Yet, mental health service use among South Asian American middle aged women is extremely low. Currently, there are limited studies exploring this specific demographic and their attitudes towards mental health. This qualitative study seeks to close this gap by examining the factors that influence mental health treatment-seeking behaviors among immigrant South Asian American women between the ages of 45 and 65.

Methods: This study used thematic analysis of semi-structured interviews to yield findings about mental health treatment-seeking behaviors. South Asian American women between the ages of 45 and 65 were recruited to participate in hour-long in-depth interviews discussing their experiences and opinions to better understand their viewpoint of mental health. These interviews were then analyzed via MAXQDA software to find commonalities in participants' mental health experiences. Feminist theory was used as a major philosophical foundation of analysis to generate themes. These themes were then used to modify the Theory of Planned Behavior to apply to mental health treatment-seeking behaviors in South Asian American women.

Results: A total of fifteen interviews were conducted with South Asian American women ranged in age from 45 to 65 years of age, with the average age of participants being 57 years old. Participants immigrated to America between the years of 1974 and 2006, from eleven different South Asian cities. Four main themes emerged: mental health understanding, positive support systems, negative influence of cultural values, and structural barriers. These themes all contribute to institutional and attitudinal barriers that may be related to low mental health service use. Modification of the Theory of Planned Behavior shows that subjective norms are a powerful predictor of mental health treatment-seeking behavior within this general population.

Conclusions: Interventions that emphasize positive social support to counteract negative cultural influence, as well as interventions to reduce structural barriers, would both be particularly effective to increase mental health treatment-seeking behavior. Future directions for research should include examining the effect of migration year on acculturative stress experiences, as well as gathering more accurate prevalence data for this demographic.

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Chapter I: Introduction and Statement of the Problem and Purpose

South Asians, often self-referred to as "desis", are defined as individuals with ethnic origins in or around the Indian subcontinent, encompassing people who originate from the countries of Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka. Significant migratory movement during the 20th century has resulted in the South Asian diaspora being one of the most far-flung and widespread across the world. 43.4 million people from this area live outside their country of origin, making South Asia the region with the highest number of emigrants in the world (*Migration data in Southern Asia*, 2021).

Within the past decade, the South Asian population in America has grown significantly, rising from 3.5 million in 2010 to 5.7 million in 2019 (*Demographic Snapshot of South Asians in the United States*, 2019; U.S. Census Bureau, 2019). Of this population, an estimated 75% are foreign-born, and immigrated to America at some point in their lives (South Asian Americans Leading Together, 2019). The South Asian American community includes not just people who migrated directly from South Asian countries, but also people whose families originate from South Asia but spent generations in other parts of the world, such as the Caribbean, Europe, Africa, and other parts of Asia, before arriving in America (*Demographic Snapshot of South Asians in the United States*, 2019).

In America's social framework, the stereotypical view of South Asian Americans tends to be that they are a "successful" immigrant group enjoying a high quality of life. While this is reflected in the case of some populations, such as Indian Americans, this perception ignores some gaping inequalities between subgroups of South Asians. For example, although 75% of Indian Americans hold a bachelor's degree or more in 2019, only 15% of Bhutanese Americans report obtaining a college degree (Budiman & Ruiz, 2021). While Indian Americans have high

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median annual household incomes and the lowest poverty rate of 6%, Nepalese Americans report the lowest median annual household income out of all Asian American subgroups (Budiman & Ruiz, 2021). In truth, almost 10% of South Asians in the United States live in poverty (*Demographic Snapshot of South Asians in the United States*, 2019). Despite these large disparities within the group, these are often ignored in favor of a strong perception of South Asians as part of the "model minority", which has unfortunately led to an oversight of social and behavioral issues within South Asian communities, greatly impacting the mental health of South Asian American people (Masood et al., 2009).

Unfortunately, much of the prevalence data for mental illness within South Asian American populations is either outdated or simply nonexistent. In most mental health studies, data on South Asian American mental health is simply grouped with other Asian communities under the broad heading of Asian American, despite distinct differences between these regional groups (Lu et al., 2020; Sun et al., 2016). Furthermore, available literature on South Asian Americans mostly focuses specifically on Indian Americans, also referred to in studies as Asian Indians. While Indian Americans do make up a majority of South Asian Americans at 80% of the population, to be fully inclusive and accurate, data that includes other subcultures of South Asia is necessary and yet, lacking. The most recent prevalence data available for the grouping of all South Asian Americans comes from 2009, and shows that 20.8% of South Asian Americans report experiencing mental health disorders in their lifetime (Masood et al., 2009).

South Asian diaspora women have been shown to experience greater levels of mental health distress when compared to men, especially when faced with lack of extended family support (Masood et al., 2009). Due to cultural values that emphasize traditional gender roles, women in particular face unique burdens and challenges that cause higher rates of psychological

distress (Sayegh et al., 2013). A study of South Asian communities in Canada and the United Kingdom also indicates that women in the South Asian diaspora are at particular risk for adverse mental health outcomes. For example, the suicide rate, as well as overall self-harm prevalence, is much greater among South Asian immigrant women than among South Asian immigrant men (Husain et al., 2006).

Several factors contribute to higher risk of mental illness for South Asian women, especially for those of middle age. First, migration-related acculturative stress, a broad term encompassing experiences ranging from discrimination from the surrounding community to intergenerational conflict within the home, is identified as a major source of stress for South Asian women specifically (Karasz et al., 2016). This disproportionate burden of stress occurs because South Asian women are often subject to greater scrutiny by their communities than their male counterparts. Women are "expected to shoulder the responsibility of 'cultural continuity' in the face of assimilation", meaning that women have to carefully calibrate their behavior to reflect traditional South Asian values, which causes complications when these values conflict with Western ideals (Masood et al., 2009). South Asian women are also generally held to a greater standard of selflessness, and are often pressured to meet the needs of the family before considering their own (Masood et al., 2009). This is especially applicable to middle-aged women, who often bear a greater level of responsibility for household and childcare concerns (Sayegh et al., 2013). Furthermore, South Asian women also report experiences of domestic abuse and marital violence, which are linked to outcomes such as depression, anxiety, and suicidal ideation (Bhugra, 2002). This represents a significant public health burden that has largely gone unexamined until recently.

Despite an evident need for mental health services, mental health service utilization is notably low among South Asian Americans. This is likely because mental health stigma is relatively high among South Asian American communities, compared to other demographics (Karasz et al., 2016). Studies conducted in other countries with a high proportion of South Asian diaspora such as the United Kingdom and Canada also indicate the presence of significant cultural taboo around mental health, as well as a lack of knowledge about mental illness in general (Karasz et al., 2016; Taylor et al., 2013). Although it is likely that similar trends are present in South Asian American communities, there are limited studies on the attitudes regarding mental health of South Asian women living in America specifically. In terms of mental health, South Asian Americans are therefore an underserved and understudied population.

This qualitative study seeks to close this gap by examining the factors that influence mental health treatment-seeking behaviors among immigrant South Asian American women between the ages of 45 and 65. This study uses the theoretical framework of the Theory of Planned Behavior, as well as feminist theory, to analyze factors that contribute to attitudes towards mental health, and how these may form barriers that affect mental health treatment-seeking behaviors. The findings from this study may inform understanding of why mental health service utilization in this population is so low, and potentially guide the creation of interventions to improve the mental health outlook for South Asian American women.

Chapter II: Review of the Literature

South Asian American Immigrants

The South Asian American community's presence first became notable in the late 1800s, when men originating from the South Asian regions of Punjab and Bengal first reached the western shores of Canada before traveling down the coast to the United States. These early migrants faced extreme prejudice and were the targets of many racist laws. As a result, they had limited opportunities, working mostly as laborers and farmers. American citizenship was not granted to South Asian immigrants until 1946, and even then, immigration was limited and discouraged. It was not until the 1965 Civil Rights movement that immigration policies were loosened through the Immigration and Nationality Act. Since this law prioritized the immigration of people with strong educational and professional backgrounds, most South Asian immigrants in the 1960s and 1970s entered as white-collar professionals, often in scientific and medical fields (South Asian American Digital Archive, 2015). This likely contributed to the modern social perception of South Asians as part of the "model minority". In recent decades, the South Asian community has increased significantly, growing about 40% between 2010 and 2019 alone. Currently, around 49% of the South Asian population identifies as female, and 80% of the population originates from the country of India (*Demographic Snapshot of South Asians in the United States*, 2019).

South Asian migration has mainly been due to "pull" factors such as a belief that America will offer better career opportunities and better quality of life (Tewary, 2005). Career advancement, in particular, has been shown to be a major motivating factor (Gunasekara et al., 2021). Many South Asian young adults first migrate to America as college students and choose to continue their professional career in America after graduation. Family ties are also a strong

impetus for migration, as many families migrate to join their extended family networks already in America. These networks are particularly important for providing new immigrants with information and access to American living systems, as well as financial and emotional support (Tewary, 2005).

The cultural values of South Asian American immigrants strongly mirror the values of societies in South Asia. While these values may differ to a certain degree based on the religion and subculture of the individual, overall, South Asian American communities place a strong emphasis on collectivism, community, a patriarchal and hierarchal family structure, traditional gender roles, educational and professional success, and a respect for authority (Jin et al., 2022). There are varying levels of adherence to traditional values in the community, which can cause both interpersonal conflict between people and internal conflict between Western and Eastern ideologies, both of which can contribute to mental health distress (Jin et al., 2022). Many immigrants also feel a strong sense of ethnic identity and take pride in maintaining their connection to their homeland and culture. This can take place physically through frequent trips back to South Asia, as well as psychologically through trying to maintain South Asian cultural touchstones while living in America (Dasgupta, 1998). However, this "reinvention" of their native culture is often created through memories of how society used to be when growing up, rather than the current state of South Asian society, resulting in immigrant communities retaining a version of society that is no longer prevalent in their homeland (Farver et al., 2002). Because of this, some South Asian American communities may in fact be more conservative and closely attached to traditional values than the current modern society in South Asia (Jin et al., 2022). This could possibly be a factor in exacerbating acculturative stress experiences for this population.

Studies on the experiences of South Asian immigrants also show that perceived race-related discrimination is a major source of stress for this demographic (Kaduvettoor-Davidson & Inman, 2013; Tummala-Narra et al., 2012). As a result of 21st century political events, such as the September 11 terrorist attacks, and economic trends, such as the rise of outsourcing to India, prejudice against South Asians specifically has increased. Sikh men, in particular, were particularly targeted in the wake of the September 11 attacks, since they are often confused with Arab men. An increase in perceived discrimination was shown to be linked to increased stress for first- and second-generation South Asian immigrants (Kaduvettoor-Davidson & Inman, 2013).

Asian American Mental Health

South Asian American mental health is rarely studied independently, and instead is often collectively examined under the umbrella of Asian American mental health. As a subgroup of Asian American, South Asian Americans share many similar cultural values and acculturative experiences with other Asian cultures. Thus, in the absence of disaggregated data on South Asian Americans alone, examining the trends in Asian American mental health overall can give some insight into the current state of South Asian American mental health.

In 2019, around 15% of Asian Americans - more than 2.9 million people - reported experiencing mental illness. According to the National Latino and Asian American Study, 17.3% of Asian Americans are diagnosed with a mental health disorder at some point in their life (Spencer et al., 2010). Yet, Asian Americans have the lowest rate of mental health treatment, with only 23.3% of individuals with a mental illness receiving treatment in 2019 (National Alliance on Mental Illness).

One reason for this discrepancy is the "model minority" myth applied to Asian Americans. The Asian American community is often perceived to be a successful and well-

adjusted group that has overcome racial bias through a strong work ethic and conformity to social norms (National Alliance on Mental Illness). Not only does this misconception ignore the heterogeneity of the Asian American community, this also creates extreme pressure for Asian Americans to appear successful and problem-free. Additionally, this stereotype can cause health professionals to misdiagnose or underdiagnose Asian Americans with mental health conditions, since they are assumed to be more well-adjusted in general (Cheng et al., 2017).

Asian Americans have also been shown to somaticize their mental health symptoms to a greater degree than other ethnic groups within America (Maffini & Wong, 2014). Somatization refers to "the experiences of emotional, social, or psychological distress that manifest in physical complaints though there is no organic basis for their symptoms" (Lin et al., 1985). In essence, when experiencing physical manifestations of mental distress, Asian Americans tend to seek treatment for these physical symptoms while ignoring or misunderstanding the underlying root cause for them. This has been linked to cultural factors such as stigma, as well as a different conceptualization of how mental and physical health are related (Maffini & Wong, 2014). This phenomenon of somatization is another major reason why mental health treatment-seeking behaviors among Asian Americans is typically so low (Maffini & Wong, 2014).

Asian Americans are also deterred from seeking care by the presence of structural barriers, such as language barriers. Overall, 32.6% of Asian Americans and 18.7% of Indian Americans report not being fluent in English (National Alliance on Mental Illness). Not only does this increase the likelihood of experiencing mental distress due to communication struggles, it also decreases the likelihood of seeking mental health care, especially given the lack of linguistically and culturally tailored mental health services (National Alliance on Mental Illness).

Acculturative Stress

Experienced by immigrants worldwide, acculturative stress refers to the "extent to which individuals have maintained their culture of origin or adapted to the larger society" (Phinney, 1996). Acculturative stress can potentially have a severe effect on mental health, leading to further issues such as substance abuse, anxiety, or clinical depression (Koneru et al., 2007).

While few studies exist examining the impact of acculturative stress on South Asian Americans specifically, the effect of acculturative stress on the South Asian diaspora has been studied in depth in other countries with large South Asian populations, such as the United Kingdom and Canada (Karasz et al., 2016). A study comparing the prevalence of mood disorders between Canadian-born South Asians and South Asian immigrants found that immigrants experienced higher rates of diagnosed anxiety disorders and self-reported greater stress within their lives, compared to their Canadian-born counterparts (Islam et al., 2014). A review of stress and mental health among South Asian diaspora found a significant disparity in mental health rates between South Asian immigrant men and women, specifically older adult women. Social isolation, acculturative stress, and more severe issues such as domestic abuse, were all found to contribute to higher rates of mental health distress (Karasz et al., 2016). Results from focus groups with South Asian women living in Canada showed that for many women, negative mental health only became a concern after migration. Acculturative stress was linked to many factors, particularly the loss of social support networks, concern over family finances, and changes in food and climate. Although most participants had regular access to a physician, they did not seek care from healthcare providers despite their increased mental health needs (Ahmad et al., 2005).

These higher rates of mental distress in South Asian women correspond with other findings about lower rates of acculturation in South Asian American women compared to men

(Farver et al., 2002). Within Asian American communities, men and women are socialized differently, which leads to women in general identifying more with their home culture. Men are typically afforded greater independence and autonomy, allowing them easier assimilation with Western culture, whereas women are monitored and restricted to a greater degree (Farver et al., 2002). This hinders the acculturative process for women, causing greater stress.

Prevalence of Stigma

One of the most documented phenomena within South Asian mental health research is the high level of stigma against discussing mental health in the South Asian diaspora (Conrad & Pacquiao, 2005; Rastogi et al., 2013). Some South Asian Americans fear that getting treatment for mental health disorders may be seen as weak by the community and potentially bring shame to their families (Das & Kemp, 1997; Leung et al., 2012). A cross-cultural study of mental illness stigma posits that Asian cultural values that prioritize collectivism and conformity means that an individual's mental health issues may often be viewed as detrimental to the group's success. As such, mental health is stigmatized at greater levels in Asian communities as compared to Western communities (Chaudhry & Chen, 2019). Instead of seeking professional mental health services, South Asian Americans are therefore much more likely to seek support from friends and family instead (Inman et al., 2007).

Another study analyzing the effects of stigmatizing beliefs on mental health service utilization used mediation analysis to compare South Asian American and Caucasian American college students. The findings demonstrated that increased personal stigma from South Asian students accounted for 32% of the observed difference in attitudes toward counseling services. They also found that stigma in this group led to many participants expressing a desire to distance themselves from people identified with a mental illness (Loya et al., 2010).

This stigma is a significant barrier in preventing South Asian Americans, especially women, from receiving treatment and care for mental health disorders. For example, South Asian American women were less likely to seek treatment for eating disorders due to mental health stigma and fear of social ostracization (Goel et al., 2022).

Theoretical Framework - Feminist Theory

Since this study examines the lived experiences of South Asian American women in traditionally patriarchal societies, feminist theory was particularly useful for the purposes of analysis. Feminist theory, which originates from the 18th century but grew prominent during the equality movement of the 1970s, is primarily used to explore the experiences of people living under oppressive systems, with the aim of dismantling these inequalities (Arinder, 2020).

Feminist theory begins with the belief that there are existing social structures that create an imbalance of power within society. These systems can discriminate against people based on various factors, such as their sex, gender, race, etc. By acknowledging and actively working to disrupt these systems, over time, greater understanding and change can be created to correct these power imbalances (Arinder, 2020). Feminist theory also encompasses intersectionality as a necessary construct of identity, acknowledging that multiple intersecting identities can contribute to unique experiences of discrimination (Hankivsky et al., 2010).

It is important to apply the principles of feminism to public health to ensure the wellbeing of women and verify that public health is progressing towards reducing the oppression of marginalized groups, rather than contributing to it. Within public health, feminist theory has helped identify new areas of research, develop new theoretical frameworks, establish differences between the experiences of men and women, reposition women as the main active agent in their own healthcare, and inform interventions tailored for the advancement of women

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(Hammarström, 1999). Within mental health specifically, feminist theory has been applied to determine best practices in care for American women in general (Bondi & Burman, 2001; Pugliesi, 1992). More recently, variations of feminist theory and intersectionality have been applied to identify mental health needs of Black and Latina women in America as well (Graf et al., 2022; Wade et al., 2022). Feminist intersectional theory has also been used to analyze mental health disparities experienced by Muslim women in Canada (Hunt et al., 2020). Thus, applying feminist theory to this study can hopefully yield similar success in terms of identifying mental health needs and barriers to mental health service use for South Asian American women.

Theoretical Framework - Theory of Planned Behavior

This study aims to examine factors that influence mental health treatment-seeking behaviors among immigrant South Asian American women between the ages of 45 and 65. To do this, the theoretical framework of the Theory of Planned Behavior was utilized to analyze the beliefs regarding mental health treatment and how these may contribute to barriers that affect treatment-seeking behaviors.

A theory-driven approach is particularly useful for qualitative research, as it provides a framework useful for identifying relationships between concepts that may not otherwise be immediately evident (MacFarlane & O'Reilly-de Brún, 2011). This study utilizes the Theory of Planned Behavior (TPB) to examine the link between attitudes towards mental health and mental health treatment-seeking behavior. As an extension of the Theory of Reasoned Action (TRA), the TPB is similarly focused on how an individual's intention affects their behavior; unlike the TRA, however, the TPB also considers a person's perceived behavioral control in addition to other factors (Ajzen, 1991). The TPB frames health behaviors as a result of a person's intentions, which are affected by three main factors: attitudes, subjective norms, and perceived behavioral

control, each of which is influenced by specific beliefs (Ajzen, 1991). The concept of "attitudes"

refers to a person's opinions regarding a behavioral practice, which are shaped by their

behavioral beliefs, or knowledge and beliefs about the behavior. The concept of "subjective

norms" refers to their perception of what others think about the behavior, including perceptions

of stigma. Subjective norms are influenced by normative beliefs, which are the perceived social

pressures to engage or refrain from the behavior. Finally, the concept of "perceived behavioral

control" refers to their subjective beliefs about the degree to which they can control the health

behavior. Perceived behavioral control is influenced by control beliefs, or beliefs regarding

whether there are external factors present that either encourage or hinder the behavior (Ajzen,

1991). As illustrated in Figure 1, all three concepts of attitudes, subjective norms, and perceived

behavioral control influence each other as well as a person's intention to engage in the health

behavior, ultimately affecting the performance of a specific health behavior.
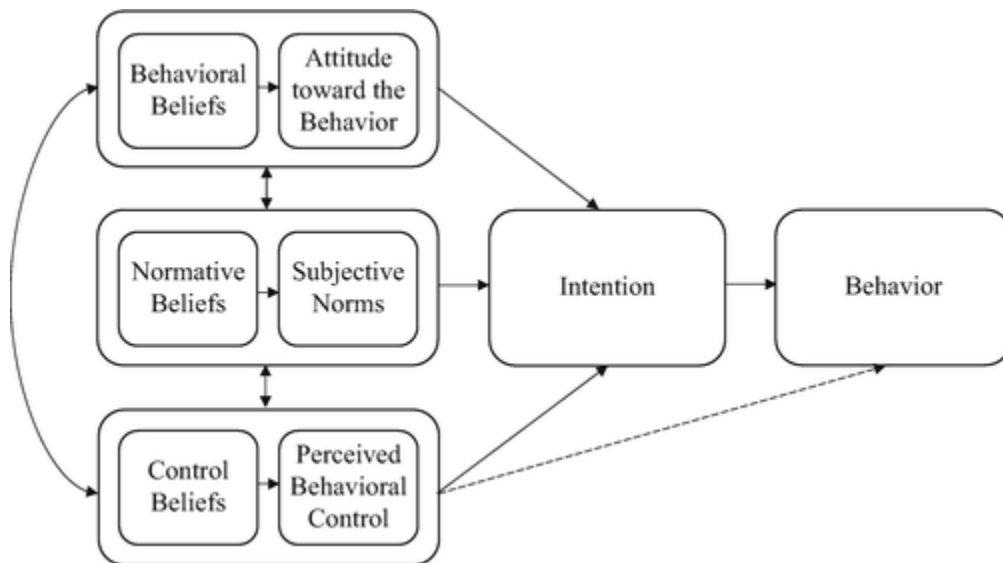
Figure 1: The Theory of Planned Behavior Conceptual Model

       The TPB is a particularly appropriate framework for this study, since it integrates

individual attitudes as well as perceptions of stigma in society within its analysis, both of which

have been shown by previous literature to be important factors in mental health treatment-seeking behavior. Other research projects studying the intention to seek mental healthcare in various populations have also used this theoretical framework to great success (Bohon et al., 2016; Tomczyk et al., 2020). Based on the findings of this study, the TPB model can be modified to more accurately reflect the experiences of middle-aged immigrant South Asian American women and can be used to inform future interventions for increasing mental health service use in this population.

Chapter III: Methodology

Introduction

This qualitative study was conducted at Emory University, with the approval of the

Emory University Institutional Review Board (IRB). South Asian women between the ages of 45

and 65 were recruited to participate in hour-long in-depth interviews discussing their experiences

and opinions to better understand their viewpoint of mental health. These interviews were then

analyzed to find commonalities in the mental health experiences of participants. In-depth

interviews are an ideal format for this study, as they offer greater insight into the lives and

conditions of these women and yield large amounts of data, ideal for noting patterns and themes

(Hennink et al., 2015).

Each participant was involved for the duration of one interview conducted via Zoom,

with no follow-up required. Interviews lasted an average of 55 minutes. A total of 15 participants

were enrolled and interviewed between October and January 2022, and the study was concluded

in April 2022.

Population and Sample

Since this study examines the very specific population of middle-aged immigrant South

Asian American women, gaining access to the right sample was critical. The original plan was to

recruit interviewees using purposive sampling, where "information-rich" participants with

certain key characteristics are recruited (Hennink et al., 2015). This was initially thought to be

the best option to gain entry into the community, given the specific parameters for the target

population. As such, South Asian American-centric organizations were targeted to find people

who would be willing to participate. Using the newsletters of organizations such as the South

Asian Mental Health Initiative & Network (SAMHIN) and South Asian Americans Leading

Together (SAALT), many leaders of South Asian communities across America were contacted. However, this strategy yielded a low response rate. Thus, convenience sampling, where participants were recruited from easily accessible populations, and snowball sampling, where enrolled participants were asked to refer future participants to the study, were then utilized.

Recruitment and Eligibility

Multiple avenues of recruitment were used. Advertisements were posted in the newsletters of various South Asian American-centric organizations, such as the South Asian Mental Health Initiative & Network (SAMHIN) and South Asian Americans Leading Together (SAALT). This study was also posted onto ResearchMatch to find more eligible participants. Advertisement posts stated the study purpose, the inclusion and exclusion criteria, and email contact information.

Participants were also recruited by contacting the moderators of Facebook groups focusing on South Asian issues or Asian mental health and asking the moderators to post advertisements for this research study. Posts included a flyer stating the study purpose, the inclusion and exclusion criteria, and contact information. A convenience sampling was taken of respondents to these posts. Current participants were also asked to pass on the flyer to anyone they thought would fit the criteria and be interested in participating. This snowball sampling technique was very effective in this case, since the South Asian community has strong ties that can reach a wide range of people across America.

To be eligible for inclusion, participants had to identify as a woman between the ages of 45 to 65 who was born and raised in a South Asian country before immigrating to the United States as an adult over the age of 18. South Asian countries were defined as any of the following: Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. Participants also had to be

fluent in English, since all interviews were conducted in English to ensure commonality across interviews and accuracy in analysis.

Due to this study's focus on perceptions and attitudes towards mental health, women who work within the field of mental health treatment, including counseling, psychology, or psychiatry, were excluded. Since women in these professions would have greater mental health literacy, this exclusion criteria ensured that all participants in this study would likely have around the same level of knowledge and experience with mental health.

Procedures and Privacy Measures

South Asian women between the ages of 45 and 65 were interviewed on their experiences and opinions to better understand their viewpoint of mental health. The video conferencing platform Zoom was used to conduct these interviews for three main reasons: first, to adhere to COVID-19 safety protocols; second, to access participants located all over the United States; and finally, to easily record interviews after participant consent was obtained. Each interview lasted between 45-70 minutes.

When potential participants expressed interest in the study, they were sent a quick online Qualtrics survey to verify eligibility and gather relevant demographic information. This information included their year of birth, country of origin, year of relocation to the United States, level of English fluency, and field of employment. Once eligibility was verified, a Zoom interview was scheduled with each participant.

A semi-structured interview guide was developed to ensure the same topics are covered during the conversation with each participant. This interview guide consisted of ten main questions in four general categories, with several further probes for most questions. The four categories covered general questions about mental health, experiences and opinions about mental

health, community influences, and mental health in the South Asian diaspora. These general categories allowed for some structure within the interviews that led to easier analysis later, but all questions were open-ended to allow interviews to be flexible and participant-guided.

All participants were informed of the parameters of the study and any risks involved in participation before they agreed to be interviewed. Consent was obtained verbally before recording, and participants were informed that they had the right to refuse to answer any question or request to stop recording at any time. To mitigate risks to participants, all interviews were conducted in password-protected Zoom rooms, personally identifying information was removed from transcripts, and randomly generated pseudonyms were used in all study documents instead of actual names. Video recordings were deleted immediately after the interview ended, audio recordings and transcripts were deleted at the end of the project, and transcripts were only shared with study personnel. Until deletion, all recordings and transcripts were stored on a secure password-protected Emory OneDrive server only accessible to study personnel.

Data Analysis Methodology

Thematic analysis of interviews was used to identify overarching themes and common ideas. Thematic analysis was a suitable approach for this study, as this allowed for "thick description" of data and helped identify similarities across the thought processes of participants (Braun & Clarke, 2006). Feminist theory, which highlights disparities in lived experiences as a result of societal power imbalances, was implemented as a major philosophical foundation of analysis (Arinder, 2020). This was particularly appropriate considering this study's focus on women and gender disparities, as well as the influence of traditional South Asian gender roles on mental health outcomes. Feminist theory was helpful both in terms of identifying relevant deductive codes and in terms of examining broader themes. The Theory of Planned Behavior

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was then applied to these themes and used to relate these findings to the health behavior of seeking mental health treatment.

Interview recordings were transcribed via Otter audio transcription software. All transcripts were deidentified before data analysis. MAXQDA software was used to analyze findings. First, memos were written for each transcript, noting recurring words, patterns, or ideas. Data exploration was conducted by creating word clouds for each case and searching common recurring keywords, such as stress, stigma, etc. Using these results, inductive codes were developed, such as "effect of divorce". Deductive codes, such as "acculturative stress," were also generated from the literature review and interview guide. These were combined into a code system for analyzing the dataset. A codebook was developed with detailed definitions for each code and subcode, including quoted coded segments for each code. This codebook formed the foundation for further analysis of emergent themes.

Cross-case relational analysis was used to explore relationships of codes throughout all cases and generate Excel spreadsheets of coded segments. Additionally, codes with overlapping or similar text segments that led to the same idea were identified through pattern analysis and code maps generated through MAXQDA. Related codes were grouped into code sets, each of which pertained to properties of themes. Memos were used throughout to document the process.

After coding the first few interviews, preliminary themes relating to behavioral beliefs, normative beliefs, and control beliefs were identified. This led to the decision to use the Theory of Planned Behavior as a major thematic framework for the study. Themes were connected to one or more of the beliefs that form the basis of the TPB based on how they could potentially affect that particular belief. The model of the Theory of Planned Behavior was then modified to reflect these new relationships and link these themes to treatment-seeking behavior.

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Chapter IV: Results

Fifteen interviews were conducted, with ten women originally born and raised in India, two women born and raised in Pakistan, and three women born and raised in Bangladesh. These women ranged in age from 45 to 65 years of age, with the average age of participants being 57 years old. Participants immigrated to America between the years of 1974 and 2006, from eleven different South Asian cities. Of the fifteen, currently, three participants actively use professional mental health services such as therapy, one participant regularly takes prescription medication to manage a mental health condition, while another participant uses both therapy and medication. The remaining ten participants do not currently use any mental health treatment services, but four of the ten have previously attended at least one therapy session in their life. Participants' mental health experiences are related in their own words, using randomly generated pseudonyms.

Based on these interviews, four main themes emerged: mental health understanding, positive support systems, negative influence of cultural values, and structural barriers. These themes all contribute to institutional and attitudinal barriers that may be related to the low mental health service use that has been observed within this general population in previous literature.

Theme 1: Mental Health Understanding

Participants self-assessed their own current understanding of mental health, with several of them stating that their familiarity with mental health has improved compared to the past. All participants were able to give examples of common mental health issues, such as depression, but some of them stated that they did not know much more than the fact that these issues existed. There was also variation in terms of how comfortable participants felt explaining the concept of mental health in their own words, with some being able to easily give a clear and specific definition, while others struggled to put their thoughts into words.

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The method by which participants gain knowledge about mental health seems linked to their understanding and level of comfort with mental health. Two properties were identified as contributing factors to participants' understanding of mental health: experiences with mental health and knowledge acquisition.

Experiences with Mental Health

Participants' understanding of mental health was extremely dependent on their own experiences with mental health, or on seeing the experiences of a loved one as they managed some mental health issues. Only one participant claimed to not have any experience whatsoever with mental health issues, whether personal or proximal.

Personal experience is perhaps the best teacher for gaining an understanding of mental health issues. Participants reported personal experiences with issues such as depression, including both persistent depressive disorder and postpartum depression, anxiety, and extreme stress in their own life. The main stressor reported was interpersonal conflict with family members, which corresponds with findings in previous literature (Farver et al., 2002; Karasz et al., 2016). Some women also cited their professional careers as a major source of stress. One woman, Penny, reported facing gender discrimination at work, which contributed negatively to her mental health, stating, "I just hated going in to work. I was never taken seriously."

Some participants also referred to previous experiences with acculturative stress after first moving to the United States. Cassie, who relocated to America in 2005, referred to "feeling completely lost for the first few months" but finding her feet by getting closer with her husband's extended family living nearby. Shelby, who immigrated in 1984 and did not have family in the country at the time, shares:

I was one of the only Indian women in my program…almost everyone else who was desi was a male, and everyone who was female was not American, so I was extremely lonely the first year…but you know, I just concentrated on my studies and got through it.

Although acculturative stress appears to have been a significant factor in their mental health in the past, none of the participants sought out any professional mental health services as a result. Instead, they mostly relied on self-managing their stress or forming connections with other South Asian Americans as they acculturated to American life, which fits the profile of South Asian immigrants previously identified in literature (Ahmad et al., 2005; Tewary, 2005). Participants indicated that currently, acculturative stress is no longer a major stressor in their lives, since after at least 15 years of living in this country, they felt relatively acclimated to life in America.

Many participants indicated that they had only a vague idea of mental health concerns until experiencing mental health issues for themselves. Before this, participants had minimal to no familiarity with mental health, as these potential concerns were typically not discussed by family and friends. Nancy, for example, was not fully aware of mental health issues until her experiences with postpartum depression:

Maybe my mom didn't go through it? Or maybe she didn't hear much about it? So I had no clue. And because that was happening, I had these weird 'Am I a fit mom? Am I a good mom?' - You know, all those questions. Internalizing all those things. But it was really not me who's doing it - it's the hormones, and all that's associated with the postpartum depression that was happening.

For several participants, their personal experience with a mental health condition was the impetus to learn more and deepen their understanding about mental health.

While most participants were able to identify that their mental health issues were in fact mental health-related, one participant, Shelby, interpreted the mental health symptoms she experienced as manifestations of a physical ailment. She did not really understand what was happening with her health until after learning that she had anxiety, which was complicating her asthma symptoms. Shelby explained:

> I've had asthma for about 25-30 years. And it was progressively getting worse…as soon as I would open my mouth, my airways would close…And I, you know, went to Mayo Clinic, went to different doctors, and everybody just kept giving me more and more inhalers. What they didn't realize was that…my anxiety had overtaken everything else. And it wasn't until just this last six months that I realized that that was actually my main diagnosis at that point. The asthma was there, but the anxiety had made it a lot worse.

Shelby's experiences correspond with the phenomenon of somatization experienced by Asian Americans in previous literature (Maffini & Wong, 2014). Somatization of her symptoms led Shelby to misinterpret her symptoms as the result of a physical issue alone, rather than a mental health-related complication. Only after realizing the issue was rooted in her anxiety was Shelby able to properly seek care and medical treatment. Now, after overcoming her initial somatization, her personal experiences with anxiety have given her a much better understanding of mental health concerns overall, as well as how physical health and mental health are related.

Besides personal experience, witnessing a loved one struggle with mental health issues can also produce an understanding of mental health. Participants described learning about mental health through helping family members manage mental health symptoms or hearing about the experiences of family or friends who sought treatment for mental health. For example, Brenda

states that before she witnessed her husband's struggle with bipolar disorder, "I didn't really know what the mental health really meant." The proximal experience of helping her husband manage his bipolar disorder is what introduced Brenda to the concept of mental health and how it can be treated, deepening her understanding of mental health. Diana's introduction to mental health came through seeing her adult children benefit from going to therapy. She relates,

> At first, I was not really sure this was worth their time, but you know, I thought why not… And I did see that both my younger daughter and my older daughter - they both say it helps. I think they are calmer and, you know, better able to handle things. So yes, it made me understand how this was helpful.

Although initially skeptical, Diana gained a more positive view of mental health treatment after seeing her daughters benefit from regular therapy sessions.

Only one participant, Jenny, reported that she has had no major mental health concerns, and was not really aware of anyone in her social circle who was dealing with mental health issues either. Although Jenny reported feelings of stress and loneliness after moving to America, she also was able to manage her negative emotions through keeping busy. She states,

> Generally, my mental health is good because I like to do things for people…the most thing I enjoy is doing something for people. Doing things with people like cooking and entertaining, or helping to send food for sick people. That makes me feel very good, feel very motivated.

Jenny's ability to occupy her time and gain motivation through acts of service helped her regulate her own mental health without need for outside intervention. However, this has led to a

lack of understanding of mental health. When asked how she would describe the term "mental health" in her own words, Jenny struggled greatly to respond:

> I don't know. I'm really not sure what the right answer is…I just feel bad…I think I am saying the wrong thing…I don't even know the right words for this. Wait, can I Google this?"

Although Jenny was able to give examples of depression and stress being mental health conditions, her hesitation seemed to stem from a lack of familiarity with the topic overall. Experience with mental health issues, whether personal or proximal, therefore seems linked with a better understanding of mental health.

Knowledge Acquisition

Knowledge acquisition refers to methods that participants used to learn about mental health, which can be dimensionalized as formal learning or informal learning. All participants were able to identify common mental health issues such as stress, depression, and anxiety, indicating some familiarity with mental health; however, most participants relied on personal experiences and word of mouth to learn about mental health. In essence, they learned about mental health through informal sources rather than formalized education. Four out of fifteen participants had some exposure to mental health education from school or college, but most participants stated that they did not receive any formal education that covered mental health.

Formal education indicates that at some point in her life, the participant received some official instruction regarding the basics of mental health, most likely as part of some school-sponsored class or program. However, even after obtaining formal instruction, most participants

spoke about their prior formal knowledge as inadequate in some way. For example, one participant, Zelda, mentioned,

> I mean, I did a basic psychology course, sometime somewhere, but I don't know if I learned about it there. You know, there's a lot of things you learn in school, but you know, you can take it in from one ear and it goes out the other.

While psychology courses certainly touch upon mental health related issues, Zelda felt as though this formal training did not actually add much to her understanding of mental health. Similarly, another participant, Tess, received some training in mental health as part of her medical school program in India. However, she comments,

> I don't really remember much about it because to be honest, it was just a requirement I had to fulfill. I don't think I took it seriously at the time - I don't think anyone really took it seriously. If I did it again now, it would probably be different.

Although a formal education is useful in at least introducing the basic concepts of mental health ideas to people, based on the feedback from the participants, they did not perceive these classes as greatly impacting their thinking or understanding of mental health.

On the other hand, informal learning, or knowledge acquired about mental health through unofficial non-school-based methods such as vicarious learning or word-of-mouth, was identified by all participants as their main method of learning more about mental health. When asked how she had come by her knowledge of mental health, Lisa stated,

I think over time, just like, exposure to media - social media and traditional media. So I

would say just movies and reading and that kind of stuff is probably where I, you know,

even thought that it's a possibility.

Lisa only mentioned media in general, but some other participants were able to point to specific

media, particularly books, which influenced them to explore mental health to a greater degree.

Rose, for example, mentions reading several self-help books, which she uses in conjunction with

professional mental health services to manage her mental health. Shelby also credits a book as

the reason she was able to identify her own symptoms of anxiety:

This book, *Unwinding Anxiety*, is really what kind of helped me because so much

of what he describes is what I was going through, and I felt like a light bulb came on and

said, you know, this was mostly anxiety.

After suspecting her issues with asthma might be more complex than just a physical

ailment alone, Shelby used a book on anxiety as her main source of understanding what was

happening to her and how she could manage her symptoms. In the absence of more impactful

formal education, these informal sources such as books and media, in conjunction with their own

experiences, became the main methods through which participants learned about mental health.

Theme 2: Positive Support Systems

One major cultural value for South Asian Americans identified in previous literature is

the importance of community (Jin et al., 2022). As a collectivistic culture, these South Asian

social networks are extremely strong and extremely influential, and prior research shows that

individuals often prefer to seek help through these networks first instead of going to mental

health professionals (Inman et al., 2007). Due to the influence of these community-oriented

cultural values, support systems created through these networks were therefore highly prized by participants as a preventative factor against mental health distress.

All participants identified speaking with a close friend or family member as an important strategy for mental health management. Furthermore, the four participants currently using therapy and counseling services all stated that they only did so because of encouragement from a close friend or family. While most participants experienced both positive support for and negative discouragement against speaking about mental health issues, they perceived positive support as an interpersonal interaction with their support system, while negative discouragement was depersonalized and attributed to a manifestation of cultural stigma rather than one person's individual opinion. Thus, this theme only considers the positive support for mental health management that participants obtained from their support systems.

Two properties emerge within this theme: social support for individual mental health management and social support for seeking professional mental health treatment.

Individual Mental Health Management

Speaking with a trusted individual was a main method of mental health management mentioned by all participants. Participants defined their support systems as friends and family members who they speak with regularly regarding both minor daily life events and more serious mental health issues. These support systems can reduce the severity of mental health distress being experienced by the participant and decrease the need for professional services. This property has two dimensions: group support and one-on-one support.

Groups could be formed from many different sources. Diana, for example, found her support system at her local mosque, stating:

There is a group of women at the mosque…we talk about everything, even mental health

issues. I think it's very important to have people with similar issues to talk to

While Diana found this group through her local mosque, based on her comments, it appears that

the main factor bonding them together is not necessarily religion, but simply similar life

experiences. This allows Diana to feel comfortable discussing more personal issues and deriving

support from this group. Similarly, Zelda also found an informal mental health support group,

albeit through non-religious means. She explains,

I came across a group of South Asian women who had encountered all kinds of issues in

their lives. And I participated in this community where I realized that, you know, I was

not alone…it was a community where we were in some ways hidden, but we recognized

and saw each other, and part of our process and journey was not to be hidden.

Zelda's support group not only offered her a sense of belonging and community, but also gave

her an outlet for communication and discussion that encouraged her to take her mental health

seriously. This is why Zelda does not feel the need to seek professional mental health services at

this time, stating "I am able to manage my mental health myself right now, but if things got

worse, I would certainly make an effort to go." As of now, the support she receives through her

group is enough to fulfill her mental health support needs.

Alternatively, support could also be received one-on-one with various important

individuals in a participant's life. Multiple participants reported speaking one-on-one with people

as their main mental health management technique, including Brenda. According to Brenda,

Like, you know, if something is bothering me, I discuss it with them and just get it, you

know, out of my system. I talk to my daughter about certain things, then I talk to my

sister about certain things. I mean, we discuss almost anything.

Brenda's support system consists of her sister and daughter, who help her work through issues

together. These individual conversations offer Brenda the support she needs to manage her daily

mental health needs without professional treatment. Another participant, Anna, also echoed

Brenda's sentiments, stating, "When I'm upset, I call my mother and just let it all out…and I

instantly feel better." For Anna, having her mother as her source of support is enough to have a

positive effect on her mental health. In this manner, participants indicated that sharing their

concerns with trusted individuals is a common and effective technique that they use to manage

their mental health.

Seeking Professional Treatment

Support systems can also be influential factors in leading participants to seek professional

mental health treatment. All participants currently undergoing some form of mental health

treatment - two pharmaceutical and four therapy-based - state that they sought treatment only

after another trusted individual urged them to do so. In particular, multiple participants

mentioned their adult daughters as the impetus behind seeking help. Rose, for example, relates,

My older daughter, she said, 'Mom, you should go for therapy, because you really need

to talk to somebody about this and get some help.' So that's pretty much how it started.

Similarly, Gina also first began taking anxiety medication due to her daughter. She said,

So, I did start developing pretty severe anxiety. And it took me a while to realize even.

Not until my daughter pointed out that I was getting really irritable, and I was getting

kind of short tempered and would react to sounds.

Adult daughters, therefore, seemed to be particularly influential for these women in terms of pointing out their mental health needs and encouraging them to seek further treatment, both in terms of therapy and in terms of medication.

Other participants noted the influence of their friends and community in convincing them to seek out mental health services. Despite needing and having access to mental health treatment, Heather did not attempt to see a therapist until her friend urged her to do so.

My friend, she suggested to me that I go see someone. And I was not convinced at

all…what was the benefit of going and seeing somebody, especially when, you know, my

marriage was on the rocks, and I was in a very terrible state.

Until her friend encouraged her to see a therapist, Heather did not feel as though there would be any benefit to therapy. Overall, the decision for participants to seek mental health treatment was strongly influenced by support from their friends and families.

Theme 3: The Negative Influence of Cultural Values

Participants specifically attributed many common mental health issues as a result of the negative influence of certain South Asian cultural values on the overall community. All participants spoke about some element of South Asian culture as a large influence on their opinions and experiences with mental health. This was especially evident with regard to stigma against mental health, but also came up in reference to double standards within traditional gender

roles and stigma against divorce, as well as their impressions and experiences of an image-conscious society.

<u>Stigma Against Mental Health</u>

Out of the fifteen participants, six of them directly identified stigma against mental health as a prominent component of South Asian culture. Perceptions of severity of stigma, however, varied from participant to participant. The dimensions for this property range from strong to medium to absent, as there was one participant who did not directly note the presence of stigma.

Strong severity of stigma against mental health, where stigma is noted as the main factor preventing women from accessing mental health care, was noted by several participants. For example, Rose states:

> They bring the stigma with them from back home [in South Asia] that you wouldn't go see a therapist unless you're bipolar, schizophrenic or something like that. Not just go for therapy, because you just want to deal with your everyday life.

Rose sees stigma as a result of cultural influence from South Asia, where therapy is reserved for more serious mental disorders, rather than general mental health management. Due to this perception, people avoid therapy out of a misunderstanding of what therapy offers, as well as a fear of being perceived as more mentally ill than they are.

Similarly, Brenda identifies overcoming cultural stigma against mental health as the first step for South Asian women seeking treatment:

> First thing is, if at all possible, to recognize and admit it. You know, that's one of the issue that most Asian women in particular have, is that they're told to just...just be strong

and, you know, that sort of thing. But they don't admit that they have this kind of

problem.

In Brenda's experience, women often do not even recognize or admit that they have mental health issues, because they think this is just a part of life that they have to be strong and endure. Brenda states that this first step of acknowledging the problem is already a challenge due to stigma, preventing many women from seeking help. Nancy also saw stigma as a major reason South Asian American women's mental health would not improve, stating, "No, I don't think much can be changed, because that's how we are conditioned and brought up." In the opinions of these women, the effects of stigma are extremely strong and long-lasting, preventing better mental health outcomes.

Some participants saw stigma as a concern of medium severity - while it is a factor of concern, it is improving gradually. Zelda asserts, "So I think there is slowly an awareness building. But I think the keyword is slowly." In Zelda's experience, while stigma against mental health is still present, she has seen it decrease over the years and thus is hopeful that this stigma will eventually be erased. Another participant, Tess, also noted that while stigma was present for her generation, she was more hopeful for future generations. She shared,

I don't know if maybe this is a result of more Americanization or what…I think that attitude of 'don't talk about mental health' is dying down with newer generations. Maybe not my generation, but my children's generation doesn't have trouble with this.

For Tess, stigma is a concerning barrier for her generation, but she has observed that future generations are not experiencing this. In her eyes, stigma is therefore decreasing overall.

One participant, Jenny, did not identify stigma as a concern at all. She did not mention the issue of stigma by name, instead stating that people in her community did not seek mental health treatment because "people just have bigger things to do. It's not a daily life thing. We are just busy doing other things." Although Jenny herself does not attribute her feelings about mental health to be due to stigma, her response seems to indicate that speaking about mental health is still discouraged as an unnecessary topic of conversation.

Treatment of Women

Participants made reference to how traditional gender roles contribute to the negative mental health outcomes of women, as they increase mental health distress while decreasing access to treatment services. They perceive that South Asian women often have limited autonomy and experience physical and emotional abuse that hinders positive mental health.

With regard to lack of opportunity, Rose spoke about how even within South Asian communities in America, women are forced to be more dependent on their families, and not given as much freedom. She states,

> Even when women come here, to the US, or they go to the UK, they end up depending on family. They are kind of in the same situation, but in a different country. You know, you're - you're not emancipated just because you're in a different country.

Participants viewed this dependence on family as a unique experience for South Asian women specifically that increases negative mental health feelings. Furthermore, this lack of emancipation restricts women from accessing mental health services without the express permission of their family.

Abuse is also a major concern for South Asian women. This can take many forms - most commonly domestic abuse with the husband as the perpetrator, but also emotional abuse being inflicted by in-laws. Gina speaks about the plight of many South Asian women:

> You know, they don't have control over their own money. They're forced to marry people they don't want to marry, and then you know the way their spouses or in-laws treat them. So there's just - there is more pressure on people causing all the mental illness, but there's also more pressure not to reveal. You know, it makes for a very toxic situation.

Gina points out how in many cases, South Asian women undergoing this experience have very few choices in their own life, causing increased mental illness as well as a lack of access to mental health treatment services. She further mentions that women are also pressured against revealing the extent of their situation, thereby discouraging them from seeking out mental health treatment services.

<u>Stigma Against Divorce</u>

All participants were currently married, with three participants reporting that this is their second marriage following a divorce. Participants who mentioned going through a divorce in the past all spoke of experiencing a cultural backlash that negatively affected their mental health.

Shelby shares, "When I got divorced pretty much all my Indian friends stopped talking to me because they didn't want a divorced woman in their friend circle." Despite the negative impact on her mental health caused by both the divorce and the ostracization, Shelby did not consider therapy or other mental health services, since she was raised with the understanding that "hardships like this are just a part of life that needed to be endured." Shelby also had support from her family that helped her recover from this time.

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Shelby did not regard the alienation as an interpersonal issue with a friend group, but rather an unfortunate result of cultural influence that emphasized ostracization in the face of nonconformity. Considering the importance of social support systems in promoting good mental health, this stigma against divorce that causes alienation from friend groups certainly compounds the already damaging effects of divorce on mental health.

Heather relates how her divorce was the impetus for her first foray into therapy:

> I just felt so low, you know? Everyone was talking about how it was so shameful and scandalous…nowadays it's more normal, but back then, this was a big deal…anyway, that's when I first tried therapy for a bit.

Although Heather no longer goes to therapy regularly, she states that therapy was useful in managing her negative mental health after her divorce. Participants related that the stigma against divorce and cultural backlash faced by South Asian divorcees played a major role in exacerbating their mental health issues.

Image-Consciousness

Participants also brought up their perception of the competitive and image-conscious South Asian society as a reason for heightened stress and depression, as well as a deterrent for publicizing mental health service use. According to Gina,

> We Indians are pretty kind of...what's the word I'm looking for... kind of image conscious, maybe we don't want people to see us in a negative light, we don't want to stand out too much, tend to kind of lie low and, you know, appear to be normal.

Several participants brought up the importance of presenting a proper image for the sake of family and community, suggesting that they felt pressure to always maintain a certain level of

normalcy. This can be seen as an effect of the pressure created by the "model minority" myth on Asian Americans (Cheng et al., 2017). Heather corroborated this sentiment, stating,

> That whole image of you trying to be a good, whole complete person, you know, is very important to people. It's very important that people see you as a balanced person…not crazy or even too weird.

Due to the immense pressure to appear "normal" within the community, the use of mental health services is discouraged as negative and abnormal. This corresponds with previous literature on the effects of collectivistic Asian cultural values on suppressing discussion of mental health (Chaudhry & Chen, 2019).

One participant, Shelby, observed that, in her experience, compared to the modern society in South Asia, "It's the immigrant population that is extremely conservative in some respects," allowing for less individual freedom. She felt that the South Asian diaspora was more limiting and judgmental when it came to freedom of expression, resulting in increased pressure to conform. Due to this cultural pressure to appear "normal" or "successful", people are reluctant to admit to mental health issues and seek treatment.

Theme 4: Structural Barriers

Seeking professional treatment is complicated by structural barriers of financial and logistical limitations. Even if participants did not experience these constraints personally, most of them identified these barriers as present for many women in their social circle.

Financial Barriers

Seven participants specifically mentioned financial barriers as a major deterrent. Even participants who have used mental health services in the past acknowledged the issues associated

with monetary limitations. Heather, for example, states that "We had this employee assistance program, and I decided to take up on that to go see this person." She was able to take advantage of the employee assistance program available through her work to pay for her therapy sessions, but indicated that she likely would not have pursued this option if she had to pay for it fully.

Another participant, Cassie, did not have mental health service coverage, and decided "I had to pay out of pocket, so…not worth." For Cassie, the financial cost of paying for therapy outweighed her perceived benefits of attending therapy. This sentiment was echoed by several other participants who saw the cost of services as a major barrier for access.

Nancy also mentioned how South Asian women who were primarily homemakers would be at a financial disadvantage:

> I work, so my money is my business…I have friends who don't work, they are stay-at-home moms…they have to go to their husbands for everything.

Financial barriers are therefore even more exacerbated for certain subgroups of South Asian women who do not have access to their own personal funds and are reliant on husbands to approve their expenditures.

<u>Logistical Barriers</u>

Logistical barriers in this case refers to organizational or functional issues preventing access to mental health treatment for women. While some participants only obliquely referred to logistical barriers preventing mental health treatment, other participants identified specific logistical limitations that factored into why women were not seeking out care. For example, Maria uses the situation of a friend who recently moved to the United States to illustrate her point about lack of access:

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She's been here for almost eight years now, but she never learned to drive - women don't

really drive in India…she's totally reliant on her son and daughter-in-law…she can't go

anywhere, do anything at all.

Maria notes that skills such as driving, which are not considered within the traditional gender

expectations for a South Asian woman, are essential when living in America. This ties in with

what is known from previous literature about the effect of gendered double standards on mental

health outcomes (Farver et al., 2002; Jin et al., 2022). For women who move to America but

never develop important skills such as these, opportunities to access mental health treatment

services are limited.

Gina was more optimistic when speaking about the issues of accessing care. Although

she too acknowledges the lack of access to mental health care, she states,

I think logistics may be a problem when you're finding someone, you know, who's good.

So access to good help, access to local help. I think with COVID, when people started

doing the tele calls and all of that, that got a little easier.

Gina indicates that while accessing local help is an issue, telehealth services have somewhat

weakened this logistical barrier.

Besides access, a lack of knowledge about how the healthcare system works in America

can also deter women from seeking mental health care. Anna specifies,

I don't think many people really know where to begin, or who to go to. You know, going

to the doctor is such a headache in America, it's not like you can just pick a place and go.

Anna observes how without knowledge of America's complicated healthcare system, people

would not know how to maneuver through this system to find a satisfactory provider. This is

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exemplified by the experiences of another participant, Cassie, who decided not to seek treatment because she "did not want to deal with the hassle" of navigating the complex healthcare and insurance systems. This represents the general view of most participants, who saw lack of access and the confusing healthcare system as major logistical barriers preventing mental health service use.

Chapter V: Conclusions, Implications and Recommendations

This analysis proposes that barriers preventing mental health treatment-seeking behaviors in South Asian women are directly related to themes of mental health understanding, positive social support systems, the negative influence of cultural values, and structural barriers. These themes were identified through the use of feminist theory, by examining the common themes across the unique lived experiences of women within an imbalanced social structure. Each of these themes can be linked to concepts found in the Theory of Planned Behavior that can explain the trend of low mental health service utilization (Figure 2). Understanding how these themes factor into barriers preventing mental health treatment is the first step in removing those barriers.
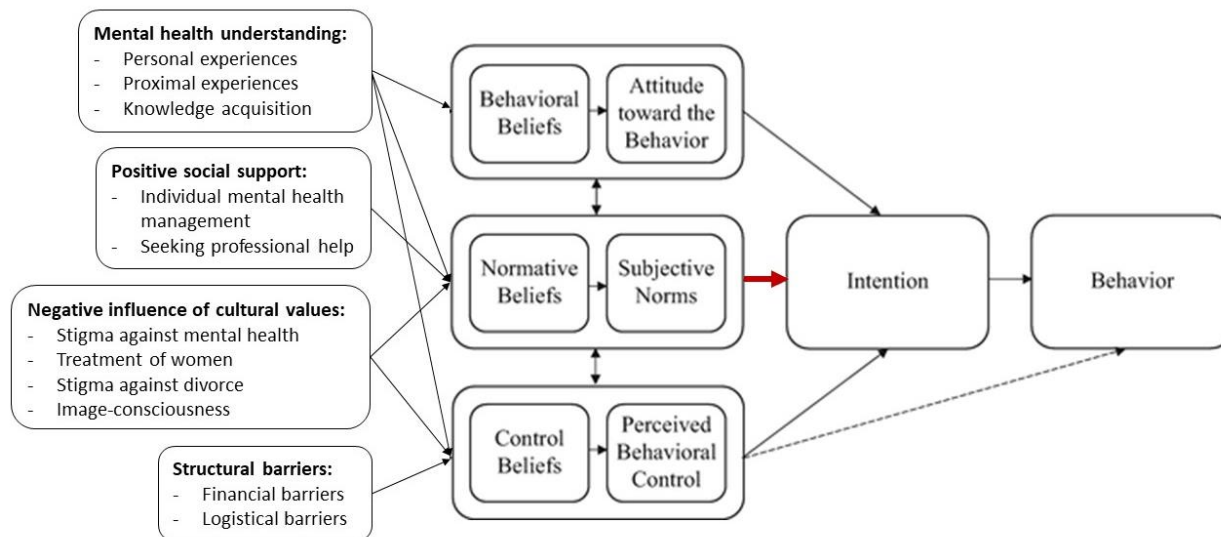

Figure 2: TPB Conceptual Model Modified for South Asian American Women's Mental Health

Discussion of Key Results

The four themes identified - mental health understanding, positive social support, negative influence of cultural values, and structural barriers - all affect an individual's behavioral, normative, and control beliefs regarding seeking mental health treatment. Some

themes can impact multiple beliefs at once: for example, the influence of cultural values affects both normative beliefs and control beliefs. All three beliefs ultimately contribute to participants' attitudes and perceptions, which affects their intention to seek mental health treatment.

While the findings of this study did not change the overall structure of the Theory of Planned Behavior as it pertains to this population, they did emphasize the heightened influence of subjective norms on intention, highlighted as a red arrow in Figure 2. Even in the presence of a positive attitude towards mental health treatment and positive perceived behavioral control, if the subjective norms are perceived to be negative, the individual is highly unlikely to engage in seeking out mental health treatment. Subjective norms are therefore the most crucial concept to target when developing interventions for increasing mental health service use.

A stronger mental health understanding, including prior experience with mental health and knowledge acquisition, is related mainly to behavioral beliefs. Before experiencing mental health issues, women were more likely to have a negative attitude towards mental health service utilization, thinking of it as unnecessary and ineffective, while greater experience and knowledge led to a more positive attitude. This corresponds with previous findings about the role of increased behavioral knowledge in changing attitudes towards health behaviors (Bohon et al., 2016). Participants reported previous experiences with acculturative stress, but not to the extreme degree mentioned in previous literature (Karasz et al., 2016). They were able to manage this stress independent of professional services, as most other South Asian immigrants have done, according to prior literature, and currently no longer feel any such acculturative stress (Ahmad et al., 2005; Tewary, 2005). One participant experienced somatization of mental health symptoms, mistaking her anxiety symptoms as asthma symptoms. This ties in with previous findings about higher rates of somatization within Asian Americans compared to other American subgroups

(Maffini & Wong, 2014). Acknowledging the link between mental health distress and physical manifestation of symptoms was associated with an increased understanding of mental health and a more positive attitude towards mental health treatment-seeking behaviors. With regard to knowledge acquisition, the low number of participants who report formal mental health education makes sense in the context of the limited availability of mental health information as they were growing up in 20th century South Asia (Thara & Padmavati, 2013). This formal education in mental health appears to have had little to no effect on participants; instead, it appears that informal learning through media and life experiences is more impactful. However, this finding may be affected by the quality of formal training participants received - by all accounts, mental health was not an emphasized part of the curriculum. Personal experiences with mental health crises appear to be an important factor in prompting women to take mental health seriously. However, even for women who acknowledge mental health as a serious concern, although most of them support the concept of seeking out mental health services, only four out of fourteen participants are actually using these services. Without clinical measures of mental health, it is impossible to determine if this lack of use is because participants do not need these services, or if participants need mental health services but are deterred by other barriers.

Strong mental health understanding can also contribute to normative beliefs, as well as control beliefs about whether individuals are able to seek treatment. Proximal experiences with mental health, a component of mental health understanding, can normalize mental health treatment seeking behavior, as the individual is aware of others in the community who are facing the same issues. As established by prior research, seeing others engage in mental health treatment can be a significant motivating factor, especially for collectivistic cultures (Chaudhry & Chen, 2019). Regarding control beliefs, women with prior experience dealing with mental

health issues are likely to already have some knowledge about how to begin the process of seeking mental health treatment. Conversely, those with very little mental health experience might feel completely lost as to how to find mental health support, leading to low perceived behavioral control.

Positive social support has a strong link to normative beliefs, as seeing others experience mental health issues and hearing encouragement for speaking about mental health leads to a more positive perception of how society regards mental health. Previous literature shows that supportive social networks can serve as a major protective factor against mental health disorders (Inman et al., 2007). Within the more community-focused collectivistic South Asian culture, the effects of support systems appear magnified. For some participants, supportive social networks were the impetus for first exploring mental health treatment. One interesting pattern found in this theme is that these support systems all seemed to consist mainly of other women, regardless of whether in a one-on-one or a group setting. Only two participants specifically mentioned relying on their husbands as a part of their support system, while either a mother, sister, daughter, or female friend was mentioned as a source of support by all women. Daughters were particularly influential in getting their mothers to agree to try mental health treatment, which suggests that female-oriented intergenerational support is important. This corresponds to prior literature about the importance of traditional gender roles within South Asian culture that tends to separate men from women, resulting in women having stronger relationships with other women rather than other men (Farver et al., 2002; Jin et al., 2022). The encouragement of family members or close friends is what helped some women overcome their initial hesitation and the cultural stigma against mental health. In this manner, a support system could perhaps lead to an increase the likelihood of seeking professional help, especially as more and more people engage in the

practice. However, for other participants, strong support systems essentially provide them with all the mental health support that they need, thus reducing their likelihood of using professional mental health services. This observation aligns with previous literature about South Asian communities preferring to use social networks for support rather than professional treatment (Inman et al., 2007). They do not seek further treatment because they have no need for it - their support systems are enough to provide the emotional regulation they need. The ultimate effect of social support on treatment-seeking behavior is therefore inconclusive and case-dependent. However, treatment-seeking behavior is in fact just an intermediary step in the process towards better mental health outcomes. Regardless of whether it leads to mental health treatment, social support has a strongly positive effect on mental health outcomes. Either the support system is enough to keep their mental health in good condition, or if the person is dealing with mental health issues beyond the scope of social support, the support system will encourage them to pursue professional care. Social support can also lead to better control beliefs, since a support system can help refer the individual to places where they can receive care.

Similar to social support, the influence of negative cultural values also has a strong effect on normative beliefs, but in the complete opposite manner. While support systems seem to establish a subjective norm of approval for mental health treatment, the influence of cultural values still leads women to perceive social pressure against mental health treatment. Women in South Asian culture still face numerous challenges when it comes to achieving equality (Farver et al., 2002; Jin et al., 2022). Mental health concerns therefore appear to be compounded by traditional patriarchal gender roles that limit women's freedom. As seen in previous literature, the large number of participants who still perceive a strong to moderate severity of stigma and an overemphasis on presenting an idealized image to society indicates that the cultural values

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present in immigrant communities are still by and large influencing people against seeking

mental health treatment (Das & Kemp, 1997; Leung et al., 2012). This perceived pressure to

maintain a "normal" or "healthy" image can be connected to the adverse effects of the "model

minority" myth explored in existing literature on Asian American mental health (Cheng et al.,

2017). One participant noted that mental health seems to be gaining popularity in communities

actually living in South Asia, and that in her experience, immigrant populations in America

actually seemed more resistant to mental health treatment. This was an interesting observation

that perhaps might be explained through immigrant communities clinging to the cultural values

of their youth in South Asia, rather than the slightly more progressive cultural values present in

modern-day South Asia (Dasgupta, 1998; Farver et al., 2002). As immigrants, these communities

have reduced access to societal changes in South Asia, but at the same time, they eschew the

cultural values of America as too foreign. What results is a "freezing" of cultural values from

decades earlier, where mental health is still a taboo topic, even though that is not necessarily the

case anymore in South Asia (Farver et al., 2002). Further study should be conducted on how this

cultural freezing affects attitudes towards mental health. These old cultural values contribute to a

strong subjective norm of avoiding mental health topics. This appears to be a strong attitudinal

barrier that prevents many women from following through with mental health service utilization.

Within the theme of negative influence of cultural values, the treatment of women has a

strong effect on control beliefs. Participants report seeing many women in their community

limited by gender stereotypes and a lack of opportunity, which corresponds to existing literature

on how women are subject to greater scrutiny and pressure to uphold traditional gender roles

(Farver et al., 2002; Jin et al., 2022; Masood et al., 2009; Sayegh et al., 2013). The imbalanced

power structure reduces the amount of autonomy women have over their own lives, thereby reducing their perceived behavioral control.

The fourth theme of structural barriers directly corresponds to the concept of control beliefs in the Theory of Planned Behavior. Financial barriers deterred many participants from following through with therapy, since they did not believe they could afford treatment. The lack of financial autonomy for homemakers, as well as the lack of driving ability, relates to previous literature about traditional gender roles that increase mental health challenges for women (Farver et al., 2002; Jin et al., 2022; Sayegh et al., 2013). The logistics of maneuvering America's complex health system was also seen as a significant deterrent for perceived behavioral control. This fits in with previous literature on the importance of social and family networks that help new immigrants gain a foothold in the country and understand how these systems work (Tewary, 2005). Since South Asian American communities do not tend to discuss mental health services, immigrants do not have their usual resource of social networks to guide them through the process of seeking mental health care. This reduces their perceived behavioral control, which is associated with lower rates of mental health service use.

Recommendations

Based on these findings, recommendations were formed, including strategies for mental health promotion interventions, as well as for future studies on this population. Ideally, future studies would strengthen the relationships previously presented in the discussion section or shed light on new relationships between concepts.

Create Interventions Using Support Systems

One of the positive impacts of collectivistic cultural values appears to be the strong social support systems that can work against the perceived negative impact of cultural influence. Since

support systems seem to have such a strong impact on mental health outcomes and mental health service utilization, interventions to improve mental health for this demographic should ideally be conducted at the community or systemic level, rather than the individual level. For example, seeking out community leaders who are open to the idea of mental health treatment and having them act as key informants for interventions can be especially effective here. Interventions that recruit community leaders who have experience with mental health issues to act as mentors to other women undergoing mental health distress could be ideal for this population. Women who have experienced postpartum depression, for example, can be recruited to check in with new mothers about their mental health needs. Similar tactics can be used for other specific mental health concerns. Using preexisting social groups, such as religious groups at temples and mosques, and introducing mental health management as a social activity can also be a good strategy to improve mental health outcomes. Encouraging these groups of women to discuss mental health issues can go a long way towards decreasing stigma within the community.

Recruit Volunteers to Act as Mental Health Treatment Guides

One major logistical barrier mentioned by participants was their confusion surrounding the complex American healthcare system. To address this barrier, an intervention that recruits women with experience receiving mental health treatment to act as "mental health treatment guides" and assist new patients in finding the right treatment. These guides could help supplant the usual social network that South Asians usually use to find help and information regarding various American systems.

Increase Telehealth Service Options

Telehealth services can help address the logistical barrier of lack of transportation that some women may experience. Targeting these services more specifically towards South Asian

American women by advertising at local places of business or religious buildings can help increase mental health service utilization.

Research Cultural Freezing

Further study could also be done on the finding about "cultural freezing", regarding how immigrant communities may be more conservative and resistant to change than modern South Asian communities. This phenomenon has only been minimally examined two decades ago, and would benefit from further scrutiny (Farver et al., 2002). In particular, it would be interesting to see if the advent of technology since "cultural freezing" was first noted in 2002 has affected this phenomenon in any way, since modern technology has increased the rate of cultural exchange between countries. Understanding "cultural freezing" to a greater degree can help address how to remove this barrier for women needing mental health services.

Examine Effect of Migration Year on Acculturative Stress Experiences

The participants in this study immigrated to the United States between the years of 1974 to 2006, which spans four different decades of migratory experiences. Many factors have changed within those four decades, including the proportion of South Asians in America, cultural values both in South Asia and the United States, the ease of communication between countries, etc. These factors would likely affect the migratory experiences and perceived acculturative stress of immigrants. Future studies could examine whether different decades of immigrants experienced different amounts of mental distress due to differing migratory experiences.

Update Prevalence Data

In order to accurately gauge the severity of the mental health burden and track the effectiveness of interventions, updated prevalence data for mental health disorders within South

Asian populations is urgently needed. As previously noted, current data is outdated, and it is difficult to find disaggregated statistics on the mental health of South Asian Americans specifically. Ideally, a study on the prevalence of mental health disorders on South Asian Americans should also examine prevalence within the different South Asian subgroups to give a fully comprehensive overview of mental health needs and avoid homogenizing the population.

Repeat Study with More Representative Sample

Repeating this study with a more representative sample of the South Asian American diaspora, including all South Asian subgroups, could potentially shed light on any differences in mental health experiences between subgroups that were not detected within this study.

Strengths and Limitations

One major strength of this study is its exploration of a very underrepresented group within mental health research. This study offers unique insight into the lived experiences of South Asian American women, who face a significant mental health burden that has only recently been examined. Furthermore, this study's sample incorporates multiple subgroups of South Asian Americans, including not just Indian Americans, but also Pakistani Americans and Bangladeshi Americans, thereby more fully representing the South Asian demographic. Not only are these three subgroups the most populous South Asian subgroups in America, the proportion of Indian Americans, Pakistani Americans, and Bangladeshi Americans within the study also roughly follows the overall proportion of these subgroups within the South Asian American diaspora. Another strength of the study is its use of the Theory of Planned Behavior, which is a reliable and well-established framework often used to analyze barriers for health behaviors.

A limitation in the methodology of this study lies in its recruitment process. Since some participants were contacted using existing networks based around South Asian mental health,

these participants came into the study with an already established interest in mental health. Therefore, the generally positive attitude towards mental health treatment seeking behavior may not be representative of most middle-aged immigrant South Asian American women. Women who did not speak English had to be excluded to ensure commonality across interviews; however, since lack of fluency with English is associated with heightened barriers to mental health service use, this decision may have ended up excluding a subgroup of South Asian women who would likely have been experiencing heightened levels of acculturative stress (Ahmad et al., 2005; Karasz et al., 2016; National Alliance on Mental Illness). Furthermore, the study's use of online recruitment and Zoom software may have excluded women who were not familiar with technology. This study would also have been strengthened by the inclusion of women from all South Asian subgroups, rather than just Indian Americans, Pakistani Americans, and Bangladeshi Americans.

This study also did not consider the influence of South Asian subcultures or religion on participants' observations and experiences of mental health. South Asia consists of a diverse set of subcultures, languages, and religions - even within just the country of India, North Indian and South Indian cultures are quite different. However, for ease of analysis, this study did not examine each culture and religion separately. Grouping all of the region together in this manner may have resulted in an overgeneralization that misses useful trends in the data. An approach that analyzes the impact of religion and culture on attitudes about mental health may shed further light on South Asian American mental health.

It is definitely possible that further relationships exist between the various properties, which can be better identified through more data. With more time, this analysis could be

expanded to be more comprehensive. Overall, this project barely scratches the surface of what analysis is possible within the framework of this study.

<u>Conclusion</u>

Feminist theory and the Theory of Planned Behavior were two particularly applicable theoretical frameworks for examining the treatment-seeking behaviors of South Asian American women. The themes that emerged from this qualitative analysis contributed in various ways to the concepts presented in the model of the Theory of Planned Behavior. Based on the findings, normative beliefs seemed especially influential on behavioral intention for this population. Normative beliefs were affected by two opposing themes of positive social support and negative influence of cultural values. To increase treatment-seeking behaviors for this population, interventions that emphasize positive social support to counteract negative cultural influence, as well as interventions to reduce structural barriers, would both be particularly effective. Future directions for research should include gathering more accurate prevalence data for this demographic.

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