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**INVESTIGATING HELP-SEEKING OF THE
INDIAN DIASPORA IN THE UNITED STATES**

A Dissertation in

Counselor Education and Supervision

by

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ABSTRACT

The focus of this study was on the Indian diaspora, ages 19-31, in the DC metro region of the United States. The purpose of my study was to explore the perceptions and lived experiences of help-seeking reasons and methods through a cultural lens using qualitative, phenomenological research methodologies. Information about the history and culture of India, as well as multicultural counseling competencies and Bronfenbrenner's Ecological Systems Theory (1977) were utilized to inform this study and data analysis.

Several findings emerged from this study. Categories of perceived acceptable and unacceptable reasons for seeking help were discussed and included academia, career, immigration, medical issues, and relationship issues. Cultural perceptions of mental illness, treatment of mental illness, mental health, counseling, and colonization also had shared perceptions among the participants. Finally, methods of help-seeking including spirituality, family, friends, a community with a similar cultural background, and self-reliance all emerged from the interviews as shared lived experiences of the participants.

Findings demonstrate the close ties that Indian immigrants keep to their country of origin in thoughts, values and beliefs, while simultaneously trying to navigate their host country's culture. Further research is needed in the integration process with this population to provide insights into the healthiest way to acculturate. Post-colonial theories should be researched to expand knowledge on identity development of Indian immigrants. Additionally, holistic counseling approaches should be researched and utilized with this group, who remains so tightly connected to their country of origin.

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“Everything we hear is an opinion, not a fact. Everything we see is a perspective, not the truth.”

— Marcus Aurelius

CHAPTER ONE: INTRODUCTION

South Asian Indian immigration to the United States is a fairly recent phenomenon with growth becoming most rapid more recently from 1990's to present day. Whatley and Batalova (2013) assert the United States is now home to 1.9 million Indian immigrants as of 2011 making them the third largest immigrant group, accounting for 5 percent of the country's 40.4 million immigrants. This population has grown to 150 times its size since 1960 when the Immigration and Nationality Act opened the channels for Asian Indian migration to the United States (Whatley & Batalova, 2013). Authors have all asserted that Asian Indian immigrants consider it vital to keep ties with their heritage throughout their acculturation process, often going as far as reinventing Indian culture in the United States (Bhattacharjee, 1992; Dasgupta, 1998; Farver, Narang and Bhadha, 2002; Mehra, 1998; and Naidoo, 2005). Whatley and Batalova (2013) show this to be true as their research affirms that one-third of the Indian immigrant population resides in only two states. The culture identity and worldview of Asian Indians including holding a collectivist orientation and emphasizing the extended family group and group interdependence are maintained through a network of religious institutions and cultural associations within areas highly populated with this immigrant group (Dasgupta, 1998; Farver, Narang & Bhadha, 2002). The systems that support Asian Indians are a natural way to explore the adaptation as immigrants to the United States. A broad framework that captures the cultural experiences of the participants, including the impact of acculturation through immigrating to the United States is Bronfenbrenner's (1977) Ecological System's Theory.

Bronfenbrenner's Ecological Systems Theory (1977) ascertains that human development occurs in varied systems. The largest system in which development takes place is the macrosystem and this includes cultural attitudes, which has embedded in it microsystems.

Immigrant adaptation assessment should take into account the range of contexts within which the individual is operating. Salo and Birman (2015) emphasize that immigrants experience the microsystem of both the United States and India, pointing out that school or the workplace would be focused on the macrosystem of the United States, and home life would be focused on the macrosystem of India. Previous literature highlights the difficulties that immigrants have generally in adaptation (Bhugra & Ayonrinde, 2004; Bhugra & Becker, 2005; Das & Kemp, 1997; Dasgupta, 1998; Farver, Narang & Bhadha, 2002; Naidoo, 2005; Virupaksha, Kumar, & Nirmala, 2014). Bronfenbrenner's Ecological Systems Theory, (1977) would suggest that not only does the Asian Indian immigrant experience the mental health difficulties of any immigrant in adjustment, they also experience the concerns that are transferred with them of the general Indian population since that culture is recreated here (Bhattacharjee, 1992; Dasgupta, 1998; Farver, Narang & Bhadha, 2002; Mehra, 1998; Naidoo, 2005; Salo & Birman, 2015).

Currently much of the literature about India emphasizes the rapid economic growth that is transforming the nation. Jain and Sandhu (2013) have noted this rapid industrialization is leading to some serious mental health concerns such as marital discords, anxiety, substance abuse, and domestic violence. The National Institute of Mental Health and Neurological Sciences (NIMHANS, 2005) recorded around 100 million people in need of services (Murthy, Isaac, Chandrashekar & Kumar, 2005). Although the Indian government made an attempt to address this growing issue in 1987 through the Mental Health Act, it was severely limited to serious psychiatric disorders (NIMHANS 2005). Therefore, people with every-day mental health disorders are being overlooked.

There are also traditional ways of healing that are given precedence over counseling to solve personal issues (Campion & Bhugra, 1998; Saravanan et al, 2008; Quack, 2012; Raney &

Cinarbas, 2005). Authors (Jain & Sandhu, 2013; Kakar, 1991; Quack, 2012; Raney & Cinarbas, 2005) include shamans, astrologers, priests, and family members in the list of possible types of traditional ways of healing that could be utilized in India. These same authors go on to maintain that people are accessing these traditional forms of healing before trained professional both due to the lack of access to trained professionals but also because of the lack of cultural relevance Western-trained counselors are exhibiting in their practice. The use of these traditional models in conjunction with mental health counselors necessitates a cultural finesse.

Authors Jain & Sandhu (2013) stress that there is a need for trained mental health counselors to help with growing number of mental health concerns. These issues can also be transferred to individuals of Indian origin living outside of India. With the growing number of Indians immigrating to the United States, especially in the last 25 years, these issues are now being seen in Indian clients in the spreading diaspora, in addition to the issues generally associated with immigration and acculturation (Bhattacharjee, 1992; Das & Kempt, 1997; Dasgupta, 1998; Farver, Narang & Bhadha, 2002; Guzder & Krishna, 2005; Mehra, 1998; Naidoo, 2005). There is now over 40 percent of Indian foreign-born that have arrived in the United States in the year 2000 or later. Counselors need to be trained in a culturally sensitive manner in order to develop a working therapeutic alliance with the people of India to provide the best care possible. This can only be attained through working in conjunction with the cultural practices that the diaspora state as important (Jain & Sandhu, 2013; Kakar, 1991; Quack, 2012; Raney & Cinarbas, 2005).

Statement of the problem

George and Pothan (2013) have shown that the main reason that psychotherapy initially failed in India was due to a lack of cultural relevance. Westernized forms of therapy were

liberally applied to a non-Western culture without ever considering their wants, needs or desires. Traditional forms of healing and outside sources of support such as family, spiritual guides, yoga and meditation were not considered or included in the treatment of people who were struggling with issues of mental health. Additionally there is very little research that asks people from India what they view as helpful in regards to mental health. In fact, the counseling profession in the form of outpatient practice is still in the very beginning stages in India (Carson, Jain & Ramirez, 2009). Authors Jain & Sandhu (2013) as well as Carson, Jain & Ramirez (2009) have hailed this time as the “golden era” for counseling in India. The future outlook for India and the surrounding region is bright, as this nation is ready for trained counselors to begin serving the desperate need. Globalization along with modern day living that includes increasing pressures is forcing people in India to seek professional assistance for their emotional problems. This extends to the Indian diaspora around the world, and most especially, the United States as the number of immigrants from India with 1.9 million immigrants being from India (Whatley & Batalova, 2013).

Qualitative research is done even less with the population of Asian Indian immigrants than the limited general research in counseling and without this research it is difficult for counselors to move forward with this profession in a nation that desperately needs assistance because of the lack of information about what the population believes it needs and the culturally appropriate ways counselors can meet that need. Although authors such as Hunt (2011), Kleinman (1987), Seidman (2006), and Whitley (2014) have ascertained how this approach lends itself to the counseling profession, there is little qualitative research being done in India itself and even less with the Indian diaspora. Qualitative research working with indigenous populations in the United States have found that more work needs to be done to provide appropriate, culturally

sensitive interventions for minority groups in the United States (Whitley, 2014). Whitley (2014) goes on to state,

“...emic perspectives must be elicited to better understand the experience of emotional distress and mental illness. These studies suggest that the one-size-fits-all solutions at both national and global levels will unlikely work given the diversity in notions of suffering, contexts of healing, and structure of (formal and informal) health care systems...knowledge produced by anthropological studies must be marshaled to catalyze change” (p. 505).

The aim of this study was to examine the lived experiences of Indian immigrants in the United States and their help-seeking perceptions, seeking to understand their “notions of suffering, contexts of healing, and structure of health care systems” as Whitley (2014, p. 505) suggests. I sought to utilize an emic, phenomenological research perspective in order to examine a culture group and their perceptions and experiences around this particular phenomenon.

Research Questions

Two primary research questions have been addressed in this proposed study. In this section I will explain how each question addresses distinct aspects of the lived experiences and cultural contexts of the Indian diaspora in the United States. In the research questions certain terms will be used such as Indian Diaspora, help-seeking, and mental health issues. I will briefly discuss these terms, but will elaborate on the meaning of these terms in the *Definition of Terms* section of this chapter.

Research Question 1: How does the Indian Diaspora in the United States perceive and describe their pattern of shared lived experiences of help-seeking?

To address this research question I have developed interview questions to the lived experiences participants have related to their particular, culturally mediated, behaviors, perceptions and feelings around seeking help as a minority of Indian immigrants in the United States. The aim of this research question was to gain understanding about the general lived experiences of help-seeking before addressing mental health more specifically.

Research Question 2: What are the perceptions and lived experience of help-seeking for mental health issues of the Indian diaspora in the United States?

This research question is focusing on the phenomena help-seeking within the context of mental health. Just having the word "experience" is a way of pointing to the fact that I was seeking comprehensive stories from the participants about how they perceive and describe mental health or help-seeking behaviors in their everyday, lived experiences. The word "perceive" implies something about the relativity of help-seeking- it's perceived differently by different people and by the same person in different situations. This is what I hoped to uncover through this study. The cultural implications cannot be ignored, as it is a specific cultural group of which I am describing the experiences. I was hoping to investigate what the lived experiences of seeking traditional methods of healing are for the Indian diaspora in the United States, such as how they seek this type of help, who do they turn to, and what the availability of services would be in the United States.

Significance of the Study

The population of Indian immigrants to the United States is rapidly expanding, (Terrazas & Batog, 2010; Whatley & Batalova, 2013), yet there is a significant lack in research about the interplay between Indian culture and counseling as well as help-seeking of this particular cultural

sub-group of the Indian diaspora in the United States in the counseling literature (Whitley, 2014). There is no shortage of mental health complaints that people in India are currently suffering from and the immigrant population are carrying these issues over and compiling them with a host of new issues just in the immigration process itself (Bhugra, 2004; Bhugra & Becker, 2004; Bhui, Stansfeld, Head, Haines, Hillier, Taylor, Viner & Booy, 2004; Carson, Jain & Ramirez, 2009; Eisenbruch, 1990 & 1991; Farver, Narang & Bhadha, 2002; Guzder & Krishna, 2005). In filling this gap, I went straight to the source to discover how this particular group is seeking help- who they are turning to for support, what supports exist for them to access in the United States that is culturally appropriate, and whether or not they actually utilize them. I was also looking to investigate what this group perceives as mental health and how they receive support for issues of this nature. My goal was to better understand the wants and needs in order to provide outreach and services to this neglected minority population by informing counselors with this information. The importance of this study cannot be disregarded as researchers are calling for qualitative research, which takes into consideration the application of western-based therapies, noting particularly that diagnostic criteria cannot and should not be utilized in non-western settings too rigidly without first researching the context of suffering and healing (Whitley, 2014).

Limitations of the Study

Limitations of the study could possibly include sample representation and researcher bias. My sample was recruited from the Washington DC area, including southern Maryland and Northern Virginia. This sample limits diversity regarding geographic location. It is important here to note that the goal of my research is to not be generalizable, but rather transferable to the degree to which the findings in the research are transferable to other settings (Hunt, 2011). In this

case, my findings will only be transferable to other people in the Indian diaspora in the United States in the same geographic location of my future participants (i.e. the East Coast).

Additionally, as a woman from the United States who is in a relationship with an immigrant from India and is also from the same geographic location as the participants being studied, there is significant room for researcher bias. Patton (2002) warns us that there could be numerous factors that could influence the data collection process as well as the analysis processes. My knowledge of the Indian population such as popular culture, Hinduism, and Hindi that I share with participants may increase the quality of the researcher participant relationships. There may be a bias towards my own culture in the United States or towards the Indian diaspora that I am interviewing as I am deeply invested in people from each culture. To address these biases, I used various methods to enhance the trustworthiness and quality of my study, such as journaling to bracket my emotional reactions and member checking. These methods will be discussed further in chapter three.

Definition of Terms

Indian Diaspora and other Ethnic Identity. Terrazas & Batog (2010) give us this definition: “Note: There is no universally recognized definition of the term diaspora. Most often, the term includes individuals who self-identify as having ancestral ties to a specific country of origin.” (Size and Distribution section, para. 11).

In their study Terrazas & Boaz (2010) used everyone who selected “Indian”, “East Indian” or “Punjabi” in response to questions on ancestry in order to calculate the size of the Indian diaspora in the United States, which gives readers an idea of how to organize this group. For counselors, this information holds significant value. These subgroups cannot be ignored or considered enculturated into the United States or we are in danger of colonizing them in our own

minds and taking away from them the ability to think or act in different ways. The Indian perceptions, values, and beliefs are still deeply ingrained and should be accessed and utilized when in therapy. The same issues that are currently affecting India will also be affecting the immigrant population and diaspora with whom counselors in the United States will be working. When discussing particular articles or studies, I have applied the terminology used by the authors such as “Southeast Asian Indians” or “Indian immigrants”. Some authors clarify their use of ethnic labels or explain how participants in a study were ethnically identified while others do not. I have used the information given to clarify ethnic labels and sample demographics if possible. Otherwise I have referred to my population as the “Indian diaspora”. When interviewing participants for this proposed study, I have used the terms that they are most comfortable with as they introduced and identify themselves.

Immigration. Migration has been defined as someone who alters their primary residence from one political margin to another and is a social phenomenon that can be understood as part of the larger society (Virupaksha, Kumar & Nirmala, 2014). Not only is this a physical action by a person or group, it is also a process of adaptation to a new environment. Immigration, in particular is the process of people moving to a new country. For the sake of this study, immigrants were people who have moved from the sub-continent known as India to the United States. Migration is a complex process. Virupaksha, Kumar & Nirmala (2014) have noted that people who migrate from developing countries such as India to developed countries such as the United States are hesitant to access needed services. It should be acknowledged that the word “immigrants” as well as “diaspora” tends to be used interchangeably in the literature.

Acculturation. Acculturation is also a part of the process of migration. Farver, Narang & Bhadha (2002) have noted that acculturation is generally concerned with behaviors, while ethnic

identity is more concerned with attitudes. Acculturation and ethnic identity will be discussed further in chapter two to put the participant population in context.

Help-Seeking. Help-seeking refers to a broad idea of the behavior, perceptions and feelings people experience when seeking assistance for a range of problems, whether physical, social, relational, or emotional. It is a complex decision-making process for a problem that challenges personal limitations (Cornally & McCarthy, 2011). Help could be identified as assistance, guidance or advice for a particular issue, and could include either emergency or non-emergency situations as perceived by the individual. This proposed study sought to investigate what help seeking meant in the context of the Indian diaspora in the United States and in the lived experiences of the participants in particular.

Mental Health Issues. Mental health, as the World Health Organization (WHO, 1946) defines it states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (p.1). This is a holistic definition that acknowledges the complexity of mental health as well as the interrelations between systems of individual health. Issues within this system are anything that could off-set the balance for a particular individual. Indeed, WHO (2014) goes on to state in a later document, "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." (Mental Health: Strengthening our response, para. 2). If there is any possibility of an individual not being able to realize their abilities, coping with normal life stresses, work productively, or make a contribution to the community then that person could have a mental health issue.

CHAPTER TWO: LITERATURE REVIEW

Research suggests that the India diaspora retains their cultural heritage, including the way they seek help, even after immigrating to another country (Dasgupta, 1998; Das & Kemp, 1997; Eisenbruch, 1990 & 1991; Farver, Narang & Bhadha, 2002). There is not much literature, however, discussing how they seek help in the United States, or for what concerns they seek help. In order to better understand the needs of this growing population in the United States, I have reviewed research concerning the Indian diaspora in the United States as well as Indians in their native land regarding mental health and help-seeking. All of this is considered within an ecological systems context.

In this literature review, I will first evaluate the research regarding the history of counseling in India in order to better understand the importance that mental health has played throughout their history as well as the cultural components that need to be infused into mental health. I will then move to discussing post-colonial issues which have deeply impacted this nation and then lead into a critique of westernized forms of counseling and the need for a broader understanding of the original multicultural counseling competencies. I will then place the Indian psyche into context utilizing Bronfenbrenner's (1977) Ecological System's Theory which emphasizes the importance of social systems on development. Finally the literature review will encompass the Indian diaspora and the acculturation process, especially within the United States. However, due to the lack of information of Indian immigrants in the United States, this review has had to encompass the Indian diaspora in other countries as well such as Canada and the United Kingdom. Unfortunately the majority of the research is quantitative which gives us a limited understanding of the experiences of these individuals and is the primary focus of this study as qualitative research is at a minimum in this arena.

History of India

What is now known as modern-day India was the first major civilization in South Asia. The development of India is much too extensive to be covered in one paper; however here I hope to outline to various pieces of India's rich history which would have significance for this particular study, which will mainly focus on culture, spirituality and indigenous methods of healing.

Of note at the beginning of India's history is the Vedic Age, when the original Hindu scriptures were composed and followed. This was an oral tradition that only became written in post-Vedic periods. The end of the Vedic Age lead into the Maurya Empire which became the largest empire in the Indian subcontinent and was pulled together as Alexander the Great and his Greek armies were leaving India. One of the most notable rulers of this time was Ashoka the Great, who brought Buddhism to India and helped this belief system spread across Asia. The Gupta dynasty would be the next empire of importance which ushered in what was known as the Golden Age of India. During this time, the peace and prosperity allowed for discoveries in the arts and sciences to truly bring together Hindu culture. The major concepts of *ayurvedic* medicine from the famous physician Sushruta, in which the original writings of mental health concepts are formulated (and will be explored in more detail later), dates to the Gupta period. Around the 13 century Muslim rule started in the north of India which introduced Islam in its wake and eventually, the rule of the Mughal Dynasty. The importance of the Muslim population being introduced cannot be underrepresented as this was the source of much fighting between the religions and general upset politically in India that continues still today. There was relative peace, however, during this time which led to expansion and economic growth and infrastructure which allowed for new trade routes with the west. Emperors of note during this time are Akbar

the Great, his son, Jahangir, down to Shah Jahan who was responsible for the Taj Mahal and other architectural masterpieces. The late 1700's saw the rise of the British East India Company, which annexed Indian states and set up alliances through treaties with Indian rulers to gain political power. This colonization continues to have unrecognized effects on the Indian population. It is responsible for the dual national languages of Hindi and English that exist even today. British rule established Christianity as well as had enormous influence on the school systems.

History of Counseling in India

Historical Background

According to George & Pothan (2013), the earliest recorded accounts globally of any mental health illness and remedies are from India in the *Artha Veda*. However, as colonization took place in India, Westernized resources and theories in the form of British medicine began to become more common and influential in the culture. George & Pothan (2013) maintain that Westernized psychotherapy was introduced in the 1920's with a focus on psychoanalysis. However, George & Pothan (2013) go on to state that around 1964 discontent with Western psychotherapeutic practices began because people were looking for a more culturally relevant practice.

People in India have a long history of seeking help (physical, mental and basic daily advice), mainly through spiritual means, traditional healers and family resources. As Kakar (1991) maintains, unlike other cultures, the people of India have always sought to explain psychiatric distress and have tried to construct methods to alleviate these disabilities. He goes on to state that there is a general understanding that individuals exist at any point in three major states; soma (body), psyche (self) and polis (social self). The polis includes family members,

peers as well as ancestral spirits and gods (Kakar, 1991). The major healing traditions can be viewed in three forces: (a) folk (or traditional) traditions; (b) mystical (or spiritual) traditions; and (c) medical (or scientific) traditions (Jain & Sandhu, 2013; Kakar, 1991; Quack, 2012).

These are not mutually exclusive but include qualities from each technique.

Folk Tradition

Under the classification of folk traditions comes one of the most ancient forms of medicines practiced in India: *Ayurveda* meaning ‘science of life’ (Das, 1995; Jain & Sandhu, 2013; Kapur, 1975; Raney & Cinarbas, 2005; Wagner, et al 1999). This traditional healing system classifies human problems into the psychic; the internal and the external (Jain & Sandhu, 2013) with the psychic branch of *Bhuta Vidya* dealing directly with psychiatry and mental health (Raney & Cinarbas, 2005). In this practice, the spiritual is still taken into consideration as is the environment, nutrition and emotional welfare to comprise a holistic approach; however the spiritual is not the only focus. Medicines are also utilized as a part of treatment including herbs, diet restriction and oils gained from the natural environment (Jain & Sandhu, 2013; Kapur, 1975; Wagner, et al 1999).

Veerweshar (2002) also states that ‘Mana’ or the mind is also a central theme in the Artha Veda. There are three characteristics or gunas that constitute the mental structure -sattwa (characterized by purity, serenity and contentment), rajas (characterized by love of fame, passion, lust and display of power) and tamas (characterized by anger, greed and ignorance). According to Veerweshar, (2002), all three are present since birth and need to be in a state of balance. If the equilibrium is disturbed, then mental health is likely to be in a state of disorder.

Spiritual Traditions

The second common system of healing traditions is the mystic or spiritual traditions that include Hindu beliefs, Muslim beliefs, Christian beliefs, astrological influences, and palmists. The majority of this study will focus on the effect of Hindu beliefs, as this particular religious tradition has had the longevity to influence the culture the most. Spirituality is a huge component ingrained in Indian society and natives typically seek the help of religious or spiritual healers before moving to western medicine (Campion & Bhugra, 1998; Chowdhury, et al 2001; Hoch, 1974; Raney & Cinarbas, 2005; Saravanan et al 2008; Wagner et al, 1999). Hoch (1974) even suggested that people are more satisfied with the help they receive from religious or spiritual healers over mental health professionals. The majorities of people in India are Hindu or are at least heavily influenced by the Hindu belief system including the beliefs in gods and goddesses as influencing current life situations as well as past lives via the notion of karma (Hoch, 1974; Jain & Sandhu, 2013). It's important here to note that karma stretches across not only an individual's current life cycle but also across the cycle of his past and future lives (Kakar, 1991). Possession of demons and/or ghosts is also embedded in the spiritual traditions (Campion & Bhugra, 1998; Kapur, 1975; Chowdhury et al 2000; Rangaswami, 1996; Wagner, et al 1999). Methods of healing from demon possession could include chaining the individual to the wall in a temple, beating them with a broom (only the demon or ghost would be injured by the beating) as well as prayers, rituals, and traditional types of medicines (Hoch, 1974; Saravanan et al, 2008; Wagner et al, 1999). Even just visiting a temple or living there and becoming a part of the daily life are supposed to have a curative effect (Raney & Cinarbas, 2005).

After the British began colonized India, these traditional forms of healing carried through the British colonization and continue still today. Psychiatry is the closest form to any type of

scientific, or medically bound, mental health care that has been in existence for the longest amount of time in India; ‘counseling’ as we know it is underutilized due to a lack of knowledge as well as a lack of resources (Hoch, 1974; Jain & Sandhu, 2013; Raney & Cinarbas, 2005; Wagner et al, 1999).

Scientific Tradition

Modern medicine (or the scientific tradition), however, has also been respected and utilized in conjunction with traditional forms of healing even if they may seem contradictory (Joel et al, 2003; Saravanan et al, 2008). Many times people have self-assessed when going to a hospital is needed right away especially in when cases are severe such as self-injurious or seriously erratic behavior (Wagner et al, 1999). In traditional medicine in India, meditation and yoga are also utilized as part of treatment. It is important to note that many doctors in India are Indian themselves, and therefore holds to many of the traditional beliefs themselves and are likely to use them as part of their response in treatment (Campion & Bhugra, 1998; Saravanan et al, 2008; Quack, 2012; Raney & Cinarbas, 2005).

Current Mental Health Problems in India

The amounts and types of psychological issues in India have greatly increased and changed over the course of the last ten years. Natural disasters have led to a few of the concerns in mental health (Shah, 2013) although it is globalization that has led to many more crises. Changes in family structure from increased globalization has led to an increase in suicide, domestic violence, increases in AIDS/HIV diagnoses, diversity issues, and immigration as well as a host of common mental health issues (Aggarwal & Berk, 2015; Carson, Jain & Ramirez, 2009; Decker, Nair, Saggurti, Sabri, Jethva, Raj, Donata & Silverman, 2013; Dongre & Deshmukh, 2012; Jacob, 2008; Shrivastava, Johnston, Stitt, Thakar, Sakel, Iyer, Shah & Bureau,

2012). Research in western society has connected these changes to rising rates of common mental disorders (Bor, Dean, Najman & Hayaatbakhsh, 2014). Counselors and professionals need to have an understanding of the growing crises currently in India in order to sufficiently understand and address these issues.

Natural disasters are a constant source of potential crisis in India that affects the mental health of individuals. Droughts, tsunamis, earthquakes, monsoons, famine and other disasters affect the sub-continent and therefore regularly throw communities in crises. In one such instance, an earthquake struck Gujarat, affecting about 16 million people in 21 districts. In a study conducted by Shah, (2013), post-traumatic stress disorder (PTSD) was found in Gujarati survivors of the earthquake as well as difficulty in managing emotions and mental-health related problems due to this tragedy. The team found that empathy, listening and prayer along with modern medical care were what supported the survivors in this time of crisis.

Suicide has long been a prevalent issue in India and is characteristically associated with students due to school-related pressure (Jacobs, 2009; Shrivastava et al, 2012). The highest rates of suicide in India were reported in people under the age of 30 indicating that the majority are of school age (Samuel & Sher, 2013). According to the World Health Organization (2012), 258,000 recorded suicides were Indian suicides. Young people between the ages of 15 and 29 are killing themselves at a rate of 35.5 per 100,000, which is the highest in the world according to the New York Times (2014). Pressure experienced by individuals in academia in India is a concept widely recognized by research (Bertolote, Fleischmann, Leo, & Wasserman, 2004). Opportunities to immigrate, seats and prestigious universities and careers are the limited resources that the mass of India's population is competing against. Sarma (2014) also recognized that self-expectation was considered as a factor related to academic distress which could lead to suicide. All of the

adolescents in a study reviewed by Samuel & Sher (2013) reported experiencing negative life events including failing examinations which led to the rate of 90% of adolescent suicides being impulsive. These high suicide rates in India are a concern for mental health professionals. It was acknowledged in an article by Shrivastava, et al, (2012) that public education and school programs, have been found to be the best strategies in reaching out to people in order to reduce stigma and raise confidence that there is mental health assistance that could be available.

Domestic violence is another significant mental health crisis, estimating that 1 in 3 women face abuse in the form of physical or sexual violence at the hands of her partner (Decker et al, 2013). Globally, women tend to be reluctant to disclose abuse for fear of not being believed or being blamed for the abuse. Additional reasons include the perceptions that violence is normal or not serious, fear of revictimization, or threat of losing children (Fanslow & Robinson, 2011; Miller, Decker, Raj, Reed, Marable & Silverman, 2010). In a study conducted by Decker, et al (2013) it was found that over 90% of participants considered crisis counseling with safety planning as the most helpful intervention. Social and cultural barriers and stigma associated with going outside the familial unit with issues such as these were reflected by only 64% of emergency crisis shelters being utilized. Trained counselors would also be able to offer services to victims observing the abuse or experiencing it firsthand.

India now has the largest number of people infected with HIV/AIDS in the world with an estimated 2.08 million people testing HIV positive (avert.org/hiv-aids-india.htm; Carson, Jain & Ramirez, 2009). This epidemic is predominately concentrated in subgroups such as female sex workers, injected drug users, and heterosexual transmission with unprotected paid sex (Charles, Jeyaseelan, Sam, Pandian, Thenmozhi & Jeyaseelan, 2013). Initially, when the cause of the transmission of AIDS was understood, lack of prevention initiatives and education were the main

contributors to the continuous spread of the disease. Despite the initiatives of numerous programs to educate the population, there are still many people in India that are living unaware of their symptoms. There are currently enormous barriers to antiretroviral treatment. Marginalized groups are typically the main sufferers of HIV/AIDS and stigma and discrimination related to their status as well as the diagnosis compounds the problem, making it even more difficult for these groups to access treatment. Inadequate counseling services as well as inadequate knowledge about the disease and how to treat it compound the barriers these groups experience (Chakrapani, Velayudham, Shunmugam, Newman & Dubrow, 2014).

Diversity issues in India are becoming a crisis that is in dire need of people with training in mental health. These issues include acceptance of persons living with a disability, people who identify as LGBT, and chronic illness but extend far beyond these few. The neglect and abuse of these important contributors to the population is adding to the nearly 30 million people that are struggling with mild/moderate psychiatric problems such as anxiety, depression, mental stress, marital issues, communal violence, substance abuse and the health problems associated with these (Sandhu, 2011; Sinha, 2010). India is sorely lacking in acceptance of diversity despite the fact that the country as a whole seems to promote acceptance of religion, language and other facets. This is made evident by the re-criminalization of same-sex relations just recently in 2013. Prakash (2013) ascertained that the people of the LGBT community are socially ostracized and persecuted by both their community and the law. People living with a physical disability are often treated similarly. The World Bank (2007) reported that there are an estimate of 40-90 million individuals living with a disability; however they are often stigmatized and are rarely able to progress beyond primary school (Singal, 2009). Differences in the poverty level as well as caste issues left over from British colonization cause many issues between subgroups. The

four recognized castes include Brahmins, Kshatriyas, Vaishyas, and Shudras based on ancient Hindu social classification system. Additionally there are three socially disadvantage groups Scheduled Cast (SC), Scheduled Tribes (ST), and other backward classes (OBC) that are currently acknowledged. Scheduled Cast (SC) consists of 16.6% of the population and Scheduled Tribes (ST) consists of 8.6% according to the 2011 CENSUS report. Previous estimates for the percentage of other backward classes (OBC) are between 32% and 52% of India's population, but the current report does not share data for this group. There is a lack of understanding of these post-colonial issues as well as a lack of empathy that makes it difficult to tackle these subversive issues.

Post-colonial Theories and Mental Health

Post-colonialism and psychological theories have had very little to do with each other until the 20th and 21st centuries. However the application of psychology to the field of postcolonial studies in understanding the psychological effects of colonization on the individual- specifically in India- needs to be taken into consideration. As counseling has developed the necessity of viewing India as a post-colonial country and its precise obstacles in deterritorializing and understanding the traumas only colonization can inflict should be considered. According to many postcolonial theorists such as Foucault, Derrida, Chakrabarty, Lyotard, Fanon, Spivak, the roots of this belief system lay in the West, with a Eurocentrism that states that Western rationality is racist and imperialist (Gandhi, 1998). The philosophy of identity that is presented in postcolonial studies is a Western, narcissistic desire to always see the world in our own self-image, and seeing any new culture as the 'other' (Gandhi, 1998). This "otherness" can also be thought of as 'the reminder' or 'the unthought' and can be extended to include anyone unlike ourselves such as criminals, vagabonds, the insane, etc. (Foucault, 1970). Postcolonial studies

join postmodernism to analyze and resist the trend that we need to overcome a particular cultural identity in favor a new, universal identity (Lyotard, 1992; Gandhi, 1998).

Colonization of India

This is not clearer than in Britain's relationship with India. The late 1700's saw the rise of the British East India Company, which annexed Indian states and set up alliances through treaties with Indian rulers to gain political power. It wasn't until 1947 that India regained its freedom. However, colonization left scars that can never be erased or undone. The vision was that the 'adult' British needed to educate, teach, and guide the 'child-like' Indians. It is vocabulary such as the British 'progressive' aiding the Indian 'primitive', the 'developed' British assisting the 'developing' Indian that has continued this colonial school of thought (Gandhi, 1998). These words force a knowledge gap between the enlightened British and the primal Indian that implies that the Indians are childish or less human than the adult-like British. Colonialism is viewed as a development project that brings the lesser humans, the colonized, to maturity. And this knowledge seems only to be obtained in connection with conquest and domination that leaves transgenerational scarring on the colonized throughout history (DeVecchio Good, Hyde, Pinto, Good, 2008; Gandhi, 1998). The social aspects of colonization cannot be overlooked. In India, for example, the Hindu ways of thought and culture have been 'deterritorialized' by the dominant knowledge system of the British. It could not be stated more clearly that in Macaulay's minute of 1835 in which he is discussing the introduction of British education in colonial India:

The intrinsic superiority of the Western literature is fully admitted...It is, I believe, no exaggeration to say that all the historical information which has been collected in the

Sanskrit language is less valuable than what may be found in the paltry abridgments used at preparatory schools in England (cited in Said, 1983, p. 12).

It is clear that the knowledge base, the culture, or the resilience of the colonized group is completely underrated and unvalued by the colonizer. They are only seen as 'lesser' or those needing something that only a 'wiser' or more 'developed' nation can bring. Even psychologists during colonial times assumed that the colonized race was inferior through their observations which were shaped by their own biases (Ward, 2012). This was the basis for anthropological qualitative ethnographical research. Mannoni (1990) argued that there were alternate psychological complexes that characterized colonialism. Dependency was suffered by the colonized while inferiority was suffered by the colonizer (Ward, 2012). But even this struggles to align with post colonialism in that it again perceives the colonized as the disadvantaged child looking to the colonizer to relieve whatever malady that ailed them.

Postcolonial Disorders

Postcolonial disorders acknowledge the presence of the colonizer- haunting in that it is no longer active, but still very much present in everyday life. Formal conceptualizations of postcolonial disorders in relation to psychology have mainly been in relation to Native American Indians in the United States (DeVecchio Good, et al 2008). Critical psychology has only begun to look at postcolonial implications of counseling (Hook, 2012). The psychoanalytic repercussions of the trauma experienced by colored subjects in encounters with White subjects have yet to be fully developed and understood. The internalization of European norms and culture in a way that erases traditional culture is a violation. Ward (2012) states that, "Other effects could include inferiority or dependency complexes, the related internalization of racism, the traumatic legacies of colonization..." (p. 171), not to mention 'postmemory', which is

described as an inherited recall of trauma very closely related to transgenerational trauma from these oppressive circumstances (DeVecchio Good, et al 2008; Ward 2012). Multigenerational or transgenerational trauma and historical unresolved grief characterize the experiences of people who have been colonized (DeVecchio Good, et al 2008; Rentmeester, 2012). The disorders that can then develop by such an erasure of identity are manifest.

Postcolonial Identity

Fanon, in his book *Black Skin, White Masks* (1967) suggests that there become problems with identity development as a child. Through utilizing European fiction and textbooks, children begin to identify with Whites- develop a White attitude and White way of the thinking that is separate from their own culture group (Fanon, 1967). Once a child leaves the village and begins to advance in society, it is only through interactions with others that the child discovers they're not actually White, but belongs to the group that they have been viewing as uncivilized- their own culture group. Imagine the collective identity trauma engendered through this process. This has also been evident in examining the Parsi elite of India who show signs of a schizoid quality of a 'split self' as they try to climb the social ladder of colonized India while still at core desiring to maintain a sense of self (Verges, 2000). "Parsis attack themselves as inadequate- inadequate as Englishmen, inadequate as Indians, inadequate as effective, socially appropriate human beings" (Lurhmann, 1996, p. 14). This struggle is a common marginalization of imperialism in that people can feel the pressure to assimilate to being white while at the same time feeling pressure to also be authentically 'ethnic' (Rentmeester, 2012). An individual's perception of themselves is skewed by the dominant group's views of themselves as 'damaged' and they begin to internalize that sense of self (Rentmeester, 2012). Postcolonial psychology seeks to understand the

relationships between the colonizer and colonized as well as between past and present (Ward, 2012).

Psychological approaches to postcolonial locations seek to understand not only the relationship between different cultures, but also between past and present. We may not yet have seen all the postponed effects of colonization; certainly many of today's racial anxieties in Britain, for example, may be traced back to Britain's colonial past and its historical relationships with formerly colonized countries. (Ward, 2013, p. 181)

Postcolonial Medicine

These issues extend into postcolonial medicine as well. Initially, Western medicine, even in postcolonial studies, was viewed as one of the benefits of European imperialism (Anderson, 1998). However, through deeper discourses of colonialism, it now seems that Western methods may have colonized the body and mind even more than any theorist would admit. This also cannot be separated from violence or conquest in that the main system that spread Western medical theory was through militarization. Medicine can also include psychological studies. In India and other similar cultures, the health of the mind was tied very closely to the health of the body. However, Western medicine again interfered with the traditional methods of healing that were being utilized before Western medicine was known; this was found to be the main complaint of psychology when first utilized in India.

Western Counseling

Western counseling theories traditionally stem from theories developed by white, male, upper class individuals and therefore reflect the societies and beliefs from which they are a part. Azuma (1984) defined the western counseling tradition this way: "Western' tradition which descended from Greco-Roman civilization, incubated in the culture of Christianity, fermented in

Renaissance humanism, achieved the industrial revolution and prospered upon rationalism and individualism.”(p.46). ‘Counseling’ as it is viewed and taught today from the Western perspective reflects these values in that it encourages individualism, talking, emotional expression, assertiveness, engagement for self, insight, self-disclosure, linear and analytic, and distinctions between physical and mental health (Azuma, 1984; Kakar, 1991; Sue & Sue, 2012).

Comparisons Between East and West

However, there is a disconnect when working with people from diverse cultural backgrounds in regards to these values and beliefs which makes counseling difficult if it is constrained to the above framework (Azuma, 1984). This was attributed by Moodly, Rai and Alladin (2010) to the differences in the perceptions of Eastern and Western socio-cultural teachings. In the table below, he demonstrates how an Eastern way of thinking deviates from the Western way of thinking. On the left side of the table he lists certain qualities which according to Western thinking are a ‘good’ thing to have. These are contrasted with ‘negative’ qualities on the right side. The brackets show the Eastern way of viewing the same quality which may be perceived as undesirable behaviors compared to those on the right as desirable behaviors to which should be emulated.

Figure 1:

Perspectives on concepts of normality and health

Assertive	Submissive
(Arrogant)	(Humble)
Independent	Dependent
(Selfish)	(Caring)
Free expression of feelings	Control of passions

(Out-of-control)

(Dignified)

Individual**Family**

(Egotistic)

(Communal)

Eleftheriadou (1994) echoes the above point. She states that Western therapy such as person-centered therapy is very popular in the United States because it emphasizes the importance of the individual, which is a western theme that is naturally encouraged. It holds implicit beliefs that the individual is responsible, and has choice and freedom in his or her own life with no constraints from the family or community. However, in many other cultures this would be unacceptable because one grows up valuing the communal self more than the individual self. Moodly, Rai and Alladin (2010) add that Indian clients can drop out of therapy if they feel their counselor is judging them from a Western frame of reference. He further argues that if a client has a more holistic conceptual system, then the therapist who is encapsulated in traditional Western thinking is not only liable to misunderstand the client but is at risk of colonizing the client through forcing them to think in a way that is unnatural for the client. Most likely clients would then not return for further therapy leaving the therapist to dismiss the client as lacking in motivation or resistant to therapy. There is a need for understanding multicultural competencies that can help bridge this extreme gap (Azuma, 1984; Das, 1995; Sue, Arredondo & McDavis, 1992).

Multicultural Counseling Competencies

In 1969, Vontress produced the idea that culture should be at the core of a client's therapy (Moodley, 2010). According to Moodley (2010), cultural issues have been addressed in counseling theories since the 1960's. Twenty-three years ago Sue and Sue made a groundbreaking change in the history of counseling when their paper on the rationale for a

multicultural perspective in counseling was developed in order to contradict the standing theories of counseling.

Original Framework

Sue et al. (1996) developed the Metatheory of Multicultural Counseling understanding that traditional theories of counseling and psychotherapy are heavily rooted in a Eurocentric viewpoint. This established values in counseling such as individualism, rationalism and autonomy that contradict many of the values held by people of a non-Eurocentric background. In order to work with clients of a diverse or minority background, poor outcomes would be experienced because the theoretical underpinnings of the traditional counseling theories are governed by Eurocentric beliefs and values, and even if eclectic or integrative approaches were to be considered the theories are too different from each other to integrate owing to the very core of how they have evolved (Sue et al. 1996). Due to the criticisms of Western counseling theories there have been recent movements to begin to understand how to better serve people from other cultures, socioeconomic statuses, ethnicities and races (Das, 1995; Sue, 1996; Sue, Arredondo & McDavis, 1992; Sue, et al, 1982; Sue & Sue, 2012).

Sue and Sue (1991) have constructed a multicultural counseling framework that argued that three characteristics of counselors need to be present to be more multiculturally focused. First, counselors need to be aware of their own worldviews and biases. Secondly, they need to understand their client's worldview without judgment. Thirdly, they need to practice intervention strategies that are relevant to the client. Within each of these areas, there are beliefs/attitudes, knowledge and skills sections that expand upon the descriptions.

Counselor's Cultural Biases

When examining counselor's own biases, (for example, if White in the United States) it's most important for counselors to acknowledge how they may be beneficiaries of a certain societal construct (White Identity development models). Culturally aware counselors must also have knowledge about their impact upon their clients (Sue & Sue, 1991). In understanding the worldview of the client, counselors must become actively involved with their clients outside of the counseling setting in order to see the client as more than just someone to be helped (Sue et al, 1982; Sue & Sue, 1991). In development of interventions that are culturally relevant, counselors need to respect and pull in religious or spiritual values as well as traditional healers and indigenous healing practices (Sue, et al. 1982; Sue & Sue, 1991). Knowledge and respect of families and hierarchical structures within a community are also of utmost importance as well (Sue, et al. 1982; Sue & Sue, 1991).

Critique

Since the development of the competencies in 1992, they have had very little change or adaptation and are currently under scrutiny. A large criticism of the portion under interventions; skills #3 that states "seek consultation with traditional, religious or spiritual healers or practitioners" (Sue, Arredondo & McDavis, 1992) is contrasted with "integrate indigenous and traditional healing practices in appropriate and meaningful ways..."(Moodley, 2010). The depth in the change of Moodley's phrase as contrasted with the original listed in the competencies is obvious and important, especially when noting that the major criticism of Western therapy in India in the past was a lack of cultural relevance (George & Pothan, 2013). Religion and spirituality have also been overlooked in multicultural counseling (Moodley, 2010) which is a

huge problem with the grounding of a significant amount of traditional healing methods in India is in Hindu or Muslim spirituality (Jain & Sandhu, 2013; Raney & Cinarbas, 2005).

Counselors cannot just assume that the Western ways of counseling which have been utilized for so long can just be carried over into other culture; that in a sense is a colonization of counseling which would further harm those we wish to assist. It is clear that there have been many detrimental effects of colonization and westernization in India. Counselors should begin to investigate the ways that colonization may have affected current indigenous populations with whom they may be working. Counselors also need to be aware of their own biases and position of power that they may occupy when working with a client from a culture that may have experienced some group atrocity. Counselors should use culturally competent modalities along with collaboration with traditional healing as well as include aspects of the postcolonial characterizations to further inform their work.

A conceptual framework that would be useful in aiding counselors with the breadth and depth of the cultural information would be to view Indian clients through Bronfenbrenner's (1977) Ecological Systems Theory Model. This broad approach to research and conceptualization of human development focuses on the client in the changing environment which he is placed in throughout his life span. This places the client in a larger social context that allows the counselor to view the client holistically rather than just individually, which is a Westernized concept. This fits nicely with the holistic view of a person from India who operates within a collectivist society.

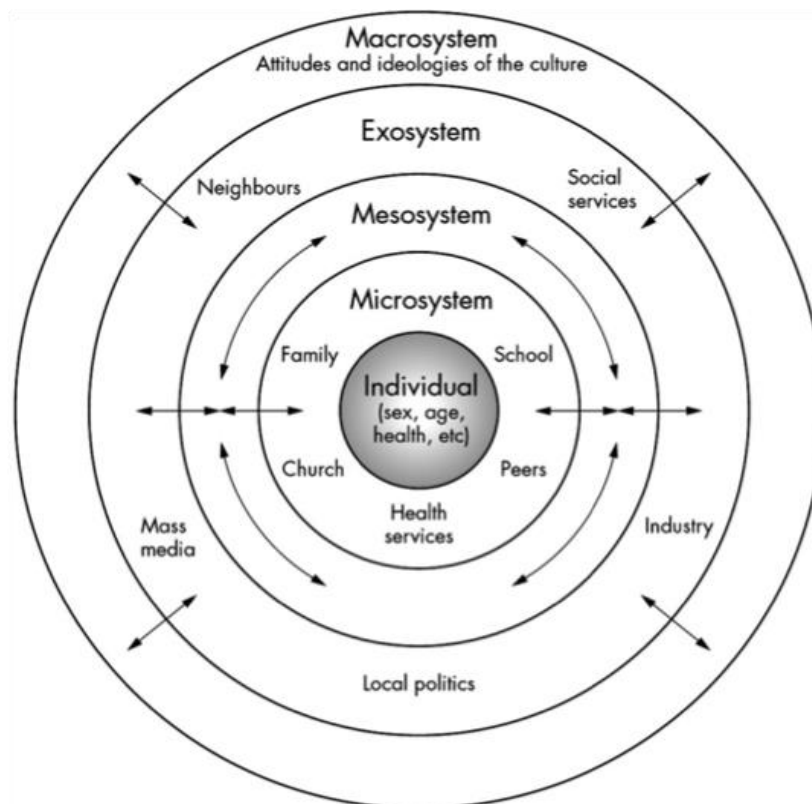
Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner's Ecological Systems Theory (1977) developed from his review of the theories of human development at the time that were too limited and short-lived in scope, and did

not encompass the individual in their full social context. Rather than limiting the understanding of human development to one person in a pre-defined research setting, Bronfenbrenner argued for a multiperson and multisystem interaction of the individual in the environment. Ecological Systems Theory is both an expansion and a convergence of the environment of the individual as described below.

There are 4 systems in which we can place the client- the microsystem, the mesosystem, the exosystem and the macro system.

Figure 2:



Model

The above is an example of Bronfenbrenner's (1977) model and clarifies how the systems are defined and interrelate. This is a nested system, meaning that within each system is the property of the next system. These environments are often not stagnant, but are changeable.

Schools, additions to families, changes in friends, changes in political structures and leaders and changes in places of employment all contribute to these systems. This is not truer than for someone who has immigrated to another country. There could be major shifts, such as the microsystem becoming more distant as people are physically further and therefore less involved in their day-to-day lives. For people from India, this could be a very difficult and significant change as the participant is no longer engaging in particular activities or roles within that system.

The individual is at the center of it all and this includes the sex, age, health, and other factors of the person. Without this basic information, the context would not be clear for how that particular person interacts with their environment as much of the interactions are then constrained by these details. For someone from India, the individual is not as important as their place within the family system. As reported by Farver, Narang & Bhadha (2002), Indian psychologists have noted that a main difference between people from India and people from the United States is in the concept of the self, with the self and the family integrated rather than separate. Although individual biographical information exists, it is all relevant only because of how it exists in the larger system. Kakar (2002) observed that the relational world of India is largely influential on the conceptualization of mental representations that have major implications for treatment. This is rarely acknowledged in the Western psychotherapy literature due to the ethnocentric nature of Western theories of psychology and counseling.

Next is the microsystem which is comprised of the immediate setting the person is contained in such as home, school, work, etc. The person has particular roles constrained to these specific environments such as daughter, employee, parent, or student. When a person from India immigrates to an ethnocentric country such as the United States, these roles within the microsystem are easily confused as the immediate setting is now greatly changed. The

importance of this change cannot be overlooked as the Indian psyche is greatly influenced by aspects of the microsystem such as the family. The wellbeing and honor of the family always takes priority over the individual (Farver, Narang & Bhadha, 2002). The role of son or daughter from a child that now lives in the United States, over 8,000 miles away, creates a gap of significance.

The mesosystem is the interrelations between the person and the major settings in their life. The mesosystem is a system of microsystems, in short. Mesosystems are where the interactions take place. Anytime a person changes their setting or assumes a new role in life, the mesosystem expands. Dasgupta (1998) has noted that the pattern for Indians immigrating to America is that they tend to affirm their ethnicity through reinventing and applying their culture in the foreign country, keeping a collectivist orientation. Individuals are actively involved in the development of their mesosystems as they incorporate the interrelations of family experiences, new relationships, work experiences, or school experiences.

Next is the exosystem and this is an extension of the mesosystem in that it begins to include other areas of social structures that are further out, or have less of an effect on, the individual. This could include neighbors, media, government, industry, etc. However it is important to note here that the Indian exosystem would have been very different today if there had never been a British colonization factor which greatly influenced how the government interacted with individuals in the past that has greatly shaped how the culture has developed today. Farver, Narang & Bhadha (2002) have noted that people from the sub-continent have English as one of their two national languages and have had exposure to Western values and thought due to the colonization of the British.

Finally, we reach the macrosystem which is the attitudes of the culture that affect the individual. This sets the pattern for informal and formal interactions and activities that take place in the exo-, meso- and microsystems for an individual. The macrosystem, or these cultural attitudes, tend to extend to the Indian diaspora worldwide and this group holds these cultural values even years after they have immigrated (Farver, Narang & Bhadha, 2002). This macrosystem is the overarching ideologies that give the framework for the concrete manifestations of the other systems in Bronfenbrenner's Ecological Systems Theory model (1977).

This is an extensive model that encompasses the full development of an individual through the changing environments in which they live and grow. Each system presented here is affected by the immigration of a person of Indian origin that moves to the United States. Acculturation needs to be examined for an understanding of the full impact on the participant.

Acculturation

Acculturation, however, is a difficult process. Recently, acculturation has been defined as “the extent to which individuals have maintained their culture of origin or adapted to the larger society” (Phinney, 1996, p. 921). It has been noted by Berry & Kim (1988), that the acculturation process is more difficult for cultural groups when the difference between the culture of origin and the new culture are significant, leading to higher stress levels as well as difficulties in psychological functioning. For South Asian Indians moving to the United States, it is true that the cultures have significant differences.

Berry's Model of Acculturation (1980) has been utilized in this study to discuss possible modes of acculturation. According to this model, there are four possible ways for an ethnic group to relate with the host culture. First is assimilation. In this mode individuals tend to identify

solely with the new culture and completely cut off from their culture of origin. Secondly is marginalization in which an individual would reject both their culture of origin as well as the host culture. Thirdly is separation, which has the individual rejecting the dominate, new culture and instead identifying solely with their own culture. Finally is the process of integration, (also known as biculturation) in which the individual is able to maintain some aspects and characteristics of their own culture while also acquiring selective aspects of the host culture. Berry's (1980; Berry, Kim, Power, Young & Bujaki, 1989; Berry, Kim, Minde, & Mok, 1987; Sam & Berry, 1995) work has gone on to show that the most helpful mode of acculturation is integration as these individuals experience less stress due to the acculturation process than those who utilize other modes of acculturation.

Ethnic identity should also be considered here in the process of acculturation. Ethnic identity as defined by Eisenbruch (1984) and Phinney (1990) is the degree of ethnic group affiliation or involvement, attitude toward ethnic group membership, sense of belonging to that ethnic group, and self-identification as a member of that ethnic group. There is doubt if an individual can be highly acculturated to Western values and lifestyle while still being strongly identified with their ethnic group of origin (Farver, Narang & Bhadha, 2002).

The process of migration, no matter the method of acculturation utilized, is still a process in which there is a grief reaction and has been identified as *cultural bereavement* (Bhugra & Becker, 2005; Nerhus, Berg, Haram, Kvitland, Andreassen & Melle, 2015). Eisenbruch (1990 & 1991) has done significant research concerning cultural bereavement and defines it this way “the experience of the uprooted person – or group – resulting from the loss of social structures, cultural values and self-identity” (p. 674). The DSM-IV states that the “duration and expression of ‘normal’ bereavement vary considerably among different cultural groups” (p. 740-741).

However bereavement of different cultural groups is often misdiagnosed by Western trained clinicians due to misinterpretations of cultural expressions of grief (Bhugra & Ayonrinde, 2004; Bhugra & Becker, 2005). One way to minimize cultural bereavement is the individual maintaining ties to the culture of origin through ethnic density (living around other people from either the same or similar culture of origin), social support, or maintenance of religious beliefs and practice (Bhugra & Becker, 2005; Bhui et al, 2005). The ethnic identity, in other words, would be strongly felt in order to minimize the effects of cultural bereavement. Dasgupta (1998) has found that the general pattern for Indian-born immigrants to the United States is to affirm their ethnicity by “reinventing Asian Indian culture on foreign soil” (p. 954).

Indian Diaspora in the United States

The amount of research literature about the Indian diaspora in the United States is fairly limited or from over 30 years ago (Das & Kemp, 1997; Dasgupta, 1998). Most of the research regarding this population has come from anthropological or sociological literature instead of the counseling or psychological literature, and the majority of that research is quantitative in nature rather than qualitative (Das & Kemp, 1997; Dasgupta, 1998; Whitley, 2014). Additionally the research is often focused on Indian immigrants in the United Kingdom or Canada rather than the United States (Bhugra & Becker, 2005; Bhui et al, 2003; Eisenbruch, 1990 & 1991; Farver, Narang & Bhadha, 2002; Guzder & Krishna, 2005). The research that has been done on the Indian diaspora in the United States has shown that this group retains its taste for traditional food, values concerning family and religion, and traditional thoughts on gender roles (Agarwal, 1991; Kaul, 1983; Naidoo, 1985 & 1986; Wakil, Siddique & Wakil, 1981). As Vertovec (2005) has observed, “...one Indian diaspora website states, "The Diaspora is very special to India. Residing in distant lands...they have retained their emotional, cultural and spiritual links with the

country of their origin. This strikes a reciprocal chord in the hearts of people of India.” (p.2).

There is a close, feeling of relation between the Indian diaspora and the land and people of India itself. This strong ethnic identity as well as the acculturation style of integration may help to reduce the risk of mental health disorders (Bhui et al, 2005).

Counseling and the Indian Diaspora

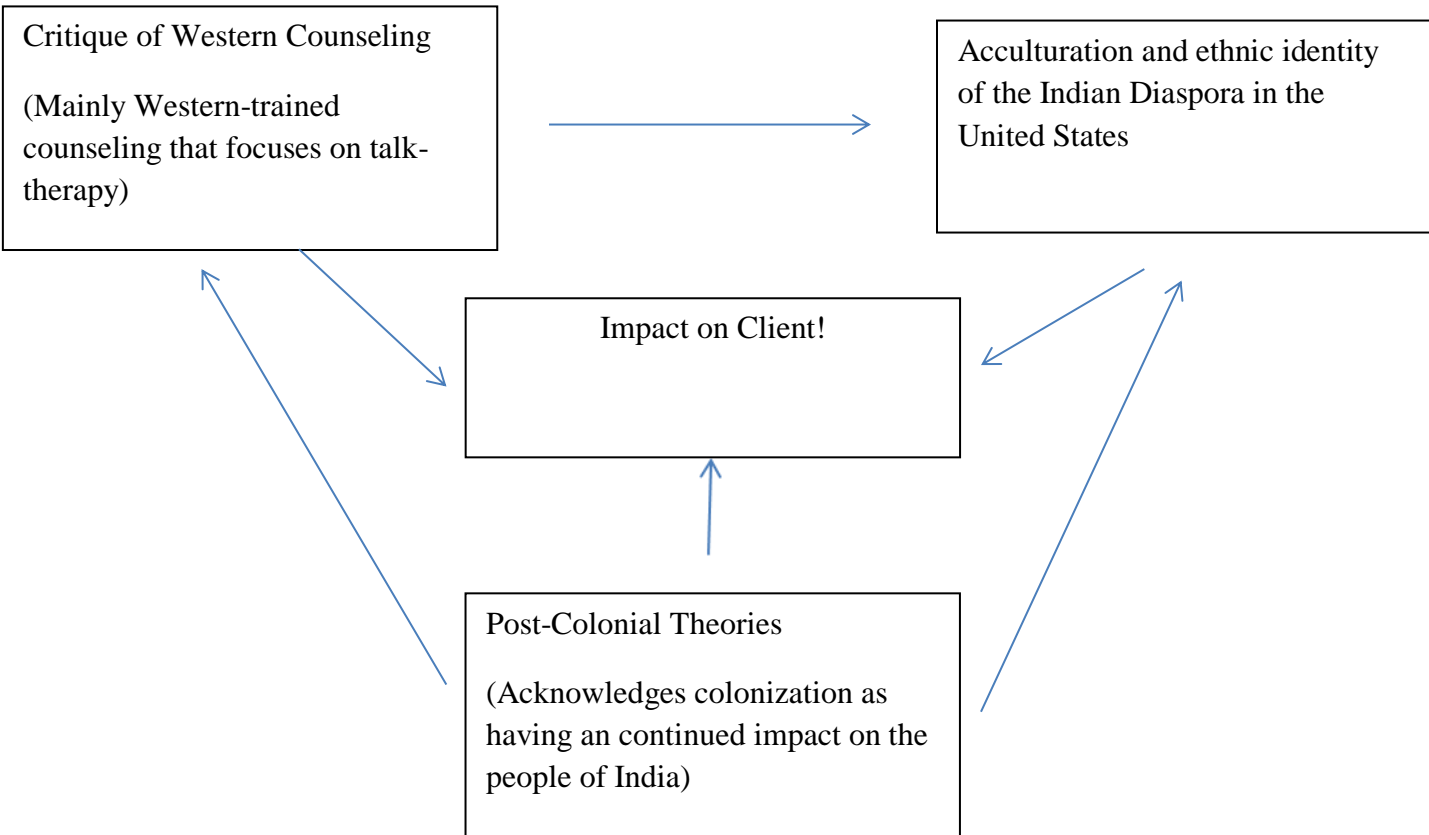
When working with an Indian client it is essential to examine every system in Bronfenbrenner’s (1977) Ecological Systems Theory that would be interplaying on their growth and development, and to include these in interventions and conceptualization of clients. These systems deeply affect the client and cannot be ignored, even when the client is out of their natural country as part of the Indian diaspora. The realms of family, neighbors, friends and spirituality are all so intricately interwoven that they can never be separated from the development of the individual. This would suggest that the same problems that plague individuals still living in India would also be seen in Indian immigrants. In addition, the style and level of acculturation and ethnic identity should be assessed and discussed. The multicultural counseling competencies of the counselor as well as an examination of their own biases should be considered when working with members of the Indian diaspora.

Summary and Conclusions

The concept map below is a working model of the theories that I have touched on in this study and how I see them interacting throughout the research. The theory from which all the research is drawn together is Bronfenbrenner’s Ecological System’s theory. This theory best describes the development of the individual Indian and their affiliation with their environment. Counseling theories discussed mainly focus on the process of mental health and are conceptualized from a White, male, individualistic approach. As India is a nation that was

colonized by the British, how that colonization affected the people and the culture there is very important. Additionally, it has an impact on the development of both multicultural counseling theories as well as major counseling theories. All of these theories individually also affect the client, which is the most important part of the counseling process. My research will look at the utilization of the intersection of these three theories in investigating help-seeking behaviors of individuals of the Indian diaspora in the United States. Below is a visual of the presented concept map.

Figure 3:



CHAPTER THREE: METHODOLOGY

Introduction

The essential philosophical assumption of qualitative research is to understand how people make sense of the world and the experiences people have, and most importantly, this should all be from the participant's perspective. The focus is to understand social settings rather than trying to control them. This research study sought to investigate how a particular culture group perceives mental health counseling concepts. Authors Jain & Sandhu (2013) stress that there is a need for trained mental health counselors to help with growing number of mental health concerns. These issues can also be transferred to individuals of Indian origin living outside of India.

With the growing number of Indians immigrating to the United States, especially in the last 25 years, these issues are now being seen in Indian clients in the United States. Counselors, however, need to be trained in a culturally sensitive manner in order to develop a working therapeutic alliance with the people of India to provide the best care possible. This can only be attained through working in conjunction with the traditional healers and indigenous healing methods that are already in place in the country, as well as seeing the clients in a systems perspective (Jain & Sandhu, 2013; Kakar, 1991; Quack, 2012; Raney & Cinarbas, 2005). Because of the lack of information in counseling of Indian's viewpoints on the profession, I sought to conduct one on one interviews in order to ground the research in how to best serve the population of Indian immigrants in the United States. My research questions include:

Research Question 1: How does the Indian Diaspora in the United States perceive and describe their lived experiences of help-seeking behaviors?

Research Question 2: What is the lived experience of help-seeking for mental health issues of the Indian diaspora in the United States?

A qualitative, phenomenological study would be the best approach to gain this information.

Pilot Study

In order to evaluate the most effective and salient themes in this methodology, I conducted a pilot study in order to a) refine ideas about the selection of participants and the most effective manner of conducting the interviews and b) to refine the questions for the interview to facilitate the sharing of participant's experiences. Findings regarding the shared experiences of the participants in regards to their perceptions of mental health and mental illness will be shared here.

I conducted one 60-90 minute interviews with three individuals who emigrated from India to the United States. These participants were recruited using snowball and convenience sampling and were asked to share their perceptions of mental health and mental illness. To protect the identity of the participants, they will only be listed as participants 1, 2 and 3. They are presented as follows:

- Participant #1 was a man and grew up in a very small rural area in the eastern part of India. He has lived in the United States for 3 years and plans to go back to India after working in the United States for a few years. He is currently working on his PhD in Engineering.
- Participant #2 was a woman who lived in a large city in India before moving to the United States for schooling. She has been here for around 10 years and has no immediate plans to move back to India. She is working in the IT field.

- Participant #3 was a woman who was raised in a rural area in eastern India. She has lived in the United States for a little over 2 years and plans on moving back to India. She is currently working on her masters in engineering.

Over the course of the interview process, several key elements were revealed that offered clarity about the focus of this study. The first was that the focus of perspectives on mental health and mental illness were too broad and not defined enough for individuals to have much experience with or to have extensive perspectives. For all of the individuals, the word counseling had not been heard until after they reached the United States. The second was that there is still an overwhelming amount of stigma attached to the idea of mental health or mental illness and help seeking behaviors regarding this issue and that was confirmed through my research study as participants' evaded questions about personal experiences with these constructs if involved themselves or their close friends or family. One participant disclosed personal experience with a mental health issue for which help was sought, but more research needs to be done before concluding that this is common behavior. This helped me to expand my questions for the current study to incorporate all forms of help seeking perspectives and experiences rather than just restricting it to mental health or mental illness. This also allowed for themes about psychosomatic complaints to emerge more naturally with the participants.

Another trend that was revealed was that in regards to career advice, it is more common and acceptable to seek help. This question was asked in order to complement questions about general counseling and to understand if there was a negative view of seeking help about career in comparison to seeking help for mental health concerns. Therefore, questions regarding career help-seeking were included in the current study. Themes in regards to education and career were another element that I was surprised at coming up in the interviews. The importance and

relevance to counseling, however, kept coming up both in how society responded to people within the educational context as well as the stress that it put on students in Indian culture. Because of the importance of education, exams become more daunting; parents impose more of their views rather than listening to their children's desires; and society places a lot of value on certain careers while looking down upon others. This assisted me in developing further questions regarding education and academic pressure in the current study. In conjunction with education was the theme of ragging that came up quite powerfully through the interviews and was something that was not anticipated. Due to being aware of this from the pilot study I was able to incorporate those questions regarding ragging that may have led to help-seeking for the participants in the current study.

In addition to enlightening the use of effective language, the interview itself was deemed to need more reflection of participant's experiences, rather than only including quantitative-type questions. Interviews will adhere to predetermined questions, but will follow stories shared spontaneously and encouraged through the use of prompts. This permitted more flexibility and honest revelations for participants in the current study. Furthermore, the organization of questions needed to be rethought for the current study.

The pilot study included too many personal questions at the beginning, which did not allow for a gradual sense of rapport building and relationship before engaging fully. For the current study the questions were re-thought to have a gradual build up from the contextual questions of the individual to the more personal and thought-provoking questions. There were other instances of language use that also needed to be changed, such as questions that include more than one thought and those that were vague or didn't make sense to the participants. When designing the questions for the current study, Indian immigrants were consulted so that the

wording would be relevant to the participants. In addition, my committee was involved in the development of all the questions to be sure they adhered to my methodology. The pilot study made me more aware of perceptions and setting that influence the findings of this study, and will be evaluated in the analysis.

Qualitative Research

Qualitative research is rooted in cultural anthropology and sociology (Kirk & Miller, 1986). Attention to qualitative research is increasing across a variety of disciplines, education and counseling being two of those areas (Hays & Wood, 2011; Hunt, 2011). The purpose of qualitative research is to allow professionals to understand and gain knowledge in a particular social situation or cultural area without having any preconceived ideas about potential findings (Creswell, 2014; Hunt, 2011). Creswell (2014) asserts that by the very nature of qualitative methodology, the researcher is able to move out of the quantitative framework of causal or predictive relationships and generalizability to instead focus on the individual differences and opinions related to sensitive cultural issues.

I sought to utilize an emic, phenomenological research perspective in order to examine a culture group and their perceptions and experiences around a particular phenomenon. Morrow (2007) described qualitative research as by its very nature being emic which means that it is distinctive to a few individual and group participants' views, therefore allowing for the "lived experiences" of marginalized groups of people. A qualitative research design for the intercultural study is appropriate and valuable as it focuses on the particular phenomenon of mental health and counseling from an emic perspective, which not only empowers minority clients but also allows individuals from India to be heard and understood at the deeply cultural level.

Numerous researchers (Creswell, 2013; Morrow, 2007) have stated that philosophical underpinnings should be considered before deciding and selecting the appropriate research paradigm that fits the particular study. Because my personal belief in life is that there is no single truth or explanation that exists to describe a particular phenomenon, I am drawn to the interpretive-constructivist research paradigm (Morrow, 2007). It complements my values that there are multiple realities and interpretations related to every interaction that we experience throughout life. This particular paradigm heavily influenced the development of this study including the research questions, data analysis and interpretations of the results (Morrow, 2007).

Phenomenology

One of the five main approaches to qualitative research is phenomenology. The significance of this particular process was inspired by a branch of philosophy that focused on how individual experience with a particular phenomenon is changed into consciousness or realization (Merriam, 2010; Moustakas, 1994). As previously stated, phenomenological research is unique in that it focuses on the “lived experiences” of the participants that is part of their everyday world (Merriam, 2010). Phenomenological researchers are interested in the “essence of the shared experiences” which is the central meaning understood through some particular phenomenon- this case, mental health counseling. These particular experiences are compared and analyzed between participants to identify the essences of the phenomenon in order to understand it better. The assumption of essences is the crucial trait of a phenomenological study (Patton, 2002). Eventually, patterns and themes emerge that describe the thoughts of the group around a particular phenomenon; in this case, mental health and counseling (Hays & Wood, 2011). The collaborative relationship with participants as well as the focus on shared experiences is what drew me to use phenomenology as my research design in this study.

While choosing this design, however, I had to be sure that it fit with my interpretive-constructivist paradigm. Again, this paradigm states that multiple realities exist for the phenomenon under research and that there is no single universal truth. I feel that phenomenology is the right fit for this particular study because it allows me to give voice to an underrepresented and under-studied culture (Indians). Due to the fact that I am using descriptive phenomenology rather than interpretive it allows me to set aside my assumptions related to the phenomenon and ask open-ended, descriptive questions that will help to capture that true “essence” within the research study.

Limitations:

There were a number of limitations to this study. The first is the access to all of the different sub-groups of India that reside in the US due to language barriers and finances to travel and interview each of them. The study was limited by accessibility to immigrants of India that are currently residing in the United States in the DC metro area, which also presupposes a certain social economic status of the aforementioned group; namely people within a higher SES. Although India is represented by many different religious groups within it, the largest population residing in the United States is of the Hindu tradition, and therefore people that identify as Hindu were represented in this study.

Delimitations:

I choose a very particular group of people to study. The group was limited to individuals who need to identify with their Indian culture and still retain Indian citizenship to ensure their commitment to their culture and identity. They were not in counseling or psychology educational programs in order to sample from individuals without a deep knowledge of the field and thereby representing the majority of individuals in India.

Participants

Participants were gathered in a snowball effect type of sampling method from mutual friends. This was both convenient and practical; I have many friends that are Indian and utilized that connection to find participants that fit into the parameters of the study. The participants did self-identify as Indians and hold on to traditional beliefs and practices in order to keep their culture despite the length of time they have been living in the United States through religion, language, choices of food and the people surrounding them, and other common cultural experiences. Although many Indians appear to be Westernized (in dress, job choice, being English speaking, or in living arrangements) it is important to remember that we cannot then divest them of their natural cultural heritage (Laungani, 1997). Therefore despite how these participants may “look” to a Western outsider, we cannot also ascribe to them a Western mindset.

South Asian Indians tend to develop a collective group while in the United States- mainly living with and having friends from the same cultural group as their own. The greater DC metro region is an area that is known for having people with the same cultural background with Whatley and Batalova (2013) stating the numbers as 82,300, or 4 percent of the Indian Immigrant population residing there. This area has many Hindu temples, Indian grocery stores and restaurants that cater to this particular population. Although the participants may occasionally wear Indian traditional dress for formal occasions, they typically dress in western garb. The age group naturally ranged from ages 18-35, as Indian born immigrants are more concentrated in the working ages than immigrant numbers overall (Whatley & Batalova, 2013).

There were some natural exclusions to the participants. I only pursued participants that are of Indian origin and still hold Indian citizenship. I found a distribution of gender that is

representative of the Indian born immigrant population in America; four men and three women. This is to hope to give a sense of transferability across the Indian immigrant population within the United States, and possibly to the more widespread Indian diaspora. The way of living for immigrants is not that different as living in India itself in the sense that Indians tend to naturally group together around a common language, food, spirituality and other cultural norms. It is even normal for many Indians to work for companies that hire people of similar background therefore the native language can be spoken there as well.

According to Whatley and Batalova (2013), the top working sectors are information technology, management, business and finance. The seven participants found were also from these classifications. This makes transferability much easier although not assumed. More research will need to be done in order to determine how much transferability can be assumed.

As asserted by Creswell (2013), one feature of phenomenological research method is the use of a small sample size, typically between 5-25 participants. I had seven voluntary participants complete the study. At that point, data saturation had been met in the responses from the participants (Creswell, 2013; Hycner, 1985). Due to the sensitive nature of the data being collected, the participants will remain anonymous; however I will give some contextual information about each individual.

Participant 1: This individual was a 31-year-old woman from a large coastal city in western India. She immigrated to the United States as a student around 10 years ago to complete her master's degree in Electrical Engineering and is engaged to a white American man. She has one brother and is currently an engineer for a large satellite-based communications company. Both of her parents currently live in the city and hold advanced degrees.

Participant 2: This individual is a woman from both a large central city and a large northern city in India that immigrated to the United States less than one year ago to study in the biological sciences. She is 19-years-old and has one older sister that is also in the United States. Her father is currently in the military and both her parents hold degrees.

Participant 3: This individual is a 31-year-old man from central India. He immigrated 9 years ago as a student in information technology and currently works for his uncle in a local Indian grocery store. He is from a rural village where his family continues farming. Neither of his parents is educated nor holds degrees.

Participant 4: This individual is a 30-year-old man from a large city in central India and is currently married to an Indian immigrant as well. They have lived in the U.S. for nine years. He is an engineer at a satellite communications company and originally immigrated to obtain his master's degree. He has two older sisters who live in India along with his parents.

Participant 5: This individual is a 26-year-old man that immigrated to the United States at the age of 17 for college. He is originally from a large central city in India and has one older brother. His mother holds a degree while his father holds an advanced degree, both in the arts. He is currently in the information technology side of a printing company.

Participant 6: This individual is a 31-year-old woman from a large city in the most southern part of India and immigrated to the United States around 8 years ago to obtain her master's degree. She is currently an engineer for a satellite communications company, and has one sister in the United States that is also an engineer. Both her parents hold bachelor's degrees.

Participant 7 is a 30-year-old man from a large city in northern India that immigrated to the United States around 10 years ago to complete his bachelor's degree in electrical

engineering. He currently works for a satellite communications company and is engaged to a white American woman. He has one older sister and two parents that hold advanced degrees.

There were some commonalities across most of the participants. Most of them were from large cities in India, with parents and siblings that were educated with at least a bachelor's degree if not an advanced degree. All participants went through high school in India, with a few of them having some college experience in India before continuing their education in the United States. All participants studied information technology of some sort. All of the participants grew up at least bilingual, some trilingual with English being at least one of those languages. It is also important to note that the participants were from a middle-to-higher socio-economic status. These participants came from India and immigrated as students (either bachelor or master level) and therefore have the financial status to support higher education. All participants immigrated alone originally, and none of them have parents that reside in the United States with them. All participants have immigrated to the east coast and are currently settled in the DC metro area.

Data Collection Procedures

Merriam (2010) has asserted that the human instrument is an ideal way of collecting and investigating data because humans have the ability to be receptive and flexible in data gathering, especially considering that in qualitative research understanding is the objective. The researcher (here, myself) is the primary tool for collecting data and conducting the research and cannot fail to have some personal interpretation and construction of meanings throughout the process. It will be impossible to remain "outside" of the subject matter for the research as I have my own personal opinions and biases which may influence the research questions or interpretation of the narratives. Moustakas (1994) has stated that self-reflection is a key part of the research process and that the researcher needs to understand and comply with this element throughout the life of

the study. Although I work hard not to have any biases when working with people from diverse backgrounds, it is very difficult not to frame their experiences through my own lens in order to try to connect to build the therapeutic alliance. Using qualitative research methodologies is very important to me because it leaves room for not putting my frameworks or beliefs on another culture group; not assuming that I know the best way to incorporate counseling into the Indian culture, and not imposing counseling in a colonistic way that will only retraumatize an already post-colonized and traumatized group.

Researcher personal narrative and assumptions

I am a 31 year old American woman pursuing my doctoral degree at The Pennsylvania State University. As a woman from America I came in contact with different cultures daily as the United States is commonly understood to be a blend of many different races, ethnicities and cultural backgrounds. I have moved many times in my life which has allowed me to understand the within group differences in the United States. I was born and grew up in the southeastern part of the United States for the first 12 years of my life, then moved to New England where I lived for 17 years. Although I initially grew up in an extremely low socio-economic class as a child, I was lucky enough to travel internationally since the age of twelve. Through school trips and trips with religious organizations I was able to travel to the United Kingdom and to Jamaica. Since then I have traveled personally to France, Italy, Mexico, Canada and numerous islands in the Caribbean. I have also traveled around the United States along both the east and west coasts as well as in the Midwest and the Hawaiian islands. This has given me extensive experiences with many different regions of the United States as well as the world and has put me in touch with many minority groups. The expanded worldview I gained has greatly shaped my perspective throughout my life and has taught me a value for human life and the lived experiences globally. I

believe this has driven my interest in and desire to do intercultural research. I knew through research that nations that became Westernized or industrialized quickly typically began to show many issues with mental health. I wanted to research what impact that might have on the people as well as their personal ideas of mental health, mental illness, counseling and other related constructs.

Although many nations drew my interest (Turkey, Egypt, India, Japan, Malaysia, and the majority of the Middle East), I decided to choose a nation that spoke English as a primary language. This was for ease both for me as a new researcher and also for financial purposes. Therefore I chose to do my research on India. My personal investment in India is very close to my heart, as my partner is Indian. He has greatly shaped my view of India and my perspectives on his country. He has also been teaching me some conversational Hindi as well as current pop culture (music and movies) which I gave me the resources to naturally build rapport with the participants and make them more comfortable to openly share their personal experiences with the concepts I am researching.

We currently live in the DC metro area where the Indian immigrant population is very large. There are numerous Indian grocery stores in our town which we frequent and our friends are mainly Indian immigrants, one of which that has a white American partner. We frequently communicate with our friends and family in India, moving freely between Hindi and English to do so. We also watch a mix of Hollywood and Bollywood films and listen to a mix of music in both English and Hindi. We celebrate both Hindu and Christian holidays in our home. I have now traveled to India myself and was there for three weeks in my partner's home with his family of origin. We have traveled in Agra, Jaipur and New Delhi. This has given me the indigenous

experience with a family in India and has expanded my knowledge and understanding of India and its people.

Procedures

Patton (2002) asserts that interviewing as the chosen research method is to discover what is going on in the mind of the participant. He states:

We interview people to find out from them those things we cannot directly observe. We cannot observe feelings, thoughts, and intentions. We cannot observe situations that preclude the presence of an observer. We cannot observe how people have organized the world and the meanings they attach to what goes on. The purpose of interviewing, then, is to allow us to enter into the other person's perspective. (p. 340)

A survey cannot accurately capture the full essence of a phenomenon such as mental health counseling. Therefore, the use of an interview as a method of inquiry is necessary because this particular phenomenon has such a wide scope (Merriam, 2010).

I decided to utilize the semi-structured interview format with the participants as that allowed me to follow some specific set of questions but also allowed them to guide the discussion and to teach me about topics that they considered to be associated with mental health counseling that I may not have considered. The order in which I asked the questions that I had was standardized as this allowed me to obtain complete data across the participants and increased the comparability of the responses (Patton, 2002). When formulating the original interview questions I used guidelines set forth by Patton (2002). I believe it necessary to include McCracken's long interview method as a guide, although he is an ethnographic researcher, to be sure to include the ethnographic elements that focused on culture and not just phenomenology, as this is a culturally-bound study. I also made use of numerous probes to collect the most detailed

information possible throughout the interview process and to clarify when necessary (Rubin & Rubin, 2005).

The three different probes set forth in the research included elaboration, continuation, and clarification/steering probes. Elaboration probes consisted of questions that I asked after a main interview question in order to get more detail about a particular answer or topic (Rubin & Rubin, 2005). Continuation probes were utilized in order to keep the participant talking, establish rapport and helped me to refrain from providing any responses that could have positively or negatively affected their experience (Rubin & Rubin, 2005). This included “mm hmm”, ‘ok”, or “yes”. Clarification probes were used when I had difficulty understand the participant’s grammar or language around a particular topic or subject matter (Rubin & Rubin, 2005). This typically included “can you tell me more about that?” or “what do you mean by that?”.

The procedure for data collection was to meet with and interview the 7 individuals about their perceptions of mental health and mental illness and counseling. I then met with and conducted each interview myself in order to both provide safety and for ease in gathering more participants via the snowball effect. Each session was audio taped for transcription purposes with the knowledge and consent of each participant. The aim of the study and implications of participation was clearly explained to the participants. There was also a chance for the participants to read and review the transcriptions in case they had anything to add to what they had said previously, or to correct something if they felt it was off base. This gave the participants an additional chance to be involved with the process and added a level of transparency that I believe to be important and added to the validity and reliability of the study. Finally, each participant received a final copy of the dissertation as well, to continue transparency.

Data Analysis

For the purpose of this study I decided to follow Hycner's (1985) phenomenological analysis process to guide me through my first project. He outlined a 14-step phenomenological analysis process that comprises of, (1) Transcription; (2) Bracketing and Phenomenological Reduction; (3) Listening to the interview for a sense of the whole; (4) Delineating units of general meaning; (5) Delineating units of meaning relevant to the research question; (6) Training independent judges to verify the units of relevant meaning; (7) Eliminating redundancies; (8) Clustering units of relevant meaning; (9) Determining themes from clusters of meaning; (10) Writing a summary of each individual interview; (11) Return to the participant with the summary and themes, (12) Identifying general and unique themes for all the interviews; (13) Contextualization of themes; and (14) Composite Summary. Some of the steps will be combined for the ease of reading through the material and where appropriate.

First I conducted the interview and transcribed it myself. I did this for a few reasons. Firstly, I am greatly concerned about the confidentiality of the participants mainly for my own personal concerns as I want to be sure protect them to the furthest extent of my ability. I want to also capture the verbal and non-verbals that I knew had existed during the interview process. Finally I wanted the experience of true submersion into the data to get a sense of it both as a whole as well as in pieces once I began to analyze individual segments.

The next step of bracketing means to refrain from making assumptions about the content that the participants gave me through the interviews about help seeking. This did not mean that I forgot all of my own values and experiences, but instead would take the time to examine them fully so that I would be able to separate my beliefs and suspend them while allowing the phenomena to naturally emerge from the data I had collected (Giorgi, 1997). This was difficult

especially during the interview process when I wanted to correct an assumption about the phenomenon being studied or to voice my opinion on a topic of interest. However, I recorded my own thoughts later in my research journal so that the thoughts were known and could be examined during the review process.

Delineating units of meaning is the piece that I spent the most time on and was the most enjoyable for me throughout the research process. Each verbal and non-verbal detail through the seven participants' interviews was examined to understand and stay true to the participants' meaning and experience with the phenomenon of help seeking. First the literal quote was scrutinized. Next, lines from the quote were pulled out and separated to examine even more carefully. I then found units of relevant meaning from those units of general meaning. I then utilized the qualitative software Nvivo to assist in clustering these units with direct quotes to support the formulation of the cluster, and those then moved on to become central themes. Each central theme is supported with numerous quotes from this research process. Although extremely time consuming, this was be the meat of the research process and I gained so many exciting insights. For the process of writing up a composite summary (Hycner, 1985) of the interviews which will capture the true essence of help seeking, I utilized Nvivo to assist me. I was able then to quickly group codes under the themes that I constructed through the process of delineating units of relevant meaning.

Trustworthiness

Trustworthiness incorporates being conscientious of accounting for multiple perspectives of a qualitative study (Patton, 2002). Trustworthiness criteria help establish the quality of the research and include: credibility, transferability, dependability, and confirmability (Hunt, 2011). In this

section, I will define each condition and discuss methods I employed specific to each measure to increase the trustworthiness of my study.

I also used a hermeneutic position in which I acknowledge that I cannot transcend my own social, historical, and cultural contexts. These conditions of trustworthiness take the appropriate steps (i.e. bracketing) to ensure that as much as possible, my position and context are known to the reader. My interpretations as a phenomenological researcher are always from a certain perspective contained within biases. As a result, I do not claim that my interpretations are the only interpretations possible, but that they are viable and grounded in the evidence provided (Hycner, 1985; Moustakas, 1994; Patton, 2002). The terms used below to discuss validity were coined by Lincoln and Guba (1985) and are alternative terms to the traditional quantitative counterparts in order to be more congruent with qualitative work (Creswell, 2007).

Credibility

The accuracy of the information gathered throughout the research process is credibility (Creswell, 2007). My study was enhanced by using rigorous research methods and establishing the credibility of the researcher (Patton, 2002). Rigorous methods that were included consist of prolonged engagement, data triangulation, peer review, and member checking. Prolonged engagement includes building trust with the participants and learning the culture. As I am currently living with a member of the Indian diaspora, and am consistently surrounded by members of that same group, I am daily faced with the food, language, popular culture (i.e. movies and music), religion, and holidays of the group being studied. This prolonged engagement naturally assists me in building trust with the participants in the geographical area and greatly contributed to the validation of the study (Creswell, 2007).

Data triangulation involves comparing the consistency of information obtained at different times during a study and by different sources within the same method (Creswell, 2007; Patton, 2002). I used the literature/theories and interviews as a method of triangulation. Therefore, I have already reviewed both qualitative and quantitative articles in my research area that provided a foundation for the purpose and importance of this study. These articles can also be seen as investigators that provide the corroborating evidence for my study (Creswell, 2007). I then conducted individual interviews to collect narratives on the lived experiences of help-seeking behaviors which gave me data for the study. Ultimately, data triangulation enabled me to see multiple perspectives of the phenomenon I am investigating (Patton, 2002). A strong external check of the research process was done through peer review or peer debriefing. In this process the researcher was kept honest through the peer asking difficult questions that are akin to being a “devil’s advocate” during the research data collection, challenging assumptions made to push for further understanding (Creswell, 2007).

Written accounts were kept in order to provide a detailed record (Lincoln & Guba, 1985). Reflexivity in the form of self-reflective journals, research memos, and writing as a method of inquiry in my dissertation to reveal information about myself that may have impacted data collection, analysis, and interpretation were used to establish credibility of the research (Creswell, 2007; Patton, 2002). These various writing methods, which I discussed in previous sections, promoted self-awareness of my own biases and also illuminated my credibility as a researcher by giving readers insight about aspects of myself such as gender or ethnicity that impacted my attitude toward participants and the way I interpreted their experiences.

Finally, member checks were solicited from the participants on their views of the data and credibility of the findings as well as the researcher’s interpretations. Data analysis and

conclusions were taken back to the participants via email so that they could judge the accuracy and credibility of what has been collected, both at the rough draft and final phase of the study (Creswell, 2007). This process is considered to be the strongest and most important method for establishing credibility in a study (Lincoln & Guba, 1985).

Transferability

Hunt (2011) describes transferability as the way in which findings can be applied to other contexts or settings. Thick descriptions of the researcher themselves, the context the study occurred in, the interactions of the researcher and participants all give readers the information they need to decide whether or not the findings can be applied to other contexts (Creswell, 2007; Hunt, 2011). If the description does not have enough detail, the reader cannot make an educated decision regarding transferability. Transferability is understood to require shared characteristics between the participants or context (Creswell, 2007).

I sought in this study to describe the lived experiences of help-seeking of members of the Indian diaspora in the DC metro area; however there is a possibility of extrapolation of findings to other members of the Indian diaspora throughout the United States. I remain very specific about potential extrapolations because due to the depth and small sample size of my study, I am cautious about transferability. Furthermore, as a researcher with a constructivist approach, I am interested in the particular experiences of the people with whom I will be working. I sought to learn about the specific contexts they discussed, the cultural variables they introduced, and how they interpret their perceptions of help-seeking. The purpose of my study is not to promote one perception of truth or to make generalizations (which are unsuitable for qualitative research), but rather to provide different perspectives and encourage dialogue about these perspectives to enhance counselors' approaches to outreach and service (Patton, 2000).

Dependability & Confirmability

Dependability is similar to the quantitative term “reliability” and is defined as how dependable a study appears (Creswell, 2007). Dependability also refers to how stable the approach would be if another research tried to replicate the study (Creswell, 2014). Documenting the steps of the procedures to have a detailed protocol that is easy to follow assists in ensuring dependability. Creswell (2014) recommends other procedures include checking transcriptions for mistakes and constantly comparing the data with the codes to guarantee there is not a drift away from definitions of codes. As previously mentioned, researcher credibility was established through the use of reflexivity journals. I also worked to maintain confidentiality of participants by using coding for participants and by not revealing any personally identifiable information. Only I had access to the interview audio recordings. All electronic files containing data were password protected and only I had access to these files.

Conclusion

In this chapter I have described the constructivist and critical frameworks that underlie my dissertation study. I also described my selection of a phenomenological research approach to obtain in-depth insight about the identity development and cultural navigations of people in the Indian diaspora in the United States and their help-seeking behaviors. My data collection, procedures, and analysis are all informed by phenomenological methods in which the objective is to understand the meaning that participants ascribe to their lived experiences.

Due to my own identity as an American woman in close relationships with people of the Indian diaspora in the United States, it was imperative that in this chapter I addressed managing my own biases during the research process and establishing trustworthiness of my study. Using various methods to establish trustworthiness, such as data triangulation and respondent

validation, increased my self-awareness, and fostered a study that acknowledged participants as valued members of the research process.

CHAPTER FOUR: FINDINGS

This study was intended to investigate help-seeking patterns shared among members of the Indian diaspora in the DC metro region of the United States. Interviews were held with seven Indian-born members of the Indian diaspora in which participants shared their perceptions of help-seeking as well as patterns of the shared lived experiences of help-seeking specifically within the context of mental health. Stories that describe how participants perceive mental health, mental illness, and treatment for these issues were all explored. Participants were aged 19-31; all were Indian-foreign born and had been in the United States for around one year but no more than 10 years. All were in the information technology field and all but one participant had at least a bachelor's degree. Their experiences and ideas will be explored here with respect to the research questions intended by this study, and will then be compiled into a summary of the meanings of these experiences for these Indian immigrants in regards to help-seeking.

Research questions were broad so as not to restrict the scope of information that participants might reveal and hinder the phenomenological nature of the study. Furthermore, excerpts from interviews have not been modified for grammatical correctness when necessary and when it didn't take away from the participant's original meaning in order to maintain the integrity of participant contributions. Participants were assigned numbers in order to maintain the confidential nature of information shared. Participants will be referred to as P1 for participant number 1, P2 for participant number 2, P3, P4, P5, P6 and P7 throughout the body of the study. Brackets will be used to clarify roles, names, work places and other identifying information to continue to protect the anonymity of the participants.

Research Question 1: How does the Indian Diaspora in the United States perceive and describe their pattern of shared lived experiences of help-seeking?

This research question was intended to explore the perceptions of help-seeking for all types of issues. Responses ranged from seeking help for medical issues, to immigration issues as well as relationship problems. These responses were narrowed down and organized into categories and themes based on issues for which participants sought help as well as their general perceptions of help seeking. The categories and themes were as follows:

<ul style="list-style-type: none"> ❖ Perceptions of Reasons to Seek Help <ul style="list-style-type: none"> ➤ Academic Issues <ul style="list-style-type: none"> ▪ Ragging ▪ Pressure ▪ Decision-Making ▪ Immigration ➤ Career Issues ➤ Immigration <ul style="list-style-type: none"> ▪ Racism ▪ Bicultural Relationships ▪ Identity Struggles ➤ Medical <ul style="list-style-type: none"> ▪ Homeopathic Medicine ▪ Returning to India ➤ Relationship Issues 	<ul style="list-style-type: none"> ❖ Cultural Perceptions <ul style="list-style-type: none"> ➤ Colonization ➤ Mental Illness <ul style="list-style-type: none"> ▪ Bollywood ➤ Mental Health ➤ Treatment of Mental Illness <ul style="list-style-type: none"> ▪ Spirituality ▪ Science ➤ Counseling <ul style="list-style-type: none"> ▪ Stigma 	<ul style="list-style-type: none"> ❖ Help-Seeking Methods <ul style="list-style-type: none"> ➤ Spirituality <ul style="list-style-type: none"> ▪ Karma ▪ Parental Respect ➤ Familial Support ➤ Friend Support ➤ Similar Cultural Background ➤ Self-Reliance
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Perceptions of Reasons to Seek Help

General perceptions of help-seeking were for categories such as academic issues, career issues, processes related to immigration, medical complaints, and relationship issues. A consistency that emerged was that almost every participant discussed help-seeking as something they would do as a last resort, or only after trying to figure it out on their own. Their perception seemed to be that it was something negative that Indian-born people would not want to do. The pattern of their shared experiences seemed to indicate the same as six out of seven of the participants shared the following thoughts and experiences.

P2: I would suggest very rarely will you find people who come and ask for help.

P5: So as long as you follow things, and you read the brochures and pamphlets they give you and you talk to people, you can, you can manage to get everything you need.

P6: Because Indians tend... I don't think everyone's open to seeking help in any way for that matter. When you go to a grocery store and have a problem not everyone's going to ask someone "can you help me find this?" They try to figure it out. I think they're more ashamed or they feel embarrassed if someone they think that they expected to know things.

P7: I guess more like dealing with it yourself, maybe like venting to friends. You know? I think I have more of the attitude where of you just force yourself to get over it, or just nature plays it course.

Two participants mentioned this as something that they knew they needed to do, but not acting on it for different reasons.

P1: So, I guess, we always need help. It's about telling yourself if you need, you need help and then you really need to go see somebody about it. Or, you just going to sit on it and say I need help but I don't care enough to go act on it. People know they need help but they don't act on it. They just want to avoid facing it or dealing with it until someone gives you that push and says "hey you know, it's about time." I am someone who also doesn't mind not dealing with it so I would like to sit on it for the most part but I think I'm self-motivated. At the end of the day there's times when I say ok now it's ok I don't need to deal with it but then I will tell myself ok it's about time.

P7: Yeah, I'm ok doing it; I just don't bother doing it much. I'm just lazy, just feeling like I'll get to it when I get to it and not really ever getting to it. It's pressing, it's important,

but I think I'm like whatever; I'll do it when I need to. Not even really need to but I should do it at some point, but it just delays...

Three participants shared that they would be open to help seeking as indicated above by comments such as "yeah I'm ok doing it" from participant 7, as well as the following thoughts.

P3: Yeah best thing is just ask for help you know like if you if you don't know just ask somebody, your friend, your family, "I have this problem," just don't hesitate.

P6: I mean I'm not the shy type so I know that so I won't even think of it as help, like seeking help. If you approach things in that way it's never feeling that you are the victim or the inferior person's going out and having to seek help. So maybe it's helped me out in the past too because lots of times you notice...I mean work here after coming here if you are in the class you know that there's majority Indians. You find that students are actually trying to whisper in each other's ears "what did the professor say right now?" And I've heard the professor screaming there "don't talk, ask me if you have any questions" I'd rather raise my hand and ask a question to the professor than just whisper with my friends like "what he just say right now?"

Academic Issues. The participants in this study reported three different subcategories within academic issues: ragging (known in the United States as 'hazing'), pressure within academics, immigration, and finally confusion in decision-making regarding academics and career choices.

Ragging. Ragging was mentioned by two of the participants that had attended a bachelors program in India. The following experiences indicate this phenomenon.

P1: It's hardcore. It's hardcore. The extent. Because it's, it's pretty bad. I [experienced it] a little bit like here and there. Like I never lost sleep over it. Like not that bad at all. It, it's worse when you live in dorms. I lived at home with parents.

P7: Yeah that's very common in Indian colleges, especially the kind of colleges where you're like living. Not like day school or whatever you want to call it. And I think what we went through is probably on the lower scale than the stuff that you hear about. I mean from stories and stuff you hear from people and newspapers and people killing themselves and IIT hazing and stuff like that. Like sexual activities and things like that, or like medical schools where like they strip you naked and you run around corridors holding the dick of the guy behind you as like a train, like things like that happen, like that's very common in India in engineering and medical schools. Kind of like first semester the first three or four months like everyone had to have their head shaved to a number 1 or a number 2, so probably say like this [demonstrates]. And you had like a dress code which was rubber flip flops, the typical blue and white ones which we have in India; I forget what they're called. And khaki pants and a shirt outside, hanging out. Like simple things like that. Like there were a couple of incidents like here and there, where one of these guys got a little more aggressive, who like slapped some people, you know, cause they were like drunk one night after the party and they like yeah, they like slapped us and left like marks on like our face. And then it was pretty much soon after that that it ended, cause people got really upset by it. One of the guys in our batch like popped, supposedly popped a lot of ibuprofens and like landed up in hospital cause he was so upset.

Pressure. Pressure was a main subcategory mentioned by all the participants in regards to education, both pressure put on themselves and pressure from parents. Participants shared the following comments regarding this subcategory for help-seeking purposes.

P1: Right there's always the pressure. It's like parents look at you in a way and compare you. The biggest problem that I have with Indian parents from my time is they always compare you with kids around you. But they're always compared. Then there would be the class toppers, and they were asking about how's so and so's score, how's that one's score, so that, then they would compare you. That's the Indian attitude. I wish I don't do that to my kids. I really wish. Cause it's ingrained in me. My parents did do it, they pushed me on the edge because they always prepared me and I knew they were asking about the other kids and...Going home with my grades, I knew what was coming. Like, you know, if I didn't do well I knew what was coming. And they were never content with, hey, you got an A...no, where's the plus. They always needed the extra. It was always pressure. So that's how I feel sometimes with work too.

P2: That was just like one time I really got a bad grade...and you know how particular we are about grades. Like B's not an option for you. So... But like I ended up getting a 3.8 GPA, and everybody around me was like you are a nerd, you're so smart, you're this and that. Only my family was like only if you got one more A it would have been 4.0. And then look on your transcript there would have been 5 As. Now there were 4 As and 1 B does that look good?

P3: I just I was doing bad so I dropped [the course] and I should not have done it. So then I had problem, then I was like nervous and I couldn't tell my uncle... uncle was mad but I told him "hey I dropped this one [course]" so then I looked online, so they say we can reapply, so I reapply and I got my status back.

P4: Absolutely father was inspiring, he was loving definitely I mean um, he uh, he just, it was only in terms of, he was only strict in terms of education yeah and I guess that's only

uh part of when he got angry if we didn't do as good as he wanted but probably because he was brilliant (laughs) but...

P5: "I don't want to deal with this competitiveness, this is not me, it's not what I want to do," so I said, "I'm not going to go to this school," and they were understanding and they switched me to a school that I wanted to go to, which is pretty much known for kids who don't really study much. See, if I didn't like the one year, I don't think I would have ever liked IIT. Granted, everyone who comes out of IIT is famous. But I think you, you lose who you are and become who you think you want to be.

P6: Yeah so it's very competitive that way and I think that you know nowadays kids are sent for all this coaching and training right from the 8th grade on in order to prepared for the undergrad. there's science and commerce. Even then like science means you're the elite, commerce is looked down upon. You are not that brainy that's why you have to go there because, I think especially at my school only the top 40 people who are among the top 40 students who score in the tenth ports you will be eligible to get into science stream.

P7: Like it was always stressed upon and important. Like in our family, like to yeah, study. Mom's brother's a doctor, and he [grandfather] was really strict with him. He used to run away from medical school supposedly, and come back and granddad used to like beat his ass and send him back [laughs].

Decision Making. Decision making in regards to academics to further career options was a subcategory that emerged with all but one participant. Most individuals said that they would consult with their parents regarding what classes to take, but that the final decision was up to

them since their parents may not have a full understanding of the United States education system. Participants shared the following experiences.

P3: No my uncle said “hey do you want to come [to the United States]? You have to take this test [TOEFL]” and then he applied [to colleges] and one guy he helps my uncle like you know, my college Vice President in India, so he knew the process you know then it worked and I came in 2006.

P5: And I was in computer science, freshman year, I was trying to figure out, I was on the phone with my parents and everything.

P7: I mean as far as course planning or anything went at that point, no, cause he [father] can't really decide what I need to do, like I'm the only one who can figure it out like being over here.

Immigration. Another subcategory that emerged was that participants sought help from professionals when it came to academic issues in relation to immigrating as a student to the United States, as well as differences between the Indian and American education systems.

P1: When I came here, I came through a counselor, like a university counselor. They, like once you take your TOEFL, and GRE, you kind of tell them like what areas you might want to go in, and then based, depending on the field you pick, they would kind of pick the top 5 and bottom 5, that kind of thing and say ok, we'll put, we'll give him the sure shots, we'll give him 2 sure shots and then they'll be like...stuff like that, so.

P3: So this is my last semester. So I talk with them you know. I say hey I want to change my major, they say like go to this counselor. Before I wanted to do engineering then I wanted to do double major like cyber security so now I have theater performance and cyber security.

P6: Because I think back in India if you were to ask a question to your teacher she might be asking you back as in, "weren't you listening to me, were you sleeping?" You know things like that. So that's a huge difference when you come to here, or come to the US and you ask your professor a question. He will be thinking, he will be able to consider that you're not actually a receiver completely taking everything in and that there are times when you were thinking about what he's saying previously and not just listening to what's coming out all the time. Yeah that's a huge difference in education.

P7: I mean I've probably been to like the school counselor once or twice, like not even counselor she was like your academic advisor at [school name]. But she was like useless. There's really nothing to offer there. It's more about just making sure like that the classes you're taking are like what you need to take. Nah, not even so much. All that I figured out by myself. I pretty much figure everything out by myself, you know? Like check out like whatever you need, like the degree audit resource system. No [didn't speak to his dad] because all the requirements of the program and stuff like there's no way he can figure that out by himself. Like I'm the one that needs to choose and decide what's best for me and what I should take or do.

Career Issues. In addition to academic issues, a category that emerged was participants seeking help for career related issues as well. Typically this involved discussing these issues with parents or colleagues. Four out of the seven participants mentioned that this was an experience they would seek help for and that was generally more acceptable by Indian standards to seek help for, as evidenced by most participants readily discussing this issue. Two participants were not currently working in the field they were studying for and therefore could not be included in this discussion. The following comments illustrate the category of help-seeking for career issues.

P1: Like say at work if something's bothering you and, could be you need help on how to approach the problem or you need help on how to deal with somebody your having problems with, a coworker or say a manager, and you need to understand how to deal with him or her. And you need help. I don't know, or you're not happy with your work and you need to go find another work. How do you, you know? But I would talk to them [parents] if I did have to move [change jobs], how they would feel about it, that kind of thing. Just to get their feel of what they would think. But career wise I wouldn't talk with them like that. I would probably talk to uh, people within the group, like people I work and friend in the same.

P5: And that's who I normally go to for living advice, career advice, and we carpool to work [colleague].

P6: I always I knew I was a techie. I knew I love math, I love science, so I always wanted to stick with that. So engineering was my thing, which I knew. Except that after 10th standard I wanted to take math and computer science, but my sister said "you have to do biology", because you know she wanted me to write the medical exams too. And I was like "I have no interest in biology", but she wanted me to write it. So she was, she loved biology and my mom has a bio background, but she works at a bank. So she's like "oh you know mom loves it and she would have become a doctor, but then she was married off early so she couldn't pursue it." So yeah, so I was forced into taking biology but I knew I wanted to go for engineering and I knew what I wanted to get so I got that. And then even Master's I knew but yeah nowadays in terms of how I want to focus when you talk to people around what they do and then you look it up and see if it's something interest you. Like right now I would want to become a data scientist or something like

that because I always deal with, you know, algorithms. Math always interested me so I know the next step is something in math yeah, but there are like family concerns and they're like “why do you want to leave behind what you do why would you go in that, why math?” My sisters like “don't do another techie degree just go for MBA something generic” and I'm like “management is not my thing.” I want to stick to math, but...

P7: Yeah they were like open to like what I wanted to do. I mean everyone knows that engineers aren't the most well-paid people in the country, but...

Consistencies that emerged were that parents were consulted often and had significant influence over what career path individuals would take, as evidenced by the above quotes. Another consistency was that colleagues were also considered a source of knowledge and support for their specific fields.

Immigration. A main category that emerged from the data was that participants all had the shared experience of immigrating to the United States as students. Help-seeking in regards to immigration brought out issues among all seven participants in a general way such as settling into college, driving, or obtaining necessary documents. The three main subcategories that emerged were racism, bicultural relationships, and identity issues. Racism was the most strongly discussed subcategory, with six participants commenting on that issue. Bicultural relationships were also commonly discussed with five participants commenting. Finally, identity struggles were mentioned among three of the seven participants as a subtheme with which they struggled. Some general perceptions and experiences on immigration were as follows.

P1: It's just people cause you're suddenly exposed to so many people like, you've never seen before. Like you're so used to your college, your friends, your family. And suddenly

you're in this world where you meet people from different backgrounds. The first few months I missed home. Uh, everything out here like, the way you ordered [food], I would just not try to explore too much. I'd be like, "ok what's the standard, ok let me just do whatever everybody's doing."

P2: So yeah um apart from that, every day I learn something new. You know? Every day um there are certain things I will do a certain way and like my friends who've been here for like three years will find it funny. They'll be like "uh no you do it this way. This is not what you say."

P3: Like when I came in the beginning I was kind of lonely you know. I don't know much to talk that time. You miss the culture you know like just this far you know and you miss how it is there you know?

P4: Yes and also I guess if we had come here 20 years earlier, things would have been different. It's in the last, I guess it's in the dot-com boom a big boon for Indians because it was a sector which didn't require much government interference and not much investment in the government and I guess it was the kind of thing that we needed for our economy. So a lot of people got that and joined the IT companies back in late '80s and early '90s so by the time we came here there was so many new stores and restaurants, so many Indian people at least in the major city area. You wouldn't feel out of place.

P5: I just turned 17 when I flew out here. I didn't know any better, and my brother went to Germany by himself and he did his thing so I was, like, "That's what people do," so my parents helped me pack my bags, two check-in bags, a carry on, and then I was on the plane by myself. And I was 17, I didn't have a phone, didn't have a laptop, nothing. So I had a calling card, or whatever, I could use to call and I didn't have sheets, pillows,

so...It's a huge learning experience. I had a social security card, a banking card, a laptop, cell phone within, like, two weeks of getting here.

P6: Um, well there was the part that in India I wasn't that independent. Uh, I had people to take care of me I had a maid at home. So that was one change like of coping study with cooking or you know everything else.

P7: Like I think it was alright for the most part, like first of all you're 20 you're still kinda young, you're excited to get away from home. Even though you've been living away from home for a couple of years, but just like being out in America which is sought after. It was pretty good, I mean, yeah sure when I came first right then it was like a little weird, like where am I really, like cause yeah you're read about [school name] it's more like a rural campus, but, you still don't know what to expect. And not even [town] so much, but like between the drive from like airport to [town], like 40 minute drive from the student center shuttle. So I think I pretty much settled in pretty quick. I think in my first semester probably liked missed like my friends like a bit, like you know, even like considered transferring to like [school name], cause I knew like 20 people there and I had gone there at the end of my first semester, like went and visited them all, like just thinking about it and everyone being like "yeah, yeah you should come", cause like obviously like guys, excitement, like you know? More people is better, and I was like yeah like I should do that but I didn't.

Racism. Racism was a subcategory that six out of seven individuals discussed experiencing in varying degrees. One story that was told was very severe by one participant.

P7: Sure. [laughs]. Yeah, like the Chicago incident. With that, I don't know if that was really, if you would call that like a case of racism, or was he just like drunk and angry?

About that guy that like spit on my face cause I think yeah, I guess yeah you would call that racism yeah cause we were just like standing outside having a smoke and probably like talking in Hindi and he was like around and something like "I can't understand what you're saying" or something, and then like spat on my face. That was one thing. Then like at some point in DC, this was before, some guy, some drunk white guy at the bar like literally standing at the bar, I like stepped on his shoe or something and getting like upset over that, and saying "I call people like you Osama" and like, seriously?

P3: Some people call me like FOB, fresh off the boat, so I it's okay I don't know much English at that time.

Another participant shared an experience of being denied entry to a local bar.

P1: They were nasty the way like they would say things sometimes to you that, or they would just ignore you or go treat you in a way that you know, make you feel hostile. We went into a bar and the guy let everybody in but me. He's checking my id to let me in. and I said "what the fuck?" I mean my id's my age on it. What's wrong? And they had no qualms of telling on your face that they were not going to let you in. And I said ok fine, I'll give him the finger and walked right out. I mean what's he going to do?

Most participants shared vague experiences of being unsure whether something they were experiencing was racism or not.

P2: Because even if I tried a step, they would always have like some sort of um, pre-notion related to brown people or something like that, you know?

P4: Yeah I mean...they would just be like stiff while dealing with you.

P5: And I try to, even, whenever something happens, the first thing I think of is probably racist, but you have to keep constantly telling yourself it's probably not true.

Many of them either made excuses for the individual that treated them badly or claimed that it didn't hurt them.

P1: They were getting exposed to things that they hadn't experienced and I don't blame them. They are from a small town, they hadn't, I mean they're conservative which is fine. My parents are conservative. I see that. I mean they're probably a little orthodox. My parents are orthodox. I see that. And they weren't exposed to it. So I don't blame them.

P4: I never found anything very strong except a couple of people but never that hurt, never anything that hurt me.

Clearly participants struggled with whether an incident was due to racism or not, but also experienced some extreme incidents of racism in which they were assaulted. Being a minority in a majority population was a new experience for each individual since they came from a country where they were the majority. This was a difficult transition for participants. None of them reported seeking help for it, despite the fact that six out of seven participants reported experiencing racism.

Bicultural Relationships. Five out of seven participants discussed the subcategory of bicultural relationships as a factor of immigration that would be something to seek help for and reported being in bicultural relationships. The other cultures included were white American, Spanish-American, and Pakistani. One participant shared that people of the same culture as she would judge her due to being with a white American man.

P1: People at work look at you weird. But not white people. Like Indians. Because um, once they found out, if more and more they found out, they will they were surprised I guess. And they were not willing to accept that it's possible. So they will look at you in a

way and then they would talk about you. Like “oh is she really going around with that guy? What’s wrong with her?” And they would ask other people you knew in your group who are comfortable talking to you so that’s how you find it out. So yea, I would say Indians were uncomfortable. And I wouldn’t say Indians of our generation. More like late 40s and 50s. Because it’s just like, “hey, you Indian girl, you can’t be looking at guys outside, you know, you should be looking at Indian guys.” So it’s not just, I think it’s more because I’m a girl and I’m Indian, so it was more.

Three participants discussed the difficulty of sharing that they were with someone of a different cultural background with their parents.

P1: It is hard. it’s hard to accept getting them to accept that you’re not less Indian. Which is the biggest struggle I had with my parents when they first found out about [partner’s name] and me. They thought they lost me. That’s what happened. They, they lost the daughter they had because I’m with the white person. Because I’m with the non-Indian. And they thought, you know, I would. But when they lived with me after that and they found out that I’m still the same fucking person just don’t, I just have feelings for a non-Indian, they realized oh its ok. It’s just a shock.

P3: Um she like when we had this discussion she said you know what I'm fine with you, you know marrying a Muslim but I don't want you to be like closed all like your freedom being taken away. Because if tells you like dress up in a certain way, or stay at home, don't work. I don't want you to have that.” But I personally am fine with it. Because I want to respect his religion. But sadly, the truth or like what our situation now is that we might not end up being together cause his family is not really, like they've come here three years ago, but they will not readily accept a Hindu girl.

P5: But my mom, you got to, because I keep hinting, at the girlfriends I've had, I keep hinting her that how, and for the most part, my dating life other, with the exception of one, they've all been white-Americans.

Two participants shared the difficulties of being in a bicultural relationship that caused issues that they considered seeking help for. These issues particularly had to do with language barriers—not only in regards to the actual differences in language (Hindi vs. English, for example) but also with cultural tone and meaning behind the words.

P1: Well mostly with us, like, would start out, starting out was cultural. Because like, and then there's language barrier. Like, he doesn't get the tone I'm saying it and I can't expect him to understand, but I didn't realize that I didn't say in the way that he understands.

P2: And she actually like was giving me dating advice and she said “you know always find a person who you can actually speak your language with. Because that gives you another level of comfort.” So yeah that was something that I never forgot. Cause I can understand that because there's certain ah you know feelings at one point of time you want to share it and you cannot share it in English. Like you cannot. Cause the feeling that you want to share can only come out with specific words. So I really, if I'm sad, I'll be like “I'm upset” and they will be like “yeah you will be fine and you'll”, you know? But that's it. But if I say “mere ko bahut bura lag raha hai” [I'm feeling really bad]. Then you will be like “ok now what's your problem, you know?” Something like that.

Identity Struggles. Finally, one major component to immigration was in regards to identity struggles that participants faced as a subcategory to the main category of immigration.

Three participants shared about the difficulties both with blending into the Indian culture here as

well as going home and trying to blend in when back in India with the culture there. Participants shared about “not being Indian enough”.

P1: But even in our generation like the other people, other Indians at work from the time I joined, they'll like, I lived with one right. I lived with this roommate before; she was so judgmental about me all the time. Because she goes and tells people at work and I don't need them to think that I'm some weirdo American suddenly because, and it's not like I have problem calling myself American, but I have my Indian roots so it's not like I won't gel with you for some reason or I won't do the things with you all... Because you either don't Indian food every day or you don't watch Indian movies or you don't listen to Indian music all the time or you don't go find Indian festivals as much. It's because I'm not part of this big group who hangs out all the time and celebrates these festivals. And the potluck, and the whole thing, yea. So that's, that's their image of me. I'm too American.

P5: Same with here because I don't belong here. I don't belong there. Where do I belong? people always here, “Oh, you're Indian.” When I go back, “Oh, you're an American.”

P6: It's different because I don't; actually my mother tongue is not Hindi. So I think really I come with more English so that's actually a problem when I'm I interact with such people [Indian-born people], they're like “you are an Indian why are you not conversing in Hindi?” There are people who are like even now when I go to all these groups of people there are people who just look at me and they just talk in Hindi and I reply back in English but even then they will just continue speaking Hindi.

Immigration had a host of shared lived experiences associated with it that were embedded, such as unfamiliarity with many things from the people to the landscape. The shared experiences that

were reflected across all participants were racism and bicultural relationships. Identity issues were discussed by three participants. Help-seeking was perceived through the interviews as reaching out to family or friends, observing others and following what they did, or turning to partners. How participants sought help will be discussed further in relation to the second research question.

Medical Issues. When help-seeking was introduced, one of the first categories that emerged that people discussed seeking help for were medical issues. This was a controversial issue however, because out of the four that discussed it, three said they would be ok going, but that it was a last resort for them for two reasons: either they tried homeopathic medicines first, or they went to India when they needed medical care for various reasons. Mainly, it is due to the fact that of the participants interviewed, they have not needed medical care the years they have been in the United States for things such as colds or a broken bone. Instead, if they sought medical help, it would be during their yearly or twice yearly visit to India because it was so much cheaper, or they had an extended network of doctors that they already knew and trusted. When sharing general opinions about doctors, participants said:

P1: So, yea, I would, doctors is the last thing I would do if I have to; really, really have to. I'm a self-motivator like if I go and I see my blood pressures gone up for some reason ill make sure I watch everything I eat for the next. So I don't need somebody to tell me "hey you know your blood pressures up you better watch it." No.

P5: So I haven't actually gotten any some, any kind of serious cold, nothing, if I have a stuffy nose or something I just take Dayquil. But I've never gotten sick to a point where I have to go see a doctor.

P6: But, I do have allergies like the pollen, so I do go to the doctor and pretty regularly for the spring allergies yeah.

Homeopathic Medicine. Homeopathic medicine was a subcategory discussed by two participants as something that they took part in or their parents took part in and also asked them partake. They shared the following on this category:

P1: I try home remedies because that's just how I was raised.

P5: So they get watery, they get red, I start rubbing them so I went through homeopathic therapy, like, sugar pills, and that, I think it's more of a mental thing than anything else. It's, like, the homeopathic medicine, it's pretty much, like, little sugar brown balls that you chew and I did that for several years.

Returning to India. A main subcategory that emerged was participants going to India for medical care. Four participants shared the following:

P5: Never been, even the dentist because I, for the most part, I travel to India once a year, that's when I...It's affordable because filling a, pull, is like, what, 20 bucks?

P6: I think I have a lot of doctors in my family so my only problem is finding the good doctor you know back there, it's about it's already a laid network for you, right? Your parents have been going, your family, relatives, everyone. So you know the doctor in and out, where to go. But after coming here that's been the tough part but you know you have to read reviews. But in spite of reading reviews and going to some of them it really didn't help and so that was the tricky part you know finding it on your own. So that way it's been difficult. I think I went to like three doctors and after that and good thing my Indian trip was coming up. So I went to India and then you know he just presses down and it's

like "oops, there's something wrong there." So that's the family doctor. So it was appendicitis.

Due to the fact that the participants I interviewed return to India almost yearly or more often for things like weddings, holidays, or general trips to visit family and friends, if they needed medical care they took care of it in India at that time. Participants did not seem hesitant to share what they needed medical care for, as this was a commonly accepted form of help-seeking.

Relationship Issues. The final category brought up by participants as something they would seek help for was romantic relationships. All seven participants identified as straight and all seven discussed difficulties in romantic relationships such as with bicultural relationships, failed relationships, or current relationship problems. This was also the category that they said that was hardest to seek help for. The following quotes are shared regarding the difficulty in seeking help for this issue.

P1: Either you don't make a change or I don't make the change and it can't go on like this. If you want to make this work we need to go see somebody. So we've talked about it and obviously never acted on it cause time has just, it's been discussed and I think time has, we've grown in time.

P4: See there will always be phases in life I guess. I've seen my parents and um I mean in India a lot I seen other parents, there's a lot of arranged marriages, not all of them are happy but see that's the point. How do you know that the next person you choose will actually make you happy?

P5: I rarely talk to anybody about, and my friends keep saying I keep to myself about my personal relationships.

P6: But, again, I'm not the one who would go to my friends and say "you know what I had a breakup," I would rather deal with it because I don't want to be talked about in the crowd.

Bicultural relationships as a subcategory to immigration has been discussed at length previously, but is also shared as a subcategory to romantic relationships. All participants shared that they would not talk with their parents first, if they did decide to discuss it with someone, but would instead turn to friends or siblings. That will be discussed further in the section involving research question two.

Research Question 2: What are the perceptions and lived experience of help-seeking for mental health issues of the Indian diaspora in the United States?

This question is focused on help-seeking in regards to perceptions and experiences mental health issues specifically. To understand these responses, the participants' perceptions of mental health, mental illness, and methods of healing needed to be put into context first through the more general lens of the perceptions of Indian culture.

Cultural Perceptions. This contextual lens included themselves as experts on their own culture informing and educating the outsider [me] of Indian culture. Categories such as colonization, perceptions of mental illness, perceptions of mental health, Bollywood, perceptions of counseling, and treatment of someone with a mental illness were all explored.

Colonization. Colonization was a major category brought up by three of the seven participants as having influences on things like language or city names, education, and jobs. The following participants shared:

P1: Mumbai. Bombay. However people like to put it. When I was born it was Bombay. It says Bombay on my birth certificate but it's Mumbai now so... I say Bombay because

that's where I grew up with. 80 percent of my life it's been Bombay. But I still can't say Mumbai. I have to make a sincere effort to say Mumbai. It actually, I should be more accepting of it because it's more of an Indian name. Bombay was something that the British gave us. But, and it's more, it's a more English version of Mumbai. So, I should be really proud that it's, it's, it's from my mother town and, you know, that's where we were say in my language anyways...

P2: My dad was in the army so we were...I mean we had more of like British influence.

P6: There was British in that. Those are the folks who started the refinery and I went to the school which was started for their employees of the refinery so we had a good mix of Anglo-Indians and Portuguese and Dutch and all of that.

The British influence is an issue that cannot be ignored or taken for granted. It is still influencing the way people think and affects emotions regarding basic things such as what to call their hometown, as participant one reflected.

Mental Illness. Perceptions of mental illness was the next category to be discussed, with all seven participants sharing their perceptions. Descriptions of what someone with mental illness would look like or act were shared along with Hindi words used to describe someone that was perceived as having a mental illness. Participants shared the following insights.

P1: Pagal [Hindi word for crazy] is someone who is generally, a little over the top crazy, but pagal can be used in different ways. Like someone, somebody can freak out and go pagal, but it doesn't mean he's always mentally unstable. So, but, typically pagal is a term in Hindi that is used for people who are mentally unstable. Mentally challenged. But all because they have you know, like, incidents where they'll start yelling or saying things.

P2: And they see that someone has developed um a mental illness over a period of time like they feel frustrated a lot, or they, um, they just yell you know? Like I've heard, I've seen in movies like this they will start yelling.

P3: Some people are like mentally like some people are born like this, just like born, and some people are psycho. Kind of psycho but not because of situations so much, something is going on, so this happens also you become mental illness.

P4: Behaving out of normal... it's almost like.....how do I put it ummm a person who, who definitely seems out of place in that setting where he, he could do you harm, not like violent or something but you don't know, you know? And you think oh my god, is this guy mad? I mean he just looks weird. He's staring or something you know, that's what. Because if the brain is not processing the normal way he would... I guess I'm stereotyping in a way but something like that. So I do realize that uhh mental illness in India definitely is... unless you have acute depression, or are acutely depressed it doesn't count as mental illness.

Consistencies that was shared across all participants was the idea that this person was unpredictable and possibly volatile in their behavior, and that was what constituted mental illness.

Bollywood. Another component about perceptions of mental illness was that the participants all shared throughout that Bollywood and the media had an effect on the development of their perceptions. When asked “where do you get your ideas about mental illness” all seven referenced Bollywood as one place that their thoughts came from. Participants shared the following in response to this question.

P3: Like some movie they try to like tell like be merciful with mental illness.

P4: It's how it used to be described in Bollywood and all that like mass hysteria, people with too much hysteria or just crazy actions.

P5: A movie was a biggest introduction to an illness [dyslexia] that, I don't know how many people go through.

P7: I guess it's just from about like meeting people or like watching movies. Cause you don't encounter them in day to day life very much.

Clearly media was a category that indicated it has a strong influence across the country on the development of perceptions pertaining to mental illness. That is evident in that the participants were from all different parts of the country, in both urban and rural areas and still were subjected to the reach of the media.

Mental Health. As opposed to mental illness, participants were also asked their perceptions of mental health. A consistency emerged here demonstrated that most participants were confused or hesitant in regards to this question, and hadn't seemed to have thought about it before. Insights were recorded as follows.

P5: I'm trying to think of what I would relate to mental health, I think, I guess being healthy and how you, I don't know. I guess mental health relates to how you, how you like your job, how you like your living, how you... As being a person, happy, you are, mentally, you are healthy.

P7: I haven't had any, much interaction with mental health really, you know? And it's not something I really think about much or care about much like you know? I mean I don't consider, like I don't think anything's wrong with me as far as like the mental department goes, so...

Only one participant could fully describe in what way she perceived herself as not being mentally healthy.

P1: I mean for the most part I'm reasonable, but there's times when I, I am upset over things that aren't really even necessary to be upset about. And I know myself because in retrospect I'll look and say "what the fuck is wrong with you?" Like there's no reason, it's harmless. But you still cannot get your mind off it, and you feel like you need to obsess about it, for some reason. So that's where I think I'm not mentally healthy.

Treatment of Mental Illness. How the participants perceived the treatment of mental illness ranged from what they had seen in movies to traditional methods of healing used both in India and by Indians in the United States. Counseling as well as participant's personal experiences will be discussed separately. Perceptions of how mental illness is treated by the participants is as follows:

P1: They would do those things first, because like...depends on how much your parents, on how much his or her parents, believe on it. So obviously...but they would do something, it's just normal practice, nowadays it's normal to use scientific ways and try whatever else you can. And at the same time, simultaneously they will try, you know pooja [prayers], and seeing if you know, something, some form of negativity could be relieved off him and it may help or may not. But it couldn't hurt, is what they say and they would try. I think that would be more common.

P2: Like if there's somebody in their family members who they respect, they would always keep them in their house. There's not a term, or they would say oh “woh bimar hai” [they're sick] or something like... They're, they're not just not doing well. And every time you'll come oh they have a cold, this time, their kidney or they're going to like oh

they're having a heart surgery. Whereas they will actually be going to the hospital to like get them treated. Or you know stuff like that. And those people are mostly kept home.

P3: Like back home they have like some mental, like, sometimes they try to keep them like in different places. I saw in the movie so they one guy has like some problems. So they take him different place you know they treat and keep, try to like. It's kind of like prison it's kind of, it was kind of prison. Back home maybe they might beat him it depends you know? Like mental illness, sometimes you tie them... Still I say here is better than India for mental illness.

P7: Right, people with disabilities are like looked upon and made fun of. Not like to say that that doesn't happen over here. But I think there's way more resources available over here for treatment and diagnosis as compared to what it would be in India. I'm sure that things are improving in India, like definitely. I don't think everyone's, like people's opinions in India are really changing, though. I mean they'll still make fun of you, surely. I mean yeah that's not going to change. I mean the attitude of the Indian people doesn't really change. You know? It's always more of, like where all these people came from. Even if one improves, 20 others move from villages have similar feelings. And not just villages but like anyone in general, cause it's each one looking out for their own.

Consistencies about treatment as described by the participants ranged from going to the doctor's, to spirituality, to keeping people home inside the house, to sending them to an asylum or 'prison' as described by participant 3. He also mentioned that people could be tied down, or beaten.

Treatment of mental illness varies greatly, and a consistency that emerged was the perception that although things are getting better in India, there are more resources to seek out for help here in the United States.

Counseling. Perceptions of counseling as a form of treatment came up in the interviews only when participants were directly asked about counseling. A consistency here was that counseling was perceived by participants as something that is much stigmatized and not something individuals would readily try to utilize. Insights are as follows:

P1: They look at it as a taboo. They look at it as inefficiency of theirs if they need to go to a counselor. Very stigmatized, because society likes status.

P4: And again counseling is a stigma here, for Indians or there, not as much here I'd say.

P7: I don't remember hearing it or anyone discussing it as far as a "therapist" is concerned when I lived there, but it's probably a little more common now. I don't know how much counseling services would really help cause you might go to counseling but the mindset of the regular people you're involved with on a day to day basis, if that's not improving then there's no point of going to the counseling part.

Help-seeking in the form of counseling is a stigmatized perception among Indians, and it is a perception that immigrants carry with them, as seen in the above responses. One participant did acknowledge that it's not as much as a stigma for Indians living here, in the United States, but also did not know anybody that had undergone counseling here and denied utilizing counseling services himself. The lived experiences of help-seeking of the participants will be discussed below.

Help-seeking Methods. The help-seeking methods is the overarching theme that ties the categories together. The subthemes that emerged from the participants shared lived experiences of help-seeking were through a variety of resources including dealing with it alone through drinking or technology, friends, family, a community of similar cultural background, and spirituality for issues pertaining to mental health. These experiences are either what they

themselves have done, or ways they have observed close family and friends seeking help.

Patterns of seeking help through spirituality, familial support, and people of a similar cultural background were all most highly observed.

Spirituality. Spirituality was the highest observed subtheme when asked about mental illness and mental health as a support in most participants' lives as well as a form of treatment utilized. One participant shared the following in regards to seeking help from spirituality during an issue pertaining to mental health:

P1: I feel like there's a power and it's binding the world and binding me and it watches over me. And I feel she's [goddess] there to protect me. If I have a pain or trouble, I pray and it helps or it doesn't help. It's psychological. Like I was on the plane the last time I went to the [country name]. I, in the middle of the flight, I was sick. I needed to get off that plane. I was desperate to get off that plane. I was freaking out. So I was freaking out and I think just saying her name over and over, over and over calms me down. I mean obviously I had tea and I tried to walk around, drink water, breathe, breathe easy, do all that stuff. But yea I uh, started praying, praying, praying, praying. Just saying her name. Like just saying it over and over and it, they say it calms your mind if you just say things in repetition. And there's really, yea, I think, I believe in like, I know that it's probably psychological but I know that if I just say her name when I'm in trouble, I always believe that if you do something in the right heart it works. It works out. If as long as you have a right conscience and a right heart. I don't need to call somebody if I'm in... like I obviously need to sometimes, but if I'm alone and I'm scared about something or I'm out somewhere where I'm freaking out, I quietly pray and I feel better. I think it just calms me down.

Karma. Two participants shared that although they were indifferent to spirituality, they strongly believed in karma. This seemed to be a subtheme among participants as it's evident that Hinduism has infused the culture.

P2: Like dad my mom my dad always says like work hard, do not- you know? And the results will be nice, do not worry, do not this, do not do that. So I would not lie, I would not cheat, I would not, and I deeply, deeply believe in karma. If I have done something wrong to you, it will come back to me. Not today, not tomorrow, but in 10 years from now, it will come back.

Parental Respect. Another participant shared that although he's personally indifferent to religion, he will follow some religious traditions in seeking help for healing because his parents want him to, and he doesn't want to disappoint his parents. He shares that his parents go to see a Guru in India known for helping with all issues, and that sometimes he attends as well. The respect for religion out of deference to their parents was a theme shared among participants. He shares:

P7: I guess a pretty big part [of help seeking] cause mom's always looking at him for like solutions to their problems, visiting him pretty frequently. Body problems, financial problems, or like anything else. Yeah. Just like you know, like when, how, when is it going to become better, and how, and like do something if you can, kind of, or like things are bad, and stuff like that. And then, like everything else, like back problems, or like anything else with her, or like dad or [sister]. They take her once in a while. I've been a few times, yeah. I mean just sit there, takes a couple of minutes really, it's not much to do, and he'll like ask you, like what's bothering you and he'll do his little thing, like if you're shoulder's bothering you he'll put his hand on your shoulder, or something like

that. I guess, I mean, he's supposed to have more powers than a normal human being, which he can pass on to you to help heal you.

Another participant shared that although she has a small temple in her home here in the United States, she no longer follows the rituals except when she's at home out of respect for her parents.

She shares:

P6: Well back in India, I was always taken to the temples, right I have to go with the parents. If you say no to it, it's like "oh you're being offensive, you're not listening, you're not following tradition." There's so many questions you have to answer a lot more than when you're here. So now I have the freedom to say that, but even now when I told my mom "why you want to do that?" She's like "don't question me this give me peace of mind." So I'm like okay respect what she wants to do so let her do what she wants.

Religion was also perceived to be a general form of healing sought after for mental illness.

Participants shared the following thoughts:

P1: There would be different poojas [prayers] depending on the problems you're facing. So, and I wouldn't be able to describe what poojas they do, cause the priests decide that. But they'd look at your birth certificate, but not just your birth certificate, they'd look at your... We call it kundli. So the kundli, it's like astrology.

Although not every participant reported religion as a personal support, the integration of spirituality throughout the culture was a major theme.

Familial Support. The support of families was another subtheme that every participant talked about as being a form of support for them when help-seeking for issues pertaining to mental health or mental illness. Whether participants sought help from parents or siblings depended on the issue that was bothering them. For example, if it was a relationship issue,

participants shared that they would typically not talk to a parent about it because they were not open to sharing that information with them. That was a pattern seen across all participants. Some selected quotes regarding this are as follows:

P7: Not to family, just never grown up like speaking to them about it.

P6: Relationship advice: sister. that's why sisters really good cause every time there's a problem I'm going through, a number of breakups, you go to your sister and she's like no that's fine just move on. I don't know, I just like to hear that and then she keeps saying that, "you know what I see you come out of it before, you come out of it again." And then she'll check on me.

For any other issue than relationship help-seeking, a consistency emerged of participants turned to their parents. Three quotes that illustrated this best are as follows:

P3: If you have parents you first talk to them.

P4: f I need something if I feel something I generally tend to talk about that with my wife or parents, I'll always speak to my parents. I'm just closer to my family.

P5: Other than that, help-seeking, it's usually calling my parents. Dad understands, he knows, he's listening.

One participant shared that he spoke to his father for financial advice.

P7: Like once in a while I'll talk to dad about money, like not really what to do, but just generally like trying to figure out, kind of talking over of like where things get spent and how much gets saved, it's important to do that, to save money for future. Just generally too, you know?

Friend Support. Another method of help-seeking if participants didn't feel comfortable talking to family was to talk to friends. It's important to note that as immigrants, these friends

could be people in India or in the United States, and geography didn't seem to be a factor in how much a participant shared with a friend. The subtheme of friendship as a strong source of support for participants was demonstrated by the following quotes.

P1: Like, you know really close girl friends who have seen me go through you know problems and whatever and like if I've had issues with [partner] I will call them and then I will, and it, and there have been times when I would tell them everything.

P6: And then I have, like you know, a handful of best friends, but they're not like nearby. I have a few friends in India but then you're always on the chat group with them. So every time something goes wrong we have this, 'hey hello, I'm not happy right now.' So they just come in and they're like "go do this go do that." Yeah so that's actually really nice you know. We are there and talk to each other so it's nice.

P7: Yeah like mostly yeah I would start with friends like maybe move on to family depending on the issue, but that's not usually the first course of action.

Similar Cultural Background. One subtheme that emerged as support for the participants in this study was living near people of a similar cultural background in order to provide the provision in the form of religion, food, or language. In fact, this was so extensive that more than one participant said that they could get through the day only speaking Hindi at work, at home, and at the local grocery store.

P2: That's, I would say was like the root cause of how I've started feeling comfortable and started gaining confidence was because I knew there were like other people with me and I could and its weird but like after a while like when I just had to speak English, I actually craved speaking Hindi. And then finally when I could speak Hindi with someone I used

to feel like really, really nice. So like you know so that just brings you really close. Just like we know we always hear like food brings people closer.

P4: Yes it's easier to convey your feelings as I said, having the right oohs and ahhs and the right words in a statement makes all the difference, and what the impact is and what the other person understands from it. Because it's not just words right, there's your actions, it's those unsaid things or things that are not actually words that were said kind of thing. It's just easier that way. At least for me. I mean I'll be frank I don't have long discussions with people who are not from India.

P5: First year of college, I was part of the, uh, what's the club, they call, I forget the name, it was called Organization Alliance of Students from the Indian subcontinent or something like that.

P7: Yeah, I mean like the area is filled with Indian people, like, the area we live in, not just this town, but the whole DC area and Northern Virginia. There's Indian stores- three on one street- so I visit them because I'm Indian so I want Indian food so I need those places to get stuff that I need. Like my work environment's just full of Indian people, they just exist. And you work in a technology company which hires a lot of foreign people, which is a lot of Indian or Chinese, so you'll naturally encounter them more than I would in another place.

The consistency of support owing to a similar cultural background was due to work related situations, such as technology and engineering fields, or due to geography, as indicated by the last participant's statement "this whole area is filled with Indian people". That meant that also people had the comfort of speaking the same language and eating the same types of foods made

with ingredients that aren't readily available in the United States. That seemed to form a sense of community for these participants that was relied upon.

Self-Reliance. Finally, many participants discussed help-seeking as something they would figure out on their own, meaning they would not discuss it with anyone else, but would deal with it themselves. This subtheme of self-reliance seemed strong as evidenced by the vocabulary used. One participant stated:

P7: I guess more dealing with it yourself. Yeah I think I have more of the attitude where of you just force yourself to get over it, or just nature plays it course. I definitely like to keep stuff to myself and somethings I don't feel the need to talk to people, and I feel that's common with many other people too. Like I'm sure, yeah.

The same participant said that at times, he drinks to deal with a personal issue.

P7: I guess I drink. Yeah, but it only relieves it temporarily, for a couple of hours. It doesn't solve the long term solution unless you keep drinking. [laughs]. But I don't think anything's that important or that has that much relevance that I need to permanently pluck it out of my memory.

One participant mentioned using technology, particularly the internet, when seeking help.

P1: Or just Google something like... there's enough on the web.

Summary of Findings

Categories and themes that emerged from this research were divided among the research questions. Specifically, patterns of shared perceptions and lived experiences from the participants were grouped according to perceptions of reasons to seek help, cultural perceptions, and help-seeking methods. Summaries of shared patterns across participants for this research will be shared below.

Perceptions of Reasons to Seek Help

Participants reported that in regards to help-seeking, it was simultaneously something that they reported that they're open to, but also that it's hard to follow through. Categories of academic issues, career issues, immigration, medical issues and relationship issues were all shared perceived reasons for seeking help.

The categories of academic and career issues were seen as something that were acceptable to seek help for, and they typically sought help from parents or professionals such as academic advisors. Academic issues contained categories such as ragging, or hazing that participants experienced in college. They also experienced confusion over the correct path to take for career purposes. This was echoed in career help-seeking, and participants discussed speaking with colleagues to gain further understanding and clarity. Additionally, within career issues participants shared help-seeking for difficulties with coworkers and colleagues.

Immigration was a category that all seven participants shared as something for which they would seek help. Initially getting to the United States in regards to documents, finances and visas was complicated and typically family or professional help was utilized. Once in the United States, subcategories emerged such as racism, bicultural relationships, and identity struggles. Racism was the subtheme that carried the most weight as they dealt with both vague and blatant experiences. In regards to bicultural relationships, participants said that they experienced judgement from other Indian immigrants. They discussed how difficult it was to share about the relationship with their parents. In addition, participants talked over general relationship concerns in regards to being from two different cultures as something for which they would seek help. Identity struggles, and not knowing where they belonged was another struggle for participants.

One participant shared, “I don’t belong here [in the United States], I don’t belong there [in India]; where do I belong?”

Medical issues were another category in which it was more acceptable for seeking help. Participants shared that they would either utilize homeopathic treatments they learned in India, or would return to India for medical treatment since they visit so often. They shared that it’s cheaper and that they have more trust in doctors in India.

Relationship issues were the final category that participants shared about seeking help for. Typically this involved difficulties in a current or failed relationship, or in a bicultural relationship. Participants shared that this was the most difficult area for them to seek help for, and a shared pattern that emerged was that they would not talk to parents regarding relationship issues.

Cultural Perceptions.

Placing the participant in their cultural context was most important in moving forward in discussing their perceptions and lived experiences regarding perceptions of reasons to seek help and help-seeking methods and the categories within these major subjects. As Indian-born immigrants who had been living in the United States for, on average, 8 years their culture is influenced by numerous factors. Colonization of the British, mental illness, mental health and counseling were all explored through the lens of cultural perceptions.

Colonization was a factor that a few participants discussed as an aside to a completely separate issue. The influence that colonization exerts on them still in regards to their emotions about a city name change was evident in one participant’s residual feelings of guilt of not calling it by the original Indian name. Another participant shared how the British influence had affected

jobs and the education system in her region. Clearly this is a current issue and theme the participants shared experiencing as India only gained independence in 1947.

Mental illness was discussed through the lens of culture. Subcategories that emerged were participants sharing their descriptions of people with mental illness as typically someone seeming volatile or unpredictable in their behavior. Another subcategory was that many participants hesitated on this question and reported that they weren't sure as they hadn't had real-life experience pertaining to this concept. All participants shared the consistency that Bollywood had influenced their perceptions regarding mental illness.

Mental health was another concept that participants hesitated to discuss, mainly due to the consistent lack of knowledge or language around this concept. With some participants the idea emerged of mental health as having to do with success or happiness in relation to how you're living life. A shared consistency among participants was that this was not a concept that they had thought about before and weren't sure how to respond.

Treatment for mental illness was discussed and again Bollywood was referred to as a category for information when participants didn't have personal experiences to share. Traditional methods of healing was a category that emerged such as bringing a person to temple for the priests to perform prayers. One participant mentioned that people perceived to have a mental illness may be tied up or beaten. Another participant shared that someone with a mental illness would be hidden inside the home, or taken to an asylum. Medical help was sought as well for treatment and was considered the "scientific" way of healing. Counseling was not discussed until directly asked.

A consistency in response to perceptions of counseling was that it is stigmatized and considered only as a last resort, if at all. An idea that many participants shared was that even the

word ‘counseling’ was not something familiar to them as a treatment for mental illness. One participant shared that he didn’t see counseling working until the attitude of the general Indian population were changed regarding this concept. However a consistency of the participants’ beliefs that services for mental illness were getting better in India was shared.

Help-Seeking Methods

Subthemes emerged from participants who shared different resources that they have personally utilized when seeking help for issues pertaining to mental health. Resources considered were religion, family, friends, self-reliance, or a community with a similar cultural background. Of these, the themes of the community, religion and family were considered the most strongly sought-after forms of help-seeking.

Spirituality was a subtheme mentioned by all seven participants as a source of support for if not them personally, then their families. Two participants said they didn’t consider themselves as religious, but still strongly believed in karma, which is evidence of Hinduism permeating the culture. A few participants said they did not consider themselves religious, but still utilized spirituality as a way to seek help out of respect to their parents. A few participants said they found spirituality to be a source of strength and support during difficult times and noted prayer and astrology as aspects of help-seeking in religion.

Familial support was another very strong subtheme that emerged as a form of help-seeking that was shared across all participants. Both parents and siblings were discussed as people they would seek out with an issue pertaining to their mental health. Parents were sought after first for anything except a relationship issue, which was identified as too personal to share with parents. Participants shared parents as a resource for help-seeking with academics, careers, finances, and general sadness or loneliness.

Friends emerged as a subtheme as the next line of support if something couldn't be discussed with family members. All but one participant discussed utilizing friends as a source of support and shared that they used technology as their friends were typically scattered worldwide to keep in touch. Friends made in India or the United States were equally likely to be viewed as a source of support and strength.

Another common subtheme was living in a community of people with a similar cultural background as an alternative source of support for participants. As the DC metro area is an area known for a strong Indian community, this was not surprising. Food, language, groceries, work, and clubs were all mentioned as sources of comfort and support for participants who were recently immigrated or lonely. The sense of community assisted participants in gaining strength and feeling comfortable in the United States.

Finally self-reliance was a subtheme discussed by participants as a way to handle mental health issues. One participant mentioned using technology such as the internet to find answers. Another participant mentioned alcohol as a way to deal with personal issues. A consistency of there being things they would not want to discuss, and time would allow it to pass, emerged from the interviews.

CHAPTER FIVE: DISCUSSION

Two major categories (perceptions of reasons to seek help and cultural perceptions) were found in this study each having several sub-categories. The findings highlighted the perceptions about what problems participants would consider seeking help for and provided the cultural lens through which the participants viewed both perceived problems as well as ways to seek help for those problems. The overarching theme from the study is the help-seeking methods that participants use, which encompass spiritual, cultural and social supports. The theme of help-seeking methods included the shared ways in which participants sought help that emerged from the interviews.

The most important finding from the study was the theme of help-seeking methods in which participants discussed the various social, cultural and spiritual supports they utilized when seeking help. The subthemes included spirituality, familial support, friend support, a similar cultural background, and finally, self-reliance. The theme added to the literature and expanded our previously perceived needs and expectations of the Indian diaspora in the United States by highlighting the intense connection members of the diaspora maintain with their home culture even after almost ten years in the United States.

A summary of these major findings will follow, and each will be discussed in terms of reasons for findings and with respect to current literature on immigrants from India and help-seeking. This discussion will be followed by theoretical and practical implications, and potential impacts.

Perceptions of Reasons to Seek Help.

What emerged from the interviews were patterns of shared categories for which participants sought help. These included academic issues, career issues, immigration, medical

issues and relationship issues. Sub-categories also emerged that acknowledged different themes participants identified. Within academic issues, subcategories of ragging, academic pressure, decision making, and immigration were all patterns of issues that participants shared in regards to seeking help. Immigration included subcategories of racism, bicultural relationships, and identity struggles. Finally, medical issues included the shared subcategories of homeopathic medicine and returning to India for medical care.

Help-seeking as a whole was perceived by all participants as a necessary part of life, but that simultaneously could be difficult to do depending on the subject matter, and only as a means of last resort. As one participant shared, “Because Indians tend... I don't think everyone's open to seeking help in any way for that matter. When you go to a grocery store and have a problem not everyone's going to ask someone "can you help me find this?" They try to figure it out. I think they're more ashamed or they feel embarrassed if someone they think that they expected to know things” (P6, p. 63). This is a significant finding that underlies the difficulty that Indian immigrants may have in seeking help.

Academic Issues. Academic issues was one of the areas that participants shared feeling comfortable seeking help. Within this context, the subcategories of ragging, pressure, decision making, and immigration all emerged as areas in academia in which participants had personal experience seeking help.

Ragging. The issue of ragging [‘hazing’ in the United States] was relatively unknown to me until the pilot study was conducted. This helped in informing the research questions for the present study. This first subcategory emerged with two out of the seven participants who had both begun their bachelor’s degrees while still in India, and who had both experienced this phenomenon. Both participants shared how extreme ragging can get, especially for individuals

that lived in the dorms on campus. P1 said, “It’s hardcore. It’s hardcore. The extent. Because it’s, it’s pretty bad. (P1, p. 63). P7 continued, “Yeah that’s very common in Indian colleges, especially the kind of colleges where you’re like living... One of the guys in our batch like popped, supposedly popped a lot of ibuprofens and like landed up in hospital cause he was so upset” (P7, p. 63-64). Extreme ragging is presented here as a reason for individuals to attempt death by suicide. This participant also expressed that this was not the worst that ragging could get. She said, “And I think what we went through is probably on the lower scale than the stuff that you hear about” (P1, p. 63).

Pressure. Academic pressure was another subcategory that emerged in every single participant as a shared experience. Academic pressure from parents as well as pressure that they put on themselves. Participant 1 shared, “there’s always the pressure. It’s like parents look at you in a way and compare you... That’s the Indian attitude... it’s ingrained in me... And they were never content with, hey, you got an A; no, where’s the plus. They always needed the extra. It was always pressure” (P1, p. 64). This was perceived by all participants as the “Indian attitude”. For example participant 2 also said, “and you know how particular we are about grades” (P2, p. 64). This insinuates that Indian immigrants believe they are a culture known for academic pressure.

These two subcategories are important findings because previous research has suggested that academic pressure is a leading cause of suicide in India today (Jacobs, 2009; Shrivastava et al, 2012). Opportunities for immigration are one reason cited for the pressure to succeed (Bertolote, Fleischmann, Leo, & Wasserman, 2004). Literature suggests that when immigrants from India in particular, come to the United States they retain their culture, which would suggest that they would also retain this pressure (Agarwal, 1991; Kaul, 1983; Naidoo, 1985 & 1986; Wakil, Siddique & Wakil, 1981). Additionally, since they are typically immigrating to further

their education, this is an area that counselors need to be aware of as an indicator of mental health. Furthermore, the pressure both from parents and pressure from individuals themselves are adding to this, as participant 1 explained when she stated, “It’s ingrained in me” (P1, p. 64).

Research supports the suggestion that self-expectation in regards to academics is another variable that could lead to suicide (Sharma, 2014).

Decision Making. Confusion in regards to decision making was another subcategory under the category of academics for help-seeking. A pattern of shared experiences of participants contacting parents for decision-making advice regarding academics emerged. Participant 6 shared “And I was in computer science, freshman year, I was trying to figure out, I was on the phone with my parents and everything” (P6, p. 66). However, it was also noted that parents could not always contribute as they may not have a full understanding of the American education system. Participant 7 shared, “I mean as far as course planning or anything went at that point, no, cause he [father] can't really decide what I need to do, like I'm the only one who can figure it out like being over here” (P7, p. 66). Decision making was compounded by the process of immigration and cultural differences.

Immigration. Immigration, then was another subcategory in academics in which participants shared they would seek help. Many participants sought professional help through academic counselors for this complicated process. Participant 1 shared, “When I came here, I came through a counselor, like a university counselor. They, like once you take your TOEFL, and GRE, you kind of tell them like what areas you might want to go in, and then based, depending on the field you pick, they would kind of pick the top 5 and bottom 5...” (P1, p. 66).

These subcategories of decision making and immigration were considered acceptable and normal areas in which to seek help. As stated above, the importance of education is embedded in

the Indian culture and retains a place of importance for individuals (Jacobs, 2009; Sharma, 2014). Additionally, Indians value seeing themselves as part of a communal self rather than a distinct individual (Azuma, 1984; Eleftheriadou, 1994; Moodly, Rai and Alladin, 2010). This research supports the believe that parental contribution is required to major life decisions such as academic majors. Academic decisions and assistance in regards to immigrating was also seen as a reason to seek help. Immigration is a complex process that in itself causes emotional reactions (Bhugra & Becker, 2005; Nerhus, Berg, Haram, Kvitland, Andreassen & Melle, 2015). Utilizing the resources for assistance in regards to finding and applying to schools in a different country is a necessity if there is no family member who has personal experience to assist an individual through the process.

Career Issues. Career issues were very closely related to the academic issues addressed above. Four out of the seven participant shared this was an area they would seek help for. Participant 1 shared, “Like say at work if something’s bothering you and, could be you need help on how to approach the problem or you need help on how to deal with somebody your having problems with, a coworker or say a manager, and you need to understand how to deal with him or her. And you need help” (P1, p. 68). Typically the help was sought from a colleague or parents, which again is supported by the literature that states Indians view themselves as communal rather than individual (Azuma, 1984; Eleftheriadou, 1994; Farver, Narang & Bhadha, 2002; Moodly, Rai and Alladin, 2010). These findings also suggest that it is easier for Indian immigrants to seek help for career-related issues rather than general mental health issues.

Immigration. Help-seeking for immigration issues was a category shared by all participants with subcategories that emerged. These subcategories included seeking help for bi-cultural relationships, racism, and identity issues. Participant 1 shared, “It’s just people cause you’re

suddenly exposed to so many people like, you've never seen before. Like you're so used to your college, your friends, your family. And suddenly you're in this world where you meet people from different backgrounds. The first few months I missed home" (P1, p. 70). Participants expressed shared experiences of feeling lonely, being exposed to people of different backgrounds, or learning to drive.

Racism. Six out of seven participants shared experiences of racism when immigrating to the United States. One participant shared a very drastic story of being spit on. He said, "About that guy that like spit on my face cause I think yeah, I guess yeah you would call that racism yeah cause we were just like standing outside having a smoke and probably like talking in Hindi and he was like around and something like "I can't understand what you're saying" or something, and then like spat on my face" (P7, p. 70). Another participant shared that she had been denied entry to a bar due to her ethnic background. It's important to note in regards to this finding that none of these participants sought help for the instances of racism that they experienced. Some participants weren't even sure if they were experiencing racism or not, but clearly considered it an option.

Bicultural Relationships. Five out of seven participants discussed seeking help for issues due to their relationships, which were all bicultural and included white Americans, Spanish-Americans, or Pakistanis. Two participants discussed seeking help for their relationships mainly due to language barriers, not just in content, but also in regards to tone. Participant 2 said, "Cause I can understand that because there's certain ah you know feelings at one point of time you want to share it and you cannot share it in English. Like you cannot. Cause the feeling that you want to share can only come out with specific words" (P2, p. 75-76). Other participants had the shared experience of not discussing their relationships with their parents, but only their

siblings or friends. Participant 1 shared, “It is hard. it’s hard to accept getting them to accept that you’re not less Indian. Which is the biggest struggle I had with my parents when they first found out about [partner’s name] and me. They thought they lost me” (P1, p. 74). One participant also discussed the judgement she felt from her own cultural group in the United States. She shared, “Because it’s just like, “hey, you Indian girl, you can’t be looking at guys outside, you know, you should be looking at Indian guys” (P1, p. 74).

Identity Struggles. Three participants shared about their struggle with identity since living in the United States. One participant said, “Same with here because I don’t belong here. I don’t belong there. Where do I belong? people always here, “Oh, you’re Indian.” When I go back, “Oh, you’re an American”” (P5, p. 77). Participants also shared “not feeling Indian enough” by Indians here in the United States.

The findings in regards to immigration are extremely important because previous research has not concluded the best process of immigration for individuals. Although Berry’s Model of Acculturation (1980) has stated that integration is the most healthy way to successfully acculturate, there is doubt in regards to people immigrating from and remaining tied to an ethnic group of origin that is very different from Western values and lifestyle. (Berry & Kim, 1988; Farver, Narang & Bhadha, 2002; Moodly, Rai & Alladin, 2010). Utilizing Berry’s Model of Acculturation (1980) and his research that suggests that integration is the best way to acculturate, then it would seem that bi-cultural relationships would be a healthy way to integrate. This contradicts participants stating that bi-cultural relationships are something for which they would seek help. Participants named numerous difficulties with bi-cultural relationships including language barriers, cultural differences, not being accepted by people of a similar cultural background, and difficulties in telling their parents. Additionally, although research suggests that

establishing ethnic identity is an important process in integrating successfully, participants struggled with experiencing judgement by the people that literature suggests will offer support (Berry & Kim, 1988; Bhugra & Becker, 2005; Bhui et al, 2005; Dasgupta, 1998; Farver, Narang & Bhadha, 2002). Identity struggles are also a factor here both in regards to bicultural relationships and ethnic identity. The close tie to home to keep a strong ethnic identity can also be difficult for immigrants as evidenced by participants' statements in this study. Finally, the issue of racism needs to be addressed. As Gandhi (1998), has suggested, the post-colonial idea of Western cultures perceiving anyone unlike ourselves as the "other" puts immigrants that look different- in other words are not of European decent- at a disadvantage and in the minority. These minorities typically experience the backlash of racism (DeVecchio Good, et al 2008; Rentmeester, 2012; Ward, 2012). At times, immigrants might even internalize racist experiences and blame themselves (Ward, 2012). Participants in this study seemed to experience similar beliefs, as evidenced by participants being unsure if they were experiencing racism, or defending the individuals that expressed racist beliefs. Participant 1 shared, "They were getting exposed to things that they hadn't experienced and I don't blame them. They are from a small town, they hadn't, I mean they're conservative which is fine. My parents are conservative. I see that. I mean they're probably a little orthodox. My parents are orthodox. I see that. And they weren't exposed to it. So I don't blame them", (P1, p. 73). Rentmeester (2012) went on to say that people experience marginality in that they are trying to blend in with the white culture while simultaneously being encouraged to remain "ethnic". This research adds to the difficulty in identity adjustment in immigration that was evidenced by shared experiences of participants in this study, and brings question to Berry's (1980) suggestion that integration is the healthiest mode of acculturation.

Medical Issues. One of the first categories that emerged in regards to help-seeking was for medical issues. This was an interesting category, however, as four participants stated they would readily seek help for it, but probably not in the United States or through American health systems. The subcategories of homeopathic medicines and returning to India for medical care emerged.

Homeopathic Medicine. Homeopathy is typically a small pill encased in sugar that is a very common form of treatment in India. This is an all-natural substance that coincides with the Indian view of holistic healing techniques (Jain & Sandhu, 2013; Kapur, 1975; Raney & Cinarbas, 2005; Wagner, et al 1999). Two participants discussed utilizing this form of treatment.

Returning to India. Returning to their homeland was another way to seek help for medical issues and ailments. This could be for various reasons such as expenses, familiarity, or family input. One participant shared, “Never been [to the doctor in the United States], even the dentist because I, for the most part, I travel to India once a year, that’s when I...It’s affordable because filling a, pull, is like, what, 20 bucks?” (P5, p. 78). This was a common subcategory among participants; both that they returned home frequently and that they typically did not get sick enough to warrant a visit to the doctor.

These findings support the literature which suggests that Indian immigrants remain closely tied to their homeland (Bhattacharjee, 1992; Dasgupta, 1998; Farver, Narang and Bhadha, 2002; Mehra, 1998; and Naidoo, 2005). Additionally, this also supports previous research that suggests that it is more acceptable to seek help for somatic complaints, as participants readily discussed this form of help-seeking (Campion & Bhugra, 1998; Jain & Sandhu, 2013; Quack, 2012; Raney & Cinarbas, 2005; Saravanan et al, 2008).

Relationship Issues. Separate from bi-cultural relationships emerged the category of relationship issues as being a reason to seek help. Parents typically were not seen as a resources when help was needed, since although they might be part of the decision making process initially, they were not involved in the everyday issues of the relationships according to the shared experiences of my participants. One participant shared, “I rarely talk to anybody about, and my friends keep saying I keep to myself about my personal relationships” (P5, p. 80). Participants also shared that this was the most difficult category in which to seek help.

These findings were not surprising as seeking help outside of the family unit would be stigmatized in the culture (Decker, et. al., 2013; Shrivastava et. al., 2012). This was where stoicism and self-reliance were seen as ways to cope with issues in romantic relationships. This also reflects communal values of putting others first rather than yourself if you have an issue with someone in your family, especially your spouse (Berry & Kim, 1988; Farver, Narang & Bhadha, 2002; Moodly, Rai & Alladin, 2010).

Cultural Perceptions

Cultural perceptions of the participants emerged as a main category. This contextual lens placed the explored topics of mental health, mental illness, counseling, etc. from the interview questions into very specific themes which the participants shared. Sub categories emerged were colonization, mental illness, mental health, treatment of mental illness, and counseling. Within Mental Illness was the subtheme of Bollywood. Treatment of mental illness was broken into the subcategories of spirituality and science. Finally within counseling emerged the subcategory of stigma.

Colonization. Colonization as a category was brought up by three of the seven participants as a shared cultural perception that influenced city names, education systems and careers in India.

One participant shared, “I have to make a sincere effort to say Mumbai. It actually, I should be more accepting of it because it’s more of an Indian name. Bombay was something that the British gave us. But, and it’s more, it’s a more English version of Mumbai. So, I should be really proud that it’s, it’s, it’s from my mother town and, you know, that’s where we were say in my language anyways...” (P1, p. 81).

Post-colonial literature emphasizes the idea that in some way the colonizers are “helping” a less-fortunate group of people, and this has left transgenerational scarring (DelVecchio Good, Hyde, Pinto, Good, 2008; Gandhi, 1998). As evidenced by the participants in this study, however, it is difficult to merge their Indian identity separate from colonization. Fanon (1967) has suggested that through colonization and the artifacts it leaves behind, such as books, children begin at a young age to develop a white way of thinking. Further research has identified this problem as a “split self” particularly in Indians which gives pressure to assimilate while simultaneously feeling pressure to remain “ethnic” (Lurhmann, 1996; Rentmeester, 2012; Verges, 2000).

Mental Illness. One of the topics I sought to cover in this research study was perceptions of mental illness from the participants. Participants shared the view that someone with a mental illness would be volatile and unpredictable in their behavior. The Hindi word “pagal” [mad] was used to describe someone with a mental illness. One participant shared, “Behaving out of normal... it's almost like.....how do I put it ummm a person who, who definitely seems out of place in that setting where he, he could do you harm, not like violent or something but you don't know, you know?” (P4, p. 82). This was a collective perception among the participants.

Bollywood. A subcategory that emerged from the discussion about mental illness was the theme of learning about mental illness from Bollywood and the media. All seven participants

referenced movies as a resource and recounted Bollywood films for examples. Participant 4 again says, “It's how it used to be described in Bollywood and all that like mass hysteria, people with too much hysteria or just crazy actions” (p. 83). Despite the fact that participants were spread across India in both urban and rural settings, every one of them had considered this a resource when asked where they got their ideas about mental illness.

These findings are twofold. Firstly, these findings support the literature that says that although the idea of mental illness has existed in India for a long time, psychiatry with a medical-model focus has been at the forefront (Hoch, 1974; Jain & Sandhu, 2013; Raney & Cinarbas, 2005; Wagner et al, 1999). This means that individuals from India would not recognize common disorders such as anxiety or depression as mental illness and would only recognize extremely disturbed people such as those with paranoid schizophrenia. It is only very recently that more common mental illnesses have been recognized (Aggarwal & Berk, 2015; Carson, Jain & Ramirez, 2009; Decker, Nair, Saggurti, Sabri, Jethva, Raj, Donata & Silverman, 2013; Dongre & Deshmukh, 2012; Jacob, 2008; Shrivastava, Johnston, Stitt, Thakar, Sakel, Iyer, Shah & Bureau, 2012). Secondly, the findings recognize that media is a resources from which participants got information about mental illness. Research suggests that mental illness is surrounded by a lack of knowledge and resources (Hoch, 1974; Jain & Sandhu, 2013; Raney & Cinarbas, 2005; Wagner et al, 1999). Individuals would resort to another means from which to get information.

Mental Health. In opposition to mental illness, participants were also asked their perceptions of mental health. The main consistency that emerged here was confusion or hesitation regarding the definition of mental health. One participant said, “I’m trying to think of what I would relate to mental health, I think, I guess being healthy and how you, I don’t know. I guess mental health

relates to how you, how you like your job, how you like your living, how you... As being a person, happy, you are, mentally, you are healthy”, (P5, p. 84). This seemed to exemplify the perceptions of all the participants as evidenced by them asking me to clarify the question and taking a long time to think before answering. Only one participant could describe mental health as it pertained to herself, saying, “I mean for the most part I'm reasonable, but there's times when I, I am upset over things that aren't really even necessary to be upset about. But you still cannot get your mind off it, and you feel like you need to obsess about it, for some reason. So that's where I think I'm not mentally healthy”, (P1, p. 84).

This outlier to the participants is important in the findings because literature suggests that further research needs to be done with this population around the topic of mental health (Das & Kemp, 1997; Dasgupta, 1998; Whitley, 2014). It is clear that the majority of participants are not familiar with the terminology of therapeutic practices due to a lack of cultural relevance which with they were initially presented (George & Pothan, 2013; Jain & Sandhu, 2013; Kakar, 1991; Quack, 2012; Raney & Cinarbas, 2005). As research has shown, the Indian foreign-born population in the United States is carrying with them the ideas and perceptions from the culture of origin, as this study has supported (Bhattacharjee, 1992; Das & Kemp, 1997; Dasgupta, 1998; Farver, Narang & Bhadha, 2002; Guzder & Krishna, 2005; Mehra, 1998; Naidoo, 2005).

Treatment of Mental Illness. The treatment of mental illness was discussed with more ease than the actual definition of mental illness. Participants had clear perceptions of how individuals with a mental illness would be treated. Two subcategories emerged from the data; spirituality and science/medicine as methods of treatment. In most cases families would simultaneously try both forms of treatment.

Spirituality. Spirituality was perceived by every participant as the course that most people would take initially. One participant said, “simultaneously they will try, you know pooja [prayers], and seeing if you know, something, some form of negativity could be relieved off him and it may help or may not. But it couldn't hurt, is what they say and they would try. I think that would be more common” (P1, p. 85). Another participant shared the different forms that spiritual healing could take. He said, “Back home maybe they might beat him it depends you know? Like mental illness, sometimes you tie them...” (P3, p. 85). Here the participant is referring to trying to beat the evil spirit out of an individual deemed possessed, or chaining them to the wall of the temple for the priests to take care of. Participants also shared that they would personally seek spirituality as a help-seeking method. This will be discussed further under the theme “Help-Seeking Methods”.

Science/Medicine. Utilizing science or medicine was another form of treatment for mental illness. One participant acknowledged that there are psychiatric hospitals which could treat people. He says, “I saw in the movie so they one guy has like some problems. So they take him different place you know they treat and keep, try to like. It's kind of like prison it's kind of, it was kind of prison” (P3, p. 85). Another participant shared that people who had a mental illness might be hidden away and cared for by the family with the explanation that they were physically sick. She shares, “Like if there's somebody in their family members who they respect, they would always keep them in their house. There's not a term, or they would say oh “woh bimar hai” [they're sick] or something like... They're, they're not just not doing well. And every time you'll come oh they have a cold, this time, their kidney or they're going to like oh they're having a heart surgery. Whereas they will actually be going to the hospital to like get them treated”, (P2, p. 85).

These findings related to perceptions of the treatment of mental illness are fully supported in the literature. Research had broken down the three forms of healing into folk methods, spiritual methods, and scientific methods (Jain & Sandhu, 2013; Kakar, 1991; Quack, 2012). It has been established in the literature that individuals in Indian society will seek help from spiritual sources before Western medicine, as supported by the participants in this study (Campion & Bhugra, 1998; Chowdhury, et al 2001; Hoch, 1974; Raney & Cinarbas, 2005; Saravanan et al 2008; Wagner et al, 1999). Chaining someone to the wall of a temple or beating them are examples of traditional methods of healing that have been researched as being utilized in the literature (Hoch, 1974; Raney & Cinarbas, 2005; Saravanan et al, 2008; Wagner et al, 1999). Scientific or medicinal forms of healing are typically utilized in conjunction with spiritual forms of healing as the literature has suggested (Joel et al, 2003; Saravanan et al, 2008).

Counseling. The perception of counseling is the final subcategory to cultural perceptions and only came up as a subcategory when directly asked. No participant voluntarily spoke about counseling as a way to treat mental illness on their own, and all but one participant denied utilizing counseling services.

Stigma. The subcategory of stigma emerged from the data in relation to counseling. Counseling was perceived as a very stigmatized concept when viewed through the Indian cultural lens. One participant shared, “They look at it as a taboo. They look at it as inefficiency of theirs if they need to go to a counselor. Very stigmatized, because society likes status” (P1, p. 86). One participant acknowledged that for Indian immigrants to the United States, there might not be as much stigma associated with it. She said, “And again counseling is a stigma here, for Indians- or there, not as much here I'd say” (P6, p. 86).

The findings regarding counseling are not surprising as revealed by the literature. Counseling is still in the beginning stages in India (Carson, Jain & Ramirez, 2009; Jain & Sandhu, 2013). It is clear that individuals would utilize traditional methods of healing as discussed above since counseling is relatively unheard of (Campion & Bhugra, 1998; Saravanan et al, 2008; Quack, 2012; Raney & Cinarbas, 2005). Most of the research on counseling, however, is quantitative rather than qualitative and has not been done in the counseling profession, and typically has not been done in the United States (Bhugra & Becker, 2005; Bhui et al, 2003; Das & Kemp, 1997; Dasgupta, 1998; Eisenbruch, 1990 & 1991; Farver, Narang & Bhadha, 2002; Guzder & Krishna, 2005; Whitley, 2014). Again, the research that has been done has shown that the Indian diaspora in the United States retains cultural values (Agarwal, 1991; Kaul, 1983; Naidoo, 1985 & 1986; Wakil, Siddique & Wakil, 1981). This would suggest that Indian immigrants also carry with them their perceptions of counseling, which has been supported in this present study.

Help Seeking Methods

Shared lived experiences of participants emerged from the data about ways that participants sought help. There were a variety of resources mentioned that were broken in to the subthemes of spirituality, familial support, friend support, a similar cultural background, and finally, self-reliance. These subthemes had secondary subthemes. Spirituality had embedded the subthemes of karma and parental respect. These experiences are what participants had observed being done, or what they themselves have tried.

Spirituality. The use of spirituality was the highest observed subtheme to methods of help-seeking that emerged from the interviews. One participant shared, “if I’m alone and I’m scared about something or I’m out somewhere where I’m freaking out, I quietly pray and I feel better. I

think it just calms me down” (P1, p. 88). Most participants shared a similar feeling of utilizing spirituality as a support. Karma and parental respect emerged as secondary subthemes.

Karma. Two participants shared that although they were indifferent to religion as a personal method of support, they strongly believed in the concept of karma. One participant put it this way, “I deeply, deeply believe in karma. If I have done something wrong to you, it will come back to me. Not today, not tomorrow, but in 10 years from now, it will come back” (P2, p. 88). Karma is a concept of Hinduism which has permeated the culture of India.

Parental Respect. Another subtheme among participants was the idea of following spiritual rituals due to parental respect when seeking help. One participant who self-identifies as being indifferent about religion shared, “I guess a pretty big part [of help seeking] cause mom's always looking at him for like solutions to their problems, visiting him pretty frequently. I've been a few times, yeah. I mean just sit there, takes a couple of minutes really, it's not much to do, and he'll like ask you, like what's bothering you and he'll do his little thing, like if you're shoulder's bothering you he'll put his hand on your shoulder, or something like that” (P7, p. 88-89). Although he himself is indifferent about utilizing spirituality as a support, it's clear that his parents view it as a strong resource for numerous reasons. Two participants shared that they follow the rituals when in India, but not on their own as immigrants in the United States. Spirituality may not have been a source of personal support for every individual, but it seemed that they were familiar with it being utilized and may even maintain pieces of the religion, such as the belief in karma, without following all the rituals associated with it.

These findings support previous research that identify spirituality as a method of help-seeking utilized even before scientific approaches (Campion & Bhugra, 1998; Chowdhury, et al 2001; Hoch, 1974; Raney & Cinarbas, 2005; Saravanan et al 2008; Wagner et al, 1999). Hoch

(1974). The literature has also suggested that astrological influences, such as the use of kundli to make decisions regarding marriage as participant 1 discusses, is also a method of help-seeking utilized (Campion & Bhugra, 1998; Chowdhury, et al 2001; Hoch, 1974; Jain & Sandhu, 2013; Kakar, 1991; Raney & Cinarbas, 2005; Saravanan et al 2008; Wagner et al, 1999). Authors Hoch (1974) and Kakar (1991) have suggested that the majority of people in India are influenced by the Hindu religion including the concept of karma. This is supported in this study with two participants discussing the notion of karma and how it shapes their help-seeking experiences. Additionally, many researchers have suggested that Indian immigrants retain their traditional thoughts on religion, as supported in this study (Agarwal, 1991; Kaul, 1983; Naidoo, 1985 & 1986; Wakil, Siddique & Wakil, 1981). Seeking help through religious means out of respect for parents is also supported in the literature. As Kakar (2002) and Farver, Narang and Bhadha (2002) have noted, the concept of the self with Indian clients is integrated with the family. Although there is a geographical gap between the parents and children who have immigrated, the collectivist orientation remains (Dasgupta, 1998; Farver Narang & Bhadha, 2002). There is no surprise here then, that immigrants would continue to involve their parents in help-seeking and take their advice and suggestions even if it goes against their personal beliefs.

Familial Support. Beyond religious suggestions and advice, parents, extended family, and siblings are all sought after as a method of help-seeking. Every participant brought up family as a support for issues pertaining to mental health and mental illness. For issues pertaining to relationships, extended family and siblings were approached for help. Otherwise, participants always included parents. Stated simply, “If you have parents you first talk to them” (P3, p. 90). One participant shared that he spoke to his father for financial advice, while another participant shared having deep discussions with his father about happiness. Siblings and extended family

were also utilized as a form of support in addition to parents. Occasionally they were approached for relationship advice as well, since participants reported that sharing relationship details with their parents could be difficult. This was a shared pattern across all seven participants. One participant said, “Relationship advice: sister. that's why sisters really good cause every time there's a problem I'm going through, a number of breakups, you go to your sister and she's like no that's fine just move on” (P6, p. 90).

These findings continue to support the research that suggests that the communal self is more important than the individual, and that that thought and practice is carried across the sea with the Indian diaspora in the United States (Berry & Kim, 1988; Farver, Narang & Bhadha, 2002; Moodly, Rai & Alladin, 2010). Moodly, Rai & Alladin have suggested that Indian perspectives on being independent is the same as being selfish, and that being dependent on family is also seen as being caring. These are very different beliefs than are typically found in the West. Berry and Kim (1988) have asserted that maintaining a strong ethnic identity is the healthiest way to adapt to a new culture, and Dasgupta (1998) as noted that this is a pattern for Indians immigrating to the United States.

Friend Support. If families are not viewed as a viable resource for help-seeking, the next avenue was reported to be friends. As immigrants, friends could be geographically separated from the individual, however, that was not viewed as a barrier to help-seeking. These friends were also all of the same cultural background as them, meaning they were all originally from India. One participant said, “And then I have, like you know, a handful of best friends, but they're not like nearby. I have a few friends in India but then you're always on the chat group with them. Yeah so that's actually really nice you know. We are there and talk to each other so

it's nice" (P6, p. 91). This subtheme of friendship as a strong source of support was shared across all seven participants.

Part of maintaining a strong cultural identity would be keeping ties with the culture of origin through friends that are still members of that culture (Dasgupta, 1998; Farver, Narang & Bhadha, 2002). Salo and Birman (2015) suggested that home life macrosystem of Indian immigrants would be focused on India, rather than the United States (Bronfenbrenner, 1977). Utilizing friends with the same cultural background as a source of support was viewed as natural for all participants in this study.

Similar Cultural Background. In addition to having friends and family as support, living near people of a similar cultural background was also regarded as a form of support when seeking help. This provided participants with the comfort of food, language, or religion easily when needed. One participant shared with me, "That's, I would say was like the root cause of how I've started feeling comfortable and started gaining confidence was because I knew there were like other people with me and I could and its weird but like after a while like when I just had to speak English, I actually craved speaking Hindi. And then finally when I could speak Hindi with someone I used to feel like really, really nice. So like you know so that just brings you really close. Just like we know we always hear like food brings people closer" (P2, p. 92). All seven participants again shared this subtheme. Participants had the comfort of speaking their language of origin as well as finding ingredients for food that was comforting and that are not typically found in the United States. This sense of community was relied upon by participants when seeking help.

The research that has been done in the United States with immigrants from India supports these important findings (Das & Kemp, 1997; Dasgupta, 1998; Whitley, 2014). Research has

shown that this particular group retains its cultural tastes and traditional thoughts as supported by the participants here (Agarwal, 1991; Kaul, 1983; Naidoo, 1985 & 1986; Wakil, Siddique & Wakil, 1981). Dasgupta (1998) has gone so far as to say that Indian immigrants have “reinvented” their culture in the United States (p. 954). Whatley and Batalova (2013) have underlined this citing statistics that one-third of Indian immigrants in the United States resides in only two states. Cultural bereavement is minimized through ethnic density according to the literature, which is supported through the statements of the participants here (Bhugra & Becker, 2005; Bhui et al, 2005).

Self-reliance. Finally, self-reliance was a subtheme that emerged from the data in regards to methods of help-seeking with Indian immigrants. Technology and drinking were considered methods of “dealing” with issues that arose. One participant said, “I guess more dealing with it yourself. Yeah I think I have more of the attitude where of you just force yourself to get over it, or just nature plays it course. I definitely like to keep stuff to myself and somethings I don't feel the need to talk to people, and I feel that's common with many other people too. Like I'm sure, yeah” (P7, p. 93). Participant 1 said she used search engines to examine symptoms or ways of helping with various issues. Drinking was considered as a short term solution for one participant, who stated, I guess I drink. Yeah, but it only relieves it temporarily, for a couple of hours. It doesn't solve the long term solution unless you keep drinking. [laughs]” (P7, p. 93). Most participants mentioned that they would also try to figure out the problem on their own, or allow time to be a resource to heal rather than seeking help externally.

This was an interesting finding as the literature has ascertained that since Indians are a collectivist group, they would turn to their community for assistance (Das & Kemp, 1997; Dasgupta, 1998; Whitley, 2014). Literature also ascertains, however, that focusing on the

individual and an individual problem could be considered egotistical (Moody, Rai & Alladin, 2010). This would suggest that people of Indian origin may keep a problem to themselves in order to not burden their family or friends, and so as not to be viewed as out-of-control in regards to their feelings, as freedom of expression is often perceived in Eastern cultures (Eleftheriadou, 1994; Moody, Rai & Alladin, 2010). Valuing the communal self over the individual self may mean keeping problems to themselves.

In this study I intended to examine the perceptions and lived experiences of help-seeking as Indian immigrants in the United States. I also was examining the perceptions and lived experiences of seeking help for issues pertaining to mental health. These comprehensive stories and shared themes across participants has provided findings related to categories for help-seeking, cultural perceptions of the concepts of mental health, mental illness and counseling, as well as methods of help-seeking.

Potential Impacts and Limitations

There were four potential impacts and limitations noted in this study. These included limitations with sample representation, researcher bias, data analysis steps, and a reliance on self-report. These potential impacts could offer strengths as well as limitations and will be discussed in this section.

Sample representation is one potential impact or limitation to the current study. My sample was recruited with a snowball sample from the Washington DC metro region. This sample limits diversity regarding the geographic location of the United States and is not representative of the entire Indian diaspora in the United States. Additionally, the participants were from different geographic regions in their home country. As India is known to be a very diverse country, this limits transferability. It should be noted, however, that generalizability is

not the goal of this research, but rather to be transferable to the degree to which the findings are able (Hunt, 2011; Patton, 2002). I remain very specific about extrapolations drawn from this study due to the nature of qualitative research (Patton, 2002, p. 584). The findings from this study are limited to members of the Indian diaspora between the age ranges of 19-31, identified as Hindu, living on the East Coast of the United States. A larger sample size with a more limited geographic range from their country of origin may have provided more insight about this phenomenon.

Researcher bias should also be considered a potential impact, as I am also currently living in the same geographic region of the United States and I am engaged to a member of the Indian diaspora. This could be considered a strength or a limitation as it could have possibly influenced both the data collection process and the data analysis. This could be considered a strength as I was able to quickly build rapport with the participants, which assists in eliciting more data. As I am deeply invested in both the culture of India as well as the culture of the United States, there may be a bias towards one or the other or both. To address these biases, I underwent various methods to enhance the trustworthiness and quality of my study.

A third potential impact and limitation to this study was in the data analysis process. Hycner's (1985) phenomenological data analysis process consists of 14 steps. In the necessity of the research some of the steps were either grouped together or replaced. Step number 6, in which outside, independent judges were trained to verify the relevant units of meaning were replaced in favor of peer review with members of my doctoral committee (Creswell, 2013). Step number ten of writing an individual summary for each interview was also replaced in favor of writing up the themes and member checking the composite findings instead of each individual interview (Creswell, 2013; Patton, 2002).

A fourth potential impact to this study was that I utilized only interviews as the primary and only source of data, which requires complete reliance on self-report. To address this limitation, I utilized thick descriptions, prolonged engagement, peer debriefing, and member checks (Creswell, 2007; Lincoln & Guba, 1985; Patton, 2002). I used thick descriptions of the participant's perceptions and shared experiences by providing verbatim quotes maintained in the context of the questions being asked. The authenticity of the participant's voices enabled me to complete a detailed analysis that was true to their perceptions and experiences. Member checks were utilized to solicit views on the data and credibility of the findings as well as my interpretations. The data analysis and findings were emailed to the participants so they could judge the accuracy of the information gathered. Peer debriefing was completed by sending the findings of the study to a member of my dissertation committee to challenge or validate the data analysis process (Creswell, 2007). Prolonged engagement with the participants is evident through my living with a member of the Indian diaspora and having consistent exposure to the food, language, popular culture, religion, politics, and holidays of the group being studied. This assisted me in building trust and rapport with the participants to contribute to the validation of the study (Creswell, 2007).

Implications and Future Research

Understanding the perceptions and lived experiences of help-seeking for issues including mental health can educate counselors as to how best reach and retain clients from the Indian diaspora in the United States. In the following section I will discuss areas not formerly addressed in the literature and may foster future research associated with counseling and perceptions of mental health among the Indian diaspora.

The perception of help-seeking was shared among participants as something they would only do as a last resort, and considered negatively. Reducing stigma through psychoeducation with this population could encourage utilization of services. Perceptions of reasons to seek help elicited patterns of shared experiences among participants for which it was acceptable to seek help for, such as academic or career issues, medical issues, and some tangible aspects of immigration such as paperwork. These were familiar to participants as the majority of them had heard of or utilized these resources while still in India. There were also categories for which it was not acceptable to seek help, such as relationship issues, racism, or struggles with personal identity. Participants shared that relationships, in particular, were the most difficult to seek help for. This could be due to the shared experience among participants of not feeling comfortable talking to their parents about these issues, which would then leave them limited resources to turn to. It is evident that it is difficult for these participants to go outside the family to seek help. The more counselors are able to learn about the Indian culture, the more comfortable potential clients may feel utilizing services.

Methods of seeking help elicited patterns of shared experiences utilizing religion, family, friends, a community with a similar cultural background, or self-reliance. Spirituality was recognized by all as a form of support. Family and friends, as well as a community with a similar cultural background provided resources needed to seek help. Counselors that are able to become familiar with these groups and join with the culture may then become acceptable to this population and could help to educate and reduce stigma about counseling services. Self-reliance may then be overcome as people have an alternative source outside of the family but that is still safe and familiar to turn to.

As previously stated, there have been few recent studies about the Indian diaspora in the United States (Das & Kemp, 1997; Dasgupta, 1998). Additionally, most of this research has come from literature other than psychology or counseling, and is quantitative rather than qualitative (Das & Kemp, 1997; Dasgupta, 1998; Whitley, 2014). Additional qualitative studies that consider an emic perspective may allow participants of this population to contribute to the body of counseling literature and give researchers ideas from which to elaborate.

Findings from this study align with previous research that suggests that Indian immigrants remain closely tied to their country of origin (Bhattacharjee, 1992; Dasgupta, 1998; Farver, Narang and Bhadha, 2002; Mehra, 1998; and Naidoo, 2005). Further studies may include information regarding whether this is true in regards to help-seeking for mental health issues. Investigating members of the Indian diaspora who are currently utilizing counseling services or have in the past may increase awareness as to what contributes to their success or underutilization of counseling.

Post-colonial perspectives should also be considered when working with any population that has been previously colonized, but especially Indians (DeVecchio Good, Hyde, Pinto, Good, 2008; Gandhi, 1998; Ward, 2012). Critical psychology is only just beginning to examine the implications of post-colonial disorders on counseling (Hook, 2012). The participants from this study demonstrated patterns of perceptions regarding colonization and its influence on their present day psyche. Identity is also affected by colonization and was evident in participant 5 asking “Where do I belong?” (p. 77). This concept of a ‘split-self’ presented by Verges (2000) demonstrated by participant 5 shows the pressure to assimilate while simultaneously feeling pressure to remain authentic (Rentmeester, 2012). More studies acknowledging and contributing

to this body of literature is beneficial for the Indian immigrant population. This could also allow for openness when discussing issues of racism as immigrants in the United States.

Currently counseling theories are rooted in Western concepts of individualism, insight, self-disclosure, a focus on talking, with distinctions between physical and mental health (Azuma, 1984; Kakar, 1991; Sue & Sue, 2012). A more holistic approach with an acknowledgement of the differences as well as an emphasis on Eastern thought processes needs to be researched and applied (Azuma, 1984; Das, 1995; Sue, Arredondo & McDavis, 1992). It has been recognized that multicultural counseling competencies are not enough (George & Pothan, 2012; Kakar, 1991; Moodley, 2010; Raney & Cinarbas, 2005). Learning and integrating indigenous healing practices as well as referrals to outside healing sources should be considered as a form of practice in research.

Finally, theories of acculturation have thoroughly researched designating integration of the host culture and the culture of origin as the healthiest form of adaptation (Berry, 1980; Berry, Kim, Power, Young & Bujaki, 1989; Berry, Kim, Minde, & Mok, 1987; Sam & Berry, 1995). Research has also supported the dangers of cultural bereavement in immigration and how to combat this utilizing a strong ethnic identity (Bhugra & Becker, 2005; Eisenbruch, 1990, 1991; Farver, Narang & Bhadha, 2002; Nerhus, Berg, Haram, Kvitland, Andreassen & Melle, 2015; Phinney, 1990). Some research has shown that cultural bereavement is often misdiagnosed due to misinterpretations by Western trained clinicians (Bhugra & Ayonrinde, 2004; Bhugra & Becker, 2005). Updated on Berry's acculturation research in regards specifically to integration and the Indian diaspora should be considered. Diagnoses of cultural bereavement and ways the Indian diaspora grieves when immigrating is an important line of research that could be explored.

The benefits of a bicultural model instead of a general model of acculturation for immigrants should be considered when working with this population. Gibson (1988) has presented a model of accommodation and acculturation without assimilation for Sikh immigrants from India that better dovetails with the population of this particular study. Parents of Gibson's (1987) study told their children to do what they had to in order to get an education, but not to include in their immigration of the American culture things that were unwanted as dictated by Punjabi culture. Gibson's (1987) participants were quoted as saying, "Dress to please the people but eat to please yourself", (p. 271). This quote acknowledges both the difficulties and advantages of cultural accommodation without complete assimilation.

In summary, the findings and implications of this study drastically add to the literature due to the lack of research of the Indian diaspora in the United States (Das & Kemp, 1997; Dasgupta, 1998; Whitley, 2014). As the Indian immigrant population rapidly expands in the United States, (Whatley & Batalova, 2013), here is a need for counselors to provide sensitive, holistic, culturally enhanced interventions and services for this unique population. Understanding the perceptions and lived experiences of Indian immigrants in response to issues of mental health or mental illness adds to the research that can empower and educate counselors on what is needed and desired by immigrants from India.

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Appendix A

Interview Protocol

WARM-UP ACT

Thank you for taking the time to talk with me today. I greatly appreciate your help.

Please don't be offended if I interrupt, ask clarifying questions, or suddenly shift topics. It's in order to cover the terrain we need to.

First off, a few questions about you and your background to set the context...

Age:

Birth Place:

How long have you lived in the United States?

Occupation:

Are there many people in your place of work that have a similar cultural background?

Religion:

how religious: strong moderate inactive indifferent

how often worships: daily, weekly, monthly, several times a year, yearly, once every several years

Temple in your home? What god/goddess?

Are you a U.S. Citizen?

Counseling/Mental Health

What do you think help-seeking means?

What do you seek help for?

Who would you seek help from?

How would you describe someone with a mental illness (local indigenous terms used)?

How do you define mental health?

What traditional methods of healing exist in your belief system?

Where do you get to know your ideas about mental health (family, religion, media, etc.)?

Who would you talk to first if you had an issue pertaining to mental health (sadness, anxiety, etc.)?

Who would you talk to for career or occupational help?

Is there anything you would not talk to someone about?

PROMPTS, FOLLOW-UPS, ETC.

-Could you elaborate on that?

-Can you think of a specific example or certain time when that happened?

-Is that a fairly typical issue/problem/response/conflict for people from India/your region/your religious belief system?

-Avoid asking “why?” about what the respondent does as it may put the respondent on the defensive (but asking it about others may be a good sense-making opportunity).

-When they mention a problem/challenge, ask about strategy/tactic for resolution: “How do/did you deal with it?” and “Are there some people who manage that challenge well? How do they do it?”

Appendix B

CONSENT FOR RESEARCH

The Pennsylvania State University

Title of Project: Help Seeking Behaviors of the Indian Diaspora in the United States

Principal Investigator: Shannon Shoemaker

Address: 8 Crystal Rock Ct. Germantown, MD. 20874

Telephone Number: 301-820-0504

Advisor: Dr. JoLynn Carney

Advisor Telephone Number: 814-863-2404

Subject's Printed Name: _____

We are asking you to be in a research study. This form gives you information about the research.

Whether or not you take part is up to you. You can choose not to take part. You can agree to take part and later change your mind. Your decision will not be held against you.

Please ask questions about anything that is unclear to you and take your time to make your choice.

1. Why is this research study being done?

This research study is being done to understand the help-seeking behaviors of the Indian diaspora so that as counselors, we can work to provide the best services possible for this particular population. We are asking you to be in this research because you are an expert on your own culture and can work with us to inform us as to what types of counseling

interventions would work best for people of your cultural background, and in your current geographic location.

Approximately 6-10 people will take part in this research study in the DC metro area.

2. What will happen in this research study?

During this research study, you will:

1. Go through the screening process of 4 questions to see if you are eligible to continue in the research.
2. The principal investigator will conduct a semi-structured interview lasting about 90 minutes with questions regarding lived experiences you have had with any type or form of help-seeking, and the behaviors that proceed and follow help-seeking as well as the reasons for seeking help. Any questions that you do not feel comfortable answering, you are free to skip as we go through the interview.
3. The interview will be audio recorded and the data kept on the principal researcher's laptop under password protection at all times. The audio records will be deleted immediately after transcription. The transcriptions will be coded with no identifying information in the research study. Everyone will remain anonymous for the purpose of the write up
4. After the interviews have been transcribed, research participants will be given the opportunity to review their transcription and to add information.
5. After the transcriptions are approved, they will be analyzed and coded and written up into a full study. At that point, research participants will again be given a copy of the research for any additional input or comments for member checking purposes.

3. What are the risks and possible discomforts from being in this research study?

There is a risk of loss of confidentiality if your information or your identity is obtained by someone other than the investigators, but precautions will be taken to prevent this from happening. All identifying information (names, contact information, etc.) will be coded and kept on file under password protection. Audio records will be deleted immediately after transcription which will take place within one week (7 days) of the interview. All written notes will be typed and kept on the principal investigator's computer as well, under password protection.

Due to the nature of some of the questions and the subject of the study, there is a minimal risk for the participant because sensitive information will be asked and collected (such as questions about experience or knowledge of mental health or counseling) and could be identified with the

participant or their friends or family members by the principal investigator and research study members. However, that information will remain completely confidential in the study itself. No questions have to be answered by the participant if they chose to not answer. This could also bring up difficult memories which could potentially harm the participant. If a participant feels they need to speak to someone here are some resources:

Montgomery County Crisis Center
 1301 Piccard Drive, 1st Floor
 Rockville, MD 20850
 240-777-4000 (V)
 301-738-2255 (Mental Health Hotline)
 240-777-4673 (Abused Persons Program)
 240-777-4357 (Sexual Assault Crisis Hotline)
 240-777-4815 (TTY)

The Crisis Center provides 24-hour telephone or walk-in crisis counseling, brief crisis stabilization, and help in obtaining services for individuals and families in a situational or mental health crisis, for adult abused persons and for sexual assault victims. There is no charge for crisis services.

4. What are the possible benefits from being in this research study?

4b. What are the possible benefits to others?

If you choose to participate in this study, you will be informing and bringing knowledge of your particular culture and lived experiences to counselors in order for them to provide the best counseling services possible to your country or people from country. The mental health needs of the Indian diaspora are growing daily and there are not enough trained professionals to help with this epidemic. Additionally, research has shown that counselors who have some knowledge and understanding of the culture are better able to build trust and make better recommendations for treatment that are in line with the client's belief system. Your participation could provide that very much needed knowledge.

6. How long will you take part in this research study?

If you agree to take part, it will take you about 90 minutes to complete the initial interview with the principal investigator. You will be asked for input 2 more times throughout the study, but do not have to participate beyond the initial interview if you do not desire.

7. How will your privacy and confidentiality be protected if you decide to take part in this research study?

Efforts will be made to limit the use and sharing of your personal research information to people who have a need to review this information.

- A list that matches your name with your code number will be kept in a locked file or password protected file on the principal investigator's hard drive.
- Your research records will be labeled with your code number only and will be kept in a locked file drawer in the principal investigator's home.

In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared.

We will do our best to keep your participation in this research study confidential to the extent permitted by law. However, it is possible that other people may find out about your participation in this research study. For example, the following people/groups may check and copy records about this research.

- The Office for Human Research Protections in the U. S. Department of Health and Human Services
- The Institutional Review Board (a committee that reviews and approves research studies) and
- The Office for Research Protections.

Some of these records could contain information that personally identifies you. Reasonable efforts will be made to keep the personal information in your research record private. However, absolute confidentiality cannot be guaranteed.

11. What are your rights if you take part in this research study?

Taking part in this research study is voluntary.

- You do not have to be in this research.
- If you choose to be in this research, you have the right to stop at any time.
- If you decide not to be in this research or if you decide to stop at a later date, there will be no penalty or loss of benefits to which you are entitled.

12. If you have questions or concerns about this research study, whom should you call?

Please call the head of the research study (principal investigator), Shannon Shoemaker at 301-820-0504 if you:

- Have questions, complaints or concerns about the research.
- Believe you may have been harmed by being in the research study.

You may also contact the Office for Research Protections at (814) 865-1775, ORProtections@psu.edu if you:

Appendix C

Verbal/Email Script

Hi! My name is Shannon Shoemaker and I'm currently doing some research on Indian immigrants for my dissertation in my doctoral program at Penn State University. I'm looking for some people who are experts on their culture and who would be willing to talk with me about their personal thoughts and experiences on issues like mental health, counseling, mental illness and other similar topics. _____ put me in touch with you and thought you might be interested. Would you be interested in being a part of this study, educating myself and other counselors on how to provide the best services to people from India? The interview process would take about an hour and we can meet wherever you are most comfortable.

If willing:

Great! Let's set up a time and place that is convenient for you to complete the interview together. If you decide you don't want to participate in the study at any time, then you are free to withdraw. We will sign a consent form at the time of meeting and I will explain the process fully then. In the meantime, here is my contact information in case you have any questions or concerns: email: sshoemaker5193@gmail.com or phone 301-820-0504. Thank you for your time.

If unwilling:

Thank you so much for your time and consideration. If you later decide you would like to participate in the study, please feel free to contact me at any time. My email address is sshoemaker5193@gmail.com or I think your input could be very helpful.

Since I am the principal investigator you may contact me via email: sshoemaker5193@gmail.com or by phone at 301-820-0504.

Appendix D

Approval Letter

PENNSTATE



IRB Program
Office for Research Protections

Vice President for Research
The Pennsylvania State University
205 The 330 Building
University Park, PA 16802

Phone : (814) 863-1773
Fax: (814) 863-8699
Email : orprotections@psu.edu
Web : www.research.psu.edu/irp

APPROVAL OF SUBMISSION

Date: September 22, 2015

From: Julie James, IRB Analyst

To: Shannon Shoemaker

Type of Submission:	Modification
Title of Study:	Help-Seeking Behaviors of the Indian Diaspora in the United States
Principal Investigator:	Shannon Shoemaker
Study ID:	STUDY00003254
Submission ID:	MOD00004700
Funding:	Not Applicable
IND,IDE, or HDE:	Not Applicable
Documents Approved:	• Interview Protocol.docx (3), Category: Data Collection Instrument
Review Level:	Expedited

On 9/22/2015, the IRB approved the above-referenced Modification. This approval is effective through 8/26/2016 inclusive. You must submit a continuing review form with all required explanations for this study at least 45 days before the study's approval end date. You can submit a continuing review by navigating to the active study and clicking 'Create Modification / CR'.

If continuing review approval is not granted before 8/26/2016, approval of this study expires on that date.

To document consent, use the consent documents that were approved and stamped by the IRB. Go to the Documents tab to download them.

In conducting this study, you are required to follow the requirements listed in the Investigator Manual ([HRP-103](#)), which can be found by navigating to the IRB Library within CATS IRB (<http://irb.psu.edu>). These requirements include, but are not limited to:

- Documenting consent
- Requesting modification(s)
- Requesting continuing review
- Closing a study
- Reporting new information about a study
- Registering an applicable clinical trial
- Maintaining research records

This correspondence should be maintained with your records.

Shannon M. Shoemaker, M. Ed., NCC

8 Crystal Rock Court
Germantown, MD. 20874

301-820-0504
Sshoemaker5193@gmail.com

EDUCATION

Doctor of Philosophy in Counselor Education and Supervision 2013-2016 (expected)
Pennsylvania State University, University Park, Pennsylvania
Advisor: JoLynn Carney, Ph.D.

LICENSES/PROFESSIONAL CERTIFICATES

National Certified Counselor (NCC) #276781 2013-2018
School Social Worker/School Adjustment Counselor #449471 (MA only) 2010-present

TEACHING EXPERIENCE

Adjunct Faculty *Marymount University* 03/2015-present

- Theories and Techniques of Family Counseling; Career Counseling

Instructor *Penn State University* 01/2014-05/2015
The Pennsylvania State University, State College, PA

- Rehabilitation and Human Services Practicum

Adjunct Professor *Easter Nazarene University* 08/2013-06/2013

- Educational Psychology; Foundations of Ed; Classroom Management

Teaching Assistant *Bridgewater State University* 05/2010-12/2012

- Psychological Assessment; Creativity and Counseling; Wellness; Grief Counseling

PROFESSIONAL EXPERIENCE

Alumni Career Counselor *Career Services, Penn State University* 04/2014-03/2015
Behavioral Specialist *Blackstone Valley Voc Tech* 08/2010-06/2013
Mental Health Counselor *Charis Counseling Center* 05/2010-05/2012
Milieu Aide *South Shore Educational Collaborative* 08/2007-05/2010

PUBLICATIONS

Refereed:

Lindinger-Sternart, S., Laux, Jain, S. & **Shoemaker, S.** (in process). Testing Levinson's theory using a sample of mothers in the criminal justice system. *The Professional Counselor*.

Book Chapters

Agaskar, V., Jain, S., & **Shoemaker, S.** (in process). School Counseling In India. John Carey (Ed.)

REFEREED PRESENTATIONS

International

Shoemaker, S. (2015, September). Mental Health and the Media: Depictions of Mental Health in Bollywood. International Association for Counselling. Verona, Italy

Shoemaker, S. (2015, September). Integration of Religious and Spiritual Values in Group Therapy. International Association for Counselling. Verona, Italy.

Shoemaker, S. (2015, September). Perceptions of Mental Health in India: A Pilot Study. International Association for Counselling. Verona, Italy.

National

Shoemaker, S. (2015, April). Mental Health and the Media: Depictions of Mental Health in Bollywood. Association for Creativity in Counseling, San Antonio, TX.

Shoemaker, S. (2015, April). Creating a Bucket List to a Brighter Future. Association for Creativity in Counseling, San Antonio, TX.

Freeburg, M.N. & **Shoemaker, S.** (2013, October). Profession Advocacy Implications for Educators: Results From a Research Investigation of ACA Members Perceptions, Association for Counselor Educators and Supervisors, Denver, CO.

Freeburg, M.N. & **Shoemaker, S.** (2012, September). Counselor Wellness and the Murder Mystery Party. Association for Creativity in Counseling, Memphis, TN.

Freeburg, M.N. & **Shoemaker, S.** (2012, September). The Weight of Rocks. Association for Creativity in Counseling, Memphis, TN.