Let's talk mental health: Analysis of Indian immigrant women's culturally centered mental health perceptions and identifying modifiers in interventions

by

Sakshi Bhati

B.S., Pittsburg State University, 2018
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AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

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Abstract

Mental health problems such as depression and anxiety are common among immigrant groups in the United States. Differences in cultural values and practices inform the variety of mental health perceptions and behaviors. Negative perceptions and barriers persist among Indian immigrant women due to stigma and fear of judgment. Although previous research has documented the prevalence of mental health diseases among Indian immigrant women, there is a limited understanding of the role of Indian culture in influencing perceptions and help-seeking behaviors. This hinders improvement in interventions and campaigns for cultural communities. To fill these gaps, this health communication research aimed to develop a thorough understanding of how culture shapes mental health perceptions and help-seeking behaviors among Indian immigrant women and to elicit recommendations for enhancement in the current intervention from community mental health experts. Using Hofstede's cultural determinants theory, culture-centered approach, and collective leadership as a theoretical framework, this study employed a hermeneutic phenomenological approach using in-depth semi-structured interviews among Indian immigrant women and focus group discussion among mental health experts.

Findings indicated that the Indian culture negatively influences perceptions and behaviors among Indian immigrant women. Masculinity, collectivism, high power distance, and uncertainty avoidance restrict women's mental health expression and ability to seek help. Further, Indian immigrant women's lived experiences, along with cultural and social factors, shape their perceptions. Additionally, acculturative experiences hinder mental well-being but also improve Indian immigrant women's outlook on diseases and treatments. These women also perceive contextual and cost-related barriers while also facing difficulty in communicating about

mental health due to a lack of awareness and openness among other Asian Indians. To address these challenges, mental health experts elicited recommendations for mental health experts to be proactive in the immigrant communities. They also provided enhancement opportunities for universities to improve their accessibility for international and immigrant communities and train future therapists to become more culturally attuned. Additionally, cultural ambassadorship must be adopted to reach immigrant communities through leaders. The theoretical and practical implications of this research are highlighted in the study. The study suggests further research in understanding the role of culture in mental health topics among minority groups with the use of culture-centered approach that can accentuate development in health interventions. It provides avenues for social change scholarship in health topics that can look beyond Western biomedicine. The study concludes by presenting an overview of the completion of research goals.

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Dedication

To Papa.

Chapter 1 - Introduction

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (2004, p.11). On the other hand, the absence of psychological well-being that affects the cognitive, emotional, and behavioral state of mind can be caused by diseases such as depression, anxiety, and is referred to as mental health illness (Manderscheid et al., 2010). Western biomedicines assume a linear pattern of disease occurrence, treatment, and adherence (Dressler & Oths, 1997), leaving behind the beliefs and meanings individuals associate with disease and treatment rooted in their representational culture. Cultures may impact and contribute to the cause of illnesses and related symptoms (Bhugra et al., 2021), and due to this, diverse cultural beliefs may influence how people seek care outside the mainstream health system, such as through alternative or traditional medicine or self-reliance (Shi et al., 2020).

According to the WHO's Mental Health Report (2022), common mental health issues like depression and anxiety are not considered illnesses that need to be treated by conventional medical institutions in many cultural settings. Specific subgroups may be more sensitive due to cultural influences, which can also change attitudes and explanations of illnesses (Bhugra et al., 2021). Further, WHO (2013) points out that although the necessity for devoted assistance for those with severe mental health issues is widely recognized, current evidence-based interventions may not correspond to assumptions about how that support should look. Instead, it is usually anticipated that these illnesses would improve with the help of social and emotional support and through alternative, complementary, or conventional healing approaches (Ventevogel et al., 2013).

Over the years, mental health diseases have been prevalent in immigrant communities in the United States. Urquia and Gagnon (2011) define an immigrant as an individual who has sought permanency in a nation foreign to their birth country. This classification of foreign-born includes legal non-citizen residents, refugees, unauthorized immigrants, lawfully naturalized citizens, asylees, and permanent residents (Khullar & Chokshi, 2019). The United States attracts about 1 million immigrants every year, rapidly increasing this stratum of population in the country (Budiman, 2020). For many of these people, immigration may cause stress and psychological disorders such as depression and anxiety. The prevalence of depression has been reported in several immigrant sub-populations, such as Mexican immigrants (Hovey, 2002), Korean immigrants (Oh et al., 2002; Wu et al., 2009), Indian Immigrants (Robert et al., 2016), as well as Chinese immigrants (Zhang et al., 2013). Moreover, a study conducted among Asian immigrant elders (including nationalities such as Chinese, Vietnamese, Filipino, Indian, and Japanese) reported that 40% of the population is depressed and that high stress related to settling in the host country causes a high depression rate in these sub-groups (Mui & Kang, 2006). Several factors associated with immigration and adjusting to the host country's culture, such as linguistic barriers, economic stresses, lack of community and family support, and other sociocultural factors, have been reported to cause mental distress among immigrant populations in the United States (Delara, 2016; Mann et al., 2017; Wu et al., 2009).

Differences in cultural values and practices among immigrant sub-groups inform differences in mental health perceptions. These perceptions are often why immigrants may or may not choose to seek mental health counseling when needed. Kumar & Nevid (2010) conducted a study to understand the perceptions of mental diseases among Asian Indian immigrants, along with analyzing the effects of learning the culture of both the host and native

country on their help-seeking motives. Results indicated that there was a lack of recognition of psychological disorders among males, which had the potential for neglected help-seeking actions. Additionally, women's mental health was often associated with shame and guilt, further causing denial in their mental well-being (Kumar & Nevid, 2010). Similarly, Galvin and colleagues (2022) reported that religious beliefs and non-western medicinal attitudes and perceptions were the cause of the low utilization of mental health services among immigrants in the United States. A greater emphasis in mental health communication research must be placed on immigrants' culturally embedded perceptions, values, and beliefs that shape their psychological well-being behaviors (Galvin et al., 2022).

As the immigrant population continues to increase in the U.S., Indians remain the third largest population to migrate and are the fastest-growing population among minority groups (Budiman, 2020). Like many communities across the world that have stigmatized beliefs regarding mental health (WHO, 2013), Indians perceive mental health differently as well, associating mental health care and illness differently based on sociocultural norms and definitions (Roberts et al., 2016). Moreover, the stigma associated with the diseases and treatment persists in developing nations like India, which further keeps them from obtaining help (Mascayano et al., 2015). A study conducted by Leung and colleagues (2011) found that Asian Indians in the U.S. often reported depression caused by anxiety, unemployment, and issues in interpersonal relations. This may be due to increased expectations of family members to perform well after migration (Leung et al., 2011). Due to perceived barriers and stigmatized cultural perceptions, Indian Immigrants tend to suffer in silence since they opt out of getting professional help and rely on friends, family, and religious leaders (Leung et al., 2011).

Compared to men, women are more likely to develop mental health diseases such as depression and anxiety. Remes and colleagues (2016) conducted a systematic review of the prevalence of anxiety disorder across 48 studies. They revealed that, compared to men, women are more prone to experience anxiety disorders throughout their lives (Remes et al., (2016). Additionally, the risk of depression and anxiety is more likely to increase with age among women in the United States (Zender & Olshansky, 2009). Within this sub-group in the U.S., immigrant women tend to suffer from additional challenges when it comes to their mental health. Personal and sociocultural factors continue to shape how immigrant women perceive mental health and take action to seek help (Delara, 2016). They not only suffer from depression, but they also tend to deal with physical and mental abuse, isolation, racism, linguistic challenges, and external pressure from the family and community in the U.S. and back home, causing more distress. For instance, Wu and colleagues (2009) conducted a study to identify individual and context-based barriers to mental health help-seeking among Korean American (KA) Immigrant women. Results indicated that KA immigrant women perceived contextual barriers such as stigma, lack of partnership with religious entities, and financial constraints. Individual barriers among participants included commuting issues, lack of family support to seek help, language barriers, time constraints, and lack of knowledge regarding diseases and resources (Wu et al., 2009).

Further, among several barriers discussed, stigmatization of mental health diseases has also been reported among immigrant women. For example, Ezeobele et al. (2010) conducted a study among Nigerian-immigrant women about their perception of mental health in the United States. Results indicated that depression was perceived to be non-acceptable among participants. These women also identified religious practices to be a cure for mental health diseases (Ezeobele

et al., 2010). Additionally, immigration and law-related stress, social isolation, fear and mistrust, and anti-immigrant sentiments were also reported among immigrant women in the U.S. (Ryan et al., 2021).

Among immigrant populations, Indian immigrant women have been documented to be susceptible to mental health diseases, and several sociocultural factors have been reported to influence how they perceive diseases and counseling. For example, a study conducted among Asian Indian immigrants revealed that women have a higher rate of depression and anxiety compared to men (Roberts et al., 2015). Within this, harmful spiritual healing practices and anxiety were associated with increased levels of depression, and participants reported being stuck in a gap between maintaining Indian values and adapting to the U.S. culture (Roberts et al., 2015). Similarly, Mann and colleagues (2017) identified that conflicts related to gendered roles and procreational expectations within families back home were also a cause of mental health problems among Indian immigrant women. They also pointed out that conflicting cultural values have been significantly contributing to poor mental health well-being and reduced help-seeking behaviors (Mann et al., 2017). However, much research is needed on Asian immigrants to understand their experiences with mental health diseases (Remes et al., 2016). By examining the influence of cultural determinants on mental health perceptions through Indian immigrant women's lived experiences pre- and post-migration, we are likely to establish an in-depth understanding of how these perceptions have been impacting their mental health decision-making toward counseling-seeking in the United States. This information can then help in navigating practical enhancements in the current mental health interventions and campaigns.

Problem Statement

Research has evidenced the prevalence of mental health diseases such as depression and anxiety among Indian immigrant women and identified cultural and linguistic barriers that dissuade them from accessing mental health care (Mann et al., 2017; Roberts et al., 2015). However, there is a limited understanding of the role of cultural determinants that influence mental health perceptions and barriers. Research is needed to gain in-depth knowledge from lived experiences in the Indian culture that have shaped their perceptions of mental health diseases and treatments. It is crucial to understand how Indian immigrant women articulate mental health topics, how their lived experiences create perceptions about diseases, and how culture and its determinants play a role in the formation of these perceptions. To achieve this, it is essential to extract several facets of the Indian culture that have played a role in the formation of the mental health perceptions that enforce decision-making and behavior toward seeking help. These facets can include how gendered roles persist and encourage health meanings and outcomes in a culture, whether the communities prioritize group goals and needs over individual ones and how this affects individual decision-making, how social hierarchy can influence health behaviors, etc.

The limited understanding of the role of culture in mental health can hinder the enhancement of culturally sensitive interventions and health communication campaigns. To address this issue, this research took a process-based, critical cultural approach to mental health communication. It provided Indian immigrant women participants a platform to share their mental health perceptions and invited experts to brainstorm enhancement opportunities to supply tailored services that meet the audiences' needs.

Study Purpose

In light of advancing mental health communication research and knowledge, this study explored how mental health perceptions are developed by understanding the lived experiences of Indian immigrant women. Further, the research explored enhancement opportunities in current mental health interventions tailored to immigrant women clients. Along with studying the cultural beliefs and norms that shaped their conceptualization of mental health, the discussion also provided insights from their experience after immigration and how their health meanings have evolved compared to their experiences in India.

Health communication research focuses primarily on health education and message dissemination that fosters positive health outcomes. Scholars have discussed the importance of furthering research that foregrounds the importance of culture in health (Chandra et al., 2015; Dutta & Basu, 2007; Galvin et al., 2022; Mann et al., 2017). Beyond this, with the aim to build a comprehensive understanding of the role of culture in mental health perceptions among Indian immigrant women, this research also built a bridge between the participants and experts to communicate women's perspectives, perceived barriers and benefits, cultural meanings, and the health needs that can help them and future researchers to acknowledge the essentiality of culture and context in mental health.

To explore culturally shaped perceptions, a theoretical framework consisting of Hofstede's cultural determinant theory and culture-centered approach was used to discover how culture and its dimensions contribute to the meaning-making process of perception formation. Geert Hofstede's cultural dimensions theory is a framework that helps identify determinants embedded in transnational regions that define a culture. By infusing Hofstede's dimensions of culture, including the role of religion, power, gender, as well as societal structures (collectivism/

individualism), the study informed how mental health perceptions are embedded in the lived experiences through the phenomenon of knowing and understanding diseases such as depression and anxiety and explored how sociocultural factors have shaped the meaning-making processes among these women.

The culture-centered approach (CCA) provided a framework within which a marginalized population group (Indian immigrant women) shared their culturally shaped mental health meanings and perceptions, which were then negotiated for in an attempt to elicit improvements in the current interventions. Working within CCA, this study extended to the solution-oriented phase, where nonprofit mental health experts were invited to discuss enhancement opportunities in the current mental health interventions for immigrant women clients. To explore enhancement opportunities, agency (within CCA) and collective leadership frameworks were used to build a theoretical structure.

Significance/Justification

The findings articulating the lived experiences of knowing mental health among Indian immigrant women were utilized to generate enhancement opportunities with mental health experts. By communicating their perceived barriers and benefits without disclosing identifiable information, the study used a problem-solving technique within this research framework to offer recommendations and resources for our immigrant community members and mental health experts. Including a cultural lens to understanding mental health concepts engaged our experts to acknowledge and identify ways of tailoring services that recenter culture and its role in shaping the meanings, people associate with their healing processes. Through this, the study further aimed to add to the existing health communication literature on immigrant women's mental health perceptions and behaviors that are influenced by their culture.

The literature on mental health among immigrant populations has increasingly identified various barriers immigrants, including Asian Americans (Robert et al., 2015; 2016; Wu et al., 2009) and Latinos (Kouyoumdjian et al., 2003) face while seeking mental health help. This study goes beyond just identifying barriers, engaging in understanding how topics of power distance, uncertainty management, and Indian cultural orientation based on collectivism vs. individualism, as well as cultural and social factors such as religion, gender, family, and communities, have helped them define health topics, primarily mental and psychological well-being.

Further, engaging with nonprofit mental health experts to offer solution-oriented recommendations was an effort to showcase collective voices being reached to experts in the field. Beyond just recommendations, this engagement process attempted to create spaces for conversation for mental health experts to engage in topics that work toward a collective purpose: to serve our immigrant community members. Moreover, communicating Indian immigrant women's health perceptions (with anonymity) helped them articulate a significant aspect of their client's lives: their cultural context. Additionally, within the conceptual framework, these culturally shaped voices were being heard by experts.

Organization of the Document

Following this introduction, I have organized this dissertation into four consecutive chapters. Chapter 2 embarks on the reviewed literature, theoretical framework, and the proposed research questions. Chapter 3 provides information on the qualitative methodology adopted in the study along with details on the research methods, participants, data collection process, as well as data analysis procedure. Chapter 4 depicts the research findings that inform responses to the established research questions. Finally, Chapter 5 provides a detailed discussion of the

findings and elicits recommendations. It further concludes the research with theoretical and practice implications and limitations.

Chapter 2 - Literature Review

To understand how culture and its dimensions shape mental health perceptions, this chapter provides an overview of the existing literature on culture and mental health, the importance of context and acculturation as well as mental health perceptions globally, in the U.S., and among immigrants residing in the U.S. Additionally, it offers details on the theoretical framework applied to the current study.

Culture in Health Communication

The term culture is seen as a broad, subjective terminology that explains a system developed by social interactions and meaning construction through the transmission of information (Dressler & Oths, 1997). Defining the role of culture in understanding health and analyzing the meaning that is associated with an experience is becoming increasingly important in health communication research. Culture actively plays a moderating role in defining health behaviors and influences how individuals perceive and tackle health diseases (Dressler & Oths, 1997). Social scientists like Collins O. Airhihenbuwa, Deborah Lupton, and Mohan Jyoti Dutta have taken a critical lens of understanding health behaviors wherein culture is at the crux of meaning-making through social interactions. Lupton (1994) argued that health has been understood in a linear, individualistic fashion for generations. This approach to health communication has undermined the essence of the sociocultural context with which humans define their experiences about health diseases and treatments (Lupton, 1994).

Similarly, Dutta (2007) aims to recenter the hegemonic health communication practices consisting of individualistic, rational, and non-discursive approaches to a critical cultural framework that places discourse and meaning-making at the crux and provides spaces for marginalized populations to voice their health meanings. A significant aspect of understanding

health diseases is the social context in which individuals view diseases and treatments (Dutta-Bergman, 2004; Dutta & Basu, 2007), which several health behavior models often fail to take into consideration. Airhihenbuwa & Obregon (2000) have argued that the health belief model and other theories of health communication need to be revised in communicating health diseases and prevention among cultural groups. They often overlook the cultural determinants, such as individualism vs collectivism, that define a community's belief system (Airhihenbuwa & Obregon, 2000). For example, being a cognitive model, the health belief model explicitly lacks emotional components, particularly fear, which is a highlighted shortcoming (Witte, 1992). It specifies the variables to be targeted but does not clarify how to change an audience's beliefs about these variables (Janz & Becker, 1984).

Culture has played a significant role in how people understand diseases. A report by the Surgeon General published in 2001 explicitly places culture at the core of mental health etiology. It accentuates the role of culture in mental health symptomatology, meaning-making, causation, and prevalence (USDHHS, 2001). What symbolic meaning humans associate with health diseases and treatments is embedded in the value, language, power dynamics, and context that are established in their culture (Dutta-Bergman, 2004; Dutta, 2010; Ho & Sharf, 2021). Several models and processes have emerged that help in exploring the essentiality of culture in health systems. One such model is Kleinman's explanatory model (EM), which comprehends "culture as a system of symbolic meaning that may influence experience and social reality of individuals" (O'Mahony & Donnelly, 2007, p. 457). The model goes beyond biomedical treatment decisions and understands healthcare as a cultural system where families and communities play a vital role in health interventions, deciding what treatment plans must be adopted (Kleinman, 1984). Researchers (O'Mahony & Donnelly, 2007) investigated the cultural beliefs and ideologies that

shape immigrant women's mental health perspectives in Canada. Using Kleinman's EM, they theorized that health beliefs are embedded in the family and community values and religious norms these women represent, and they continue to practice their belief systems, which often hinders them from seeking mental health help (O'Mahony & Donnelly, 2007). This research acknowledges and understands cultural belief systems to investigate and implement holistic approaches in health programs and interventions that can help in symptom reduction and facilitate a sense of inclusion for minority and culturally centered groups. This is especially important for interventions for mental and psychological health, which are socially stigmatized in many countries and act as obstacles to seeking treatment (Mascayano et al., 2015).

Mental Health Across Cultures

Mental health is perceived differently across cultures, many of which have stereotypical ideologies that affect populations (WHO, 2022). People often choose not to seek help and live with distress, fearing discrimination in society for getting help (WHO, 2022). Low and Middle-Income Countries (LMICs) report stigmatized beliefs about mental health that often refrain people from getting diagnosed and seeking therapy (Mascayano et al., 2015). Rose and colleagues (2007) conducted a qualitative study among middle schoolers in the United Kingdom, asking for phrases to describe people with mental health diseases. They accumulated 250 terminologies from the data collection, all negative. Words like "disturbed," "nuts," and "psycho" were among the most recurring terms used by the participants (Rose et al., 2007, p. 3). Another study by Gureje et al. (2018) in Nigeria assessed community knowledge and attitudes toward mental health. Results indicated that about 90% of mentally healthy people perceived mentally ill people to have threatening behaviors, more than 80% of people feared talking to people with

mental health conditions, and that drug and alcohol use was the most prevalent cause of mental health problems (80%).

Additionally, a World Economic Forum report (2018) identified that only 10-12% of patients would seek care because of the stigma attached to mental health disorders, the knowledge gap, and restricted access to qualified assistance. Similarly, a survey was conducted in India over the span of five months by the Live Love Laugh Foundation (WEF, 2018). According to the findings on attitudes regarding mental illness, 68% of respondents think that persons with mental disorders should not be made responsible, and 60% of participants think that self-control issues and lack of willpower cause mental health problems (WEF, 2018). Furthermore, 60% of interviewees stated that mentally ill people needed their own groups so that they would not contaminate healthy individuals (WEF, 2018). Due to stigmatized mental health perceptions in many low to middle-income countries, patients with depression and anxiety choose not to seek mental health help (WHO, 2022). This tendency, whereby patients prefer not to disclose their concerns or symptoms to health experts or even their own family members, has been documented in studies conducted in Ethiopia and India (Shibre et al., 2001).

In India, people with schizophrenia report high rates of perceived stigma, and they typically attribute the stigma to the community and family members (Shrivastava et al., 2011). Further, a study conducted in Ethiopia revealed that due to the presence of mental illness in the family, approximately a third of the participants believed that they were stigmatized or had experienced some form of stigma; 42% were concerned about being unfairly targeted; and 37% wished to hide a relative's mental health condition (Shibre et al., 2001). Moreover, a South African study that examined the public's perceptions and beliefs concerning mental illness discovered that the majority of participants believed the disorders were stress-related rather than

having a medical cause (Ganasen et al., 2008). Ganasen and colleagues (2008) further argued that perhaps as a result, "talking it over" rather than seeking medical help or using medication was more frequently advised as a treatment option (p. 25).

Mental Health Perceptions in the U.S.

Despite the growing influence of Western medicine on mental health etiology, diseases such as depression and anxiety remain stigmatized in the United States. Harmful beliefs that can increasingly alienate people with mental health disabilities persist. Beliefs that people with mental health issues are violent and dangerous have been documented (Parcesepe & Cabassa, 2013). Interestingly, positive attitudes have been reported regarding help-seeking behaviors among Americans; however, taking medication for mental health diseases has conflicting attitudes, especially among children (Parcesepe & Cabassa, 2013). Ward and colleagues (2013) conducted a study among African Americans to understand their mental health attitudes, perceived stigma, and coping mechanisms. Results showed that most participants were somewhat knowledgeable about mental health disease onset but did not endorse help-seeking (Ward et al., 2013). Additionally, the majority of these participants reported relying on religious healing practices rather than seeking professional care (Ward et al., 2013).

Across research, mental health is documented as isolating among African Americans due to the long-standing stigma in the communities about the fear and dangers associated with mental ailments, which significantly worsens the living conditions of the already oppressed minority communities in the country (Harris et al., 2020). With this said, minority communities continue to perceive mental health negatively due to stigmatized beliefs and cross-cultural differences in health beliefs. For example, Breslau et al. (2017) conducted a study to provide further evidence that minority groups difference exists in the perceived needs as compared to the White

population in the U.S. Results indicated that all marginalized groups, including Blacks, Hispanics, and Asian American do not perceive a need to get treated for mental health ailments (Breslau et al., 2017) despite evidence that these groups are susceptible to mental health diseases (Bruzelius & Baum, 2019; Harris et al., 2020; Mann et al., 2017).

Among minority groups, immigrants are becoming a fast-growing population in the United States (Budiman, 2020). Research has indicated that their migration-related acculturative factors contribute to mental health problems among immigrants. For example, a study conducted to understand the post-migration trauma among 1637 Asian immigrants and 1620 Latino immigrants indicated that discriminatory practices in the host country (USA), stress, and family conflicts were the reported cause for increased disorders among these populations (Sangalang et al., 2019). The consistency of these catalysts is comprised of immigrant sub-groups in the country. Moreover, stigmatized beliefs and perceptions create more barriers for sensitive populations susceptible to mental health diseases, making them more vulnerable.

Stigmatized beliefs and perceptions are often embedded in the culture immigrants represent (Han et al., 2017). For instance, Han and colleagues conducted a study among Korean immigrants to understand the role of culture in the stigmatization of mental health. They identified that cultural norms such as saving face (a Confucian cultural practice that involves avoiding public appearance to reduce shame or negative personal experiences) increase stigma around mental health diseases (Han et al., 2017). Additionally, the collectivistic nature of Korean culture eliminates the space for people with mental health illnesses since they disharmonize the familial spirit (Hans et al., 2017). This may reduce the chance of mental health patients communicating their health needs to their families and communities. Culture plays a vital role in shaping health perceptions, especially among Asian Immigrants (Abdullah & Brown, 2011; Han

et al., 2017; Mann et al., 2017; Roberts et al., 2015). Evidently, negative perceptions can create barriers among people with mental health illnesses and can hinder help-seeking behavior.

Indian Immigrant Women's Mental Health

A variety of factors have been studied among Indian immigrant women influenced by cultural determinants that may cause mental health problems or create barriers (USDHHS, 2001). India is high in masculinity (Hofstede, 2011), pushing gender roles and assertiveness. Much research has been conducted on the effects of domestic violence on women's health and well-being. For example, among many scholars exploring the repercussions of domestic violence among Indian women, Kim and Hogge (2015) examined how Asian Indian women perceived physical and sexual abuse and its effects on their mental well-being. They also investigated factors that influence their willingness to seek counseling. Results showed that participants only perceived physical and sexual harm as abuse, downplaying the verbal and mental violence causing distress (Kim & Hogge, 2015; Roberts et al., 2015). Further, they preferred seeking help from family and friends rather than professional help, which has been consistent with other minority groups who tend to avoid professional counseling to prevent any shame that may be caused to themselves or their families (Han et al., 2017; Roberts et al., 2015; Warn et al., 2013).

Cultural factors such as collectivism vs individualism (Hofstede, 2011) also tend to influence help-seeking behaviors. People from collectivistic cultures usually rely on friends and family or seek out help with mental distress (Han et al., 2017; Karasz et al., 2019). Leung and colleagues' study (2011) on Asian Indian women in the U.S. found that participants relied on friends and family to seek informal counsel rather than professional help. This can mainly be because of the stigmatized shame attached to having psychological distress in Indian culture (Kumar & Nevid, 2011).

In the context of high-power distance in Indian culture, generational dominance has significantly contributed to Indian immigrants. Family and parental conformity and cooperation consisting of gender norms, patriarchal family structure, and obedience to older generations have been reported to cause stress (Singal, 2023). Chandra and colleagues (2016) break down the power dyed explaining the social dominance that exists among Indian families, explaining that the "power divide can exist at a gender (e.g., men > women, husband's family > wife's family) or a generational level (e.g., elders > middle-aged> children; respect the elders and carry out their wishes" (p. 206). Pressure from parents about socioeconomic well-being, career, marriage, and having children has been significantly contributing to the mental stress these women face. A study conducted among Indian immigrant women analyzed parental and generational control causing mental health issues in the United States (Varghese & Jenkins, 2009). Results indicated that mothers play a dominant role in controlling their daughter's life, causing higher depressive symptoms and lower self-esteem. Further, the study found that conflicts with family regarding cultural values persist due to distance in generational mindset and expected gendered roles (Varghese & Jenkins, 2009).

Effects of Acculturation on Mental Health

Relocating to another country and mixing ethnic culture with the new culture is called acculturation (Balidemaj & Small, 2019; Mehta, 1998). Historical research has provided evidence that acculturation, including aspects such as acceptance of the culture, adjustments in the new lifestyle, and interpersonal experiences, particularly social rejections, can lead to disturbances in mental well-being (Mehta, 1998; Prabhakar et al., 1999). Acculturation has both positive and negative effects on how immigrants perceive and cope with mental health diseases. For example, research shows that Indian Immigrants feeling accultured or fitting into the U.S.

culture reported better mental health as opposed to those who reported low levels of attachment to the U.S. culture (Kumar & Nevid, 2010; Mann et al., 2017; Mehta, 1998; Mui & Kang, 2006; Roberts et al., 2015). Further, Guruge and colleagues (2015) state that the presence of social support in the new community that immigrants form in the migrated country can improve their mental health and well-being, whereas social conflict can create tensions and negatively impact psychological welfare. Integration into the host culture has reportedly fostered positive mental well-being and high self-esteem among Indian immigrant women in the past (Joseph et al., 2020; Mann et al., 2017).

Several factors of acculturation have been studied in the past among immigrant populations across countries, including language, gender roles, discrimination, and integration into the host culture. These factors can define how Indian immigrant women perceive mental health issues and seek professional help. When settling down in the United States, a common unspoken expectation from Indian immigrant women among their family members is to adhere to their gendered role of being the caregiver, which has been reported to cause mental distress (Leung et al., 2011; Mann et al., 2017). As a consequence of acculturation, discrimination tends to hamper mental well-being among Indian immigrant women as well. For instance, Nadimpalli and colleagues (2016) conducted a study among 906 Asian Indian women exploring reports of discrimination and its effects on mental health. Results indicated that discrimination on the basis of race and accent, gender, religion, and personal characteristics had adverse effects on their depressive symptoms, worsening their mental health (Joseph et al., 2020; Nadimpalli et al., 2016; Siddiqui, 2022).

Language plays a vital role in defining the acculturation process among Indian immigrant women. Their ability to communicate in English and lack thereof, directly impacts their mental

well-being and help-seeking behavior. In Roberts and colleagues' exploration of depression and anxiety prevalence among Indian immigrant women, they found that women who chose their regional dialect to communicate in the research had a higher rate of depression and anxiety (2015). Most of these women were in their child-bearing age and were restricted to performing gendered roles rather than pursuing careers, education, and social interaction, thus resulting in a lack of English proficiency (Roberts et al., 2015). Additionally, being integrated or disconnected from the U.S. culture can also impact mental health and well-being among Indian immigrant women. Being able to behaviorally situate oneself in a different culture or strictly adhering to one's home country's culture can cause depression and anxiety among them. In Mann and colleagues' study (2017) among Sikh Indian immigrant women, they explicitly mention that women who were integrated into U.S. culture had higher levels of anxiety. These women also chose English as their responding language in the study. On the contrary, women who did not integrate into the U.S. culture and held their traditional values reported higher levels of depression (Mann et al., 2017) due to expected adherence to gendered roles isolating them from social interactions. In the study, these women chose Punjabi (the local language among Sikhs in India) as their responding language (Mann et al., 2017). Other scholars also suggest that accepting and adapting to the host country's culture lowers stress (Balidemaj & Small, 2019; Inman et al., 2014; Jang et al., 2005).

A plethora of research exists addressing common barriers immigrants have perceived while seeking mental health therapy. However, limited studies have addressed how their lived experiences inform the development of these perceptions and the negative attitudes and beliefs that hinder them from acknowledging mental health diseases as severe, let alone seeking help. Additionally, only a handful of studies have provided precise information on Indian immigrant

women (Chandra et al., 2016). Moreover, there is a gap in the literature in identifying how cultural determinants influence the development of perceptions among these women. The current literature on mental health and help-seeking behaviors among Indian Immigrant women is mainly descriptive and deserves the cultural rigor of attention (Kumar, 2010). The reviewed literature focuses on the barriers immigrants perceive to help-seeking, undermining the essentiality of their lived experiences embedded in their culture that shape their perceptions about mental health and well-being in the first place. There is a need to understand how culture influences their perceptions, which transforms into mental health decision-making, informs their attitudes toward mental health diseases, and shapes help-seeking behaviors (Gone, 2016). With this said, this research attempted to emphasize the importance of looking beyond logical positivism to gain an in-depth understanding of how Indian immigrant women perceive mental health and to dove deeper into knowing their lived experiences of comprehending mental health in their families and communities.

Theoretical Framework

This section provides an overview of the theoretical framework that informs the current research. The framework including (a) Hofstede's cultural determinants theory, (b) culture-centered approach and (c) collective leadership, discusses the potential for intersectionality that aligns conceptually to provide a foundation for this study. Additionally, this section also informs the developed research questions.

Hofstede's Cultural Determinant Theory

To reflect on the representational dimensions of national cultures, Geert Hofstede tried to understand several facets that emerged as a result of survey distribution among 40 countries. These facets were clustered together due to their commonalities in identifying societal concerns

(Hofstede, 2011). Decades of research on these clusters and the implications regarding their accuracy in determining culture led to the formation of six dimensions: power distance, uncertainty avoidance, individualism versus collectivism, masculinity versus femininity, long-term versus short-term orientation, and indulgence versus restraint (Hofstede, 1980). The current study uses Hofstede's cultural dimensions theory to understand the effects of Indian culture and its determinants on mental health perceptions and behaviors.

Hofstede's cultural dimensions theory is widely used in health research to understand the cultural determinants that shape mental health meanings. Individualism and collectivism understand the culture of a society that either identifies individuals as loose entities, responsible for their actions and engagement or is integrated into its belief system and is socially dependent on the collective, in-group exchange of knowledge respectively (Hofstede, 2011). While societies with high collectivism scores place a stronger focus on collective harmony and loyalty, civilizations with high individuality scores tend to stress individual autonomy and self-reliance (Hofstede, 2011). Individualism prevails in most Western countries, whereas collectivistic societies prevail in the East (Hofstede et al., 2010). When understanding mental health susceptibility based on this dimension, compared to collectivistic cultures, individualistic cultures tend to have a greater incidence of mental health issues, including sadness and anxiety (Matsumoto et al., 2008).

Power distance is where authority lies in the hands of the society's superior members, and the lesser powerful accept it. The unequal distribution of power is endorsed by both the follower and the leader in society (Hofstede, 2011). In contrast to civilizations with low power distance scores, high power distance cultures typically have more hierarchical social structures. In particular, persons in lower socioeconomic situations are likely to experience higher rates of

mental health issues in cultures with high power distance scores (Matsumoto et al., 2008). In a high-power distance society like India (Mathew & Taylor, 2019), power distance can be understood in several aspects of the society. For example, Mathew and Taylor (2019) investigated the power distance determinants in Indian society and found that aspects of power distance, such as parental relationships, religious values, and group orientation, are impactful in the decision-making processes of individuals in the workplace. Moreover, the Indian caste system and bureaucratic leadership (Lawler et al., 1995) support this power distance hierarchy, making India high in power distance.

The concepts of Masculinity and Femininity have been understood not at an individual level but at the collective cultural role of genders in society (Hofstede, 2011). In feminist cultures, women exert similar modesty and caring values as men; in a masculine culture, men are more assertive and competitive and hold more power in decision-making (Hofstede, 2011). Further, high-scoring masculine cultures prize success, aggressiveness, and competition, while high-scoring feminine cultures prize nurturing, teamwork, and interpersonal relationships. Research has revealed that masculine societies have a higher prevalence of mental health issues, such as substance misuse and aggressiveness, than cultures with higher rates of femininity (Matsumoto et al., 2008).

Uncertainty avoidance is a society's ability to disregard unstructured circumstances that are unanticipated and unusual (Hofstede, 2011). "Uncertainty-avoiding cultures try to minimize the possibility of such situations by strict behavioral codes, laws, and rules, disapproval of deviant opinions, and a belief in absolute Truth; 'there can only be one Truth, and we have it'" (Hofstede, 2010, p. 10). On the contrary, uncertainty-accepting cultures allow the inflow of diverse opinions and emotions and have fewer rules (Hofstede, 2011). While cultures with a low

uncertainty avoidance score are more adaptable and flexible, those with a high uncertainty avoidance score frequently have tight norms and regulations and greatly emphasize predictability. In comparison to cultures with low uncertainty avoidance scores, research has indicated that cultures with high uncertainty avoidance scores have a greater prevalence of mental health issues like anxiety and obsessive-compulsive disorder (Matsumoto et al., 2008).

Over the years, Hofstede's cultural dimensions have been utilized extensively in health communication research. For example, Mahoney et al. (2015) utilized the power distance dimension as an influencer to analyze how medical practitioners in the U.S. (low on power distance) and the Philippines (high on power distance) use social media technologies for physician/patient communication. Results from this study showed that doctors from the Philippines were more concerned about patient confidentiality, privacy, and online misinformation than U.S. doctors (Mahoney et al., 2015). Cultural differences based on the dimensions presented by Hofstede across nations have been successful in informing differences in health beliefs, perceptions, and context. For example, Sun et al. (2009) studied the impact of Hofstede's dimensions on consumers' public self-consciousness in 25 countries. Results indicated that people from high uncertainty-avoidance countries tend to be less self-conscious. Additionally, participants from collectivistic cultures were reported to be more self-conscious (Sun et al., 2009). Interestingly, the constructs of this cultural dimension theory have been vastly utilized in the analysis of cross-cultural media effectiveness in social and health behaviors including comparative analysis of newspapers in health reporting between the U.S. and China (Tang & Peng, 2015), digital health promotions for antismoking websites in Korea and the U.S. (Paek et al., 2009), differences in antibiotic consumptions (Deschepper et al., 2008), as well as analysis of gender differences in Kuwait (AlAnezi & Alansari, 2016).

Hofstede's cultural dimension theory has been vastly utilized in social and medical sciences to understand cross-cultural differences and the effects of cultural dimensions on behavior. However, very few studies pay close attention to understanding how these dimensions can be influential in perception building, especially for stigmatized topics such as mental health. This study utilized four dimensions in establishing their effects on mental health perceptions among Indian immigrant women in the U.S. Adopting the aforementioned cultural dimensions helped theorize the reasoning behind the variations in culturally shaped health perceptions and behavior. For example, in exploring the shaping of mental health perceptions among Indian immigrant women, determinants such as masculinity and femininity helped understand the power differences placed by their culture on gender in establishing and understanding concepts such as depression and anxiety and how they influence life decisions. Similarly, power distance helped theorize the role of politics, religion, and community in influencing perceptions regarding mental health diseases and treatment. Since India is a collectivistic country, the belief system differs from that of Western cultures, hence establishing the opportunity to understand the meaning-making health processes among collectivistic communities and how they tackle mental health. Moreover, from the uncertainty-avoidance dimension, hypothesizing the set of beliefs that may or may not restrict individuals from understanding mental health and seeking help was understood. Based on Hofstede's cultural dimension theory, the current study aimed to explore answers to the following research question: -

RQ1: How do Hofstede's cultural dimensions influence mental health perceptions and help-seeking behaviors of Indian immigrant women?

Culture Centered Approach

Given that the current research conceptualizes Indian immigrant women communicating mental health perceptions from a critical-cultural lens, the study uses a culture-centered approach as a theoretical framework that understands the health meanings of marginalized populations, giving voices to people to communicate their health needs. This section provides information on the culture-centered approach as a theoretical framework.

The culture-centered approach (CCA) to public health communication offers a lens through which minority communities' lived experiences can be analyzed and interpreted (Koenig et al., 2012). It is a process-based health communication perspective that focuses on the construction, negotiation, and retention of health meanings as opposed to a message-based perspective that emphasizes the development and delivery of health messages for better health outcomes (Dutta, 2008). CCA emphasizes the essentiality of articulating health problems as a part of the problem-solving discourse that the community members and the researchers are engaged in (Dutta & Basu, 2007). The cultural-centered approach "questions the constructions of culture in traditional communication theories and applications, examines how the latter have systematically erased the cultural voices of the marginalized communities, and builds dialogical spaces for engaging with these voices" (Dutta, 2008, p. 4). Through this approach, communication is essential to socially construct identities, partnerships, and cultural members' social norms since it expresses common interpretations of shared health experiences (Dutta, 2008).

By adopting a culture-centered approach within a framework of marginalization, we gain insight into the processes of knowledge production among marginalized groups. This involves listening to people's voices and conducting critical analyses of authority and dominance issues

that often suppress subaltern perspectives (Basnyat & Dutta, 2012). With that said, listening is an integral part of the CCA framework to articulate meanings that subaltern groups are placing their health needs (Dutta, 2014). Being subaltern means being excluded from dominant discourse venues and is represented by colonial, racial, class, gender, and other types of oppression that follow the mainstream's logic (Dutta, 2008). Throughout the use of CCA in health communication theorizing, the role of the researcher is active in building and sustaining a bridge or agency to provide access to resourceful structures.

Compared with other health communication theories that focus on individual behavior, CCA provides a unique platform for both subaltern participants to voice their health needs and meanings and for health communication researchers to practice the critical approaches to communication (Dutta, 2014). In the current research, CCA provides a critical cultural value to understanding health perceptions among a minority group by accentuating newer participatory communication frameworks (Dutta & Basu, 2007). It prioritizes attending to the role of culture and its dimensions in articulating mental health meanings and perceptions drawn from Indian immigrant women's experiences. Within the framework, the culture-centered approach foregrounds the roles played by culture, structure, and agency, as well as how these factors combine to shape perspectives held by minorities (Dutta, 2008; Basnyat & Dutta, 2012): -

Culture in CCA

In culture-centered approach, the interaction between culture, agency, and structure elicits communication among subaltern populations. Within this framework, communities negotiate shared meanings and practices that are representational of their culture (Dutta, 2018). Norms, values, meanings, and practices are often passed on to generations, maintaining the culture that the community has established. It also influences community members' attitudes,

decision-making, and actions (Dutta, 2018). “The culture-centered approach is a meta-theoretical framework for co-constructing discursive processes, spaces, rules, and techniques in collaboration with subaltern communities” (Dutta, 2014, p. 70). Culture is situated at the crux of CCA, which understands the contextually empowered meanings that subaltern members give to health topics and diseases, which have been erased from the dominant structures of health in the past (Dutta, 2008). Culture is a dynamic, ever-changing element of the community’s local context where meanings are formed, acquired, modified, transmitted, and orientated through interactions (Acharya, 2011, p. 52). Culture is “the communicative process by which shared meanings, beliefs, and practices get produced” (Dutta, 2011, p. 11). This approach to health communication promotes the agency's role in defining the major issues facing the community and interpreting health meanings (Dutta-Bergman, 2004; Koenig et al., 2012). Furthermore, “culture provides context that shapes knowledge creation, perceptions, sharing of meanings, and behavior changes” (Dutta et al., 2012, p. 2). In the process of understanding the cultural aspects of mental health perceptions, the study aimed to answer the following questions:

RQ2: How do the participants understand mental health and diseases?

RQ3: How has acculturation influenced Indian immigrant women’s mental health and well-being?

Structure in CCA

Structures in CCA are systems in healthcare that limit access to better outcomes for marginalized community members (Dutta, 2008). Structures are “patterns of societal organization, institutional processes, and practices, and patterns of resource distribution in society” (Dutta, 2008, p. 75). “Structures refer to how access to resources such as health, education, occupation, and employment are enabled or restricted” (Gao et al., 2015, p. 2).

Structures are evaluated in light of how people access resources at the micro, organizational, national, and international levels (Dutta, 2008). Gao et al. (2015) investigated the structural perspectives of Chinese immigrants who live in poverty and receive limited access to medical resources. The culture-centered approach was utilized to examine perceptions of restaurant workers identifying as Chinese immigrants regarding health and health care being affected by structural constraints on health outcomes (Gao et al., 2015). Understanding the structure of a health communication process is crucial to articulating the effectiveness of current health interventions in place. To evaluate structure among Indian immigrant women when it comes to their perceptions toward mental health help-seeking, this study explored answers to the following question:

RQ4: How do the participants describe common barriers perceived in help-seeking?

Agency in CCA

Agency is the subaltern's capacity to actively engage in decision-making to enhance structural processes in the community in which they are situated (Dutta, 2007). As for agency within the culture-centered approach, we seek answers through dialogic involvement and making their voices heard through research (Dutta, 2008). "The culture-centered approach investigates difficulties from the stance of cultural voices. This approach also creates the space for cultural members to identify their issues, negotiate the meaning of those issues, and search for solutions by engaging in dialogue, as they take control over agency" (Dutta, 2007, p. 312). As the study looks for participants' voices and ideas, the agency shapes the dynamic culture and surrounding structures (Dutta, 2011).

As CCA continues to expand in various health communication sectors pertaining to marginalized populations, research is needed when understanding the culture, structure, and

agency of Indian immigrant women's mental health perceptions. By articulating the role of culture and its determinants in influencing perceptions, behavior, and structural barriers, this study aimed to create spaces for cultural members to communicate their health meanings, which can help in eliciting solutions by communicating the collective, agentic voices of marginalized populations. In this process, Hofstede's cultural dimensions helped provide a detailed understanding of how culture and its determinants can shape the meaning of mental health among these women. The fact that CCA theorizes the health systems' cultural, structural, and agency contributions (Dutta, 2008) provided a strong foundation for the research questions being studied. Arguably, Hofstede's cultural determinants were used as a guiding framework in defining the participants' perceptions of the role of culture, structure, and agency in mental health. Since Dutta (2008) has articulated culture centered approach as "the notion of identifying problems and accompanying solutions from within the culture" (p. 255), CCA helped understand the root cause to develop interventions that support mental health knowledge distribution, inclusive counseling options, integration of traditional and Western healing practices, as well as cultural empowerment (Chung et al., 2008).

Collective Leadership

Building upon the agency component of the culture-centered approach, this section introduces collective leadership as a framework that complements the agency's task of creating social change. Since the agency is defined as the ability of the research participants, researchers, and experts to reconstruct social change initiatives for better health access (Dutta & Basu, 2007), collective leadership - a social change leadership perspective - exemplifies a similar approach in which entities work together to achieve shared goals (Ospina et al., 2012).

In communicating barriers identified by the Indian immigrant women with the nonprofit mental health experts, I aim to build upon the agency for change by offering spaces for mental health experts to convene and discuss potential enhancers in the current mental health intervention. Collective leadership is a practical framework that examines the accumulation of shared knowledge and potential for change. Collective leadership is the ability of a group of people to come together and willingly work toward established goals and be responsible for the success of an initiative (Magrab & Bronhein, 2018). Kliewer and Priest (2019) highlight the importance of going beyond a leader-member chain of command to a more shared environment in communities to use the potential for highly skilled leaders and invite diverse mindsets from the community to participate in collaborative community-building efforts. Together, individuals in these processes imagine the world, interpret their interactions and experiences, and mold their decisions and deeds to achieve the desired outcomes (Ospina et al., 2012).

"Collective leadership turns upside down the basic assumptions about the source, object, and result of leadership. The source of leadership is not exclusively the leader; it may also be the group or the structures and processes devised to advance the shared goal" (Ospina & Foldy, 2015, pp. 494-495). The world is recognized for its originality because social meaning is co-constructed through relational processes (Ospina et al., 2020). Collaboration skills are boosted by leadership procedures, further creating an environment where group members feel appreciated and inspired to work toward common objectives (Ospina & Foldy, 2015). Thus, leadership is a shared success (Ospina & Foldy, 2015). The collective leadership lens continues to refocus the traditional 'leader' role and their relationship with followers to a more relational paradigm where leadership is built and established within shared systems and organizations and a broad-ranging

paradox where meaning-making, communitive, and organizing processes establish and maintain relationships (Ospina et al., 2012).

Kliewer and Priest (2019) have emphasized the vitality of collaborating in academic partnerships with communities to develop goal-oriented "frameworks" and "outcomes" at both individual and collective levels (p. 8). Recent studies shift attention to group processes and outcomes (thus emphasizing the collective dimension of leadership) as they explore "ways that leadership is drawn from- instead of only added to teams" as a means of accomplishing shared work (Day et al., 2004, p. 858). Ospina and colleagues' (2012) inquiry on social change leadership suggests a broader lens of community-engaged collaborative work which focuses on "reframing discourse," "bridging differences," and "unleashing human energies" to create transformative enhancements (pp. 272–274). These inquiries inform the goal of engaged learning and identification of enhancement opportunities in the current study. Redefining mental health frameworks that work for culturally diverse audiences, reconstructing bridges to create better access for Indian immigrant women, and utilizing the resourcefulness of our community mental health experts can collectively contribute to the goal completion and can significantly provide pathways for other health communication researchers to use this framework. To achieve this, the questions this research aimed to answer are stated as the following:

RQ5: How can we improve mental health access and communication among immigrants in our communities?

RQ6: What are some enhancement opportunities offered or identified by the experts regarding the current mental health interventions?

By employing the aforementioned theoretical framework, this study aimed to untangle the dominant role of the culture and its determinants in understanding the structure and agency of

mental health among Indian immigrant women. Through this framework, the CCA took a collectivistic approach to health communication where subaltern communities, researchers, and structural entities work together toward social change efforts to create better health outcomes (Dutta, 2008). Therefore, in the pursuit of offering a solution-oriented approach, collective leadership helped in theorizing the collaborative efforts of the Indian immigrant women (agency), the researcher, and the mental health experts in not only identifying the problems but also focusing on offering developmental enhancers.

Chapter 3 - Methodology

This chapter provides information about the methodology utilized to explore the answers to the research questions provided in Chapter 2. Additionally, it informs why a qualitative approach is being taken, followed by a subjectivity statement, research designs, and analyses.

The overarching goals of this research were to develop a thorough understanding of the culturally shaped mental health perceptions of Indian immigrant women and elicit recommendations for enhancement in the current mental health intervention. Hofstede's cultural determinants were employed to explore how they shape health perceptions. Additionally, the culture-centered approach provided the framework to understand this critical cultural lens of understanding the health meanings of the marginalized population of Indian immigrant women in the United States. By applying the CCA framework, the study sought to gain insights into the role of structure, culture, and agency in how this minority population communicates about mental health. The study invited Indian immigrant women to share their culturally shaped perceptions regarding mental health and diseases through their lived experiences and their help-seeking behaviors. Following the CCA framework and collective leadership praxis, data points informing barriers and benefits identified by Indian immigrant women from the interviews were shared with mental health experts. They were then invited to discussions to provide recommendations for enhancing interventions based on their experiences and the data shared with them. The following sections provide detailed information about the process of this inquiry.

Qualitative Approach

With the established theoretical frameworks that aimed to understand the lived experiences behind Indian immigrant women's mental health perceptions and behaviors, qualitative research methodology was best suited to gain in-depth knowledge about the subject

matter. According to Renjith and colleagues (2021), “Qualitative research incorporates the recording, interpreting, and analyzing of non-numeric data with an attempt to uncover the deeper meanings of human experiences and behaviors” (p. 1). This research approach focuses on understanding behavior patterns, determining socially and culturally relevant necessities and priorities, and designing and executing contextually applicable interventions (Draper, 2004).

Unlike quantitative methods, qualitative inquiries help investigate and interpret the complexity of subjective realities of individuals and are being increasingly used in healthcare research (Renjith et al., 2021), where researchers observe, interpret, and analyze this information by becoming instruments of the study (Pezalla et al., 2012). Moreover, because the present study demanded the theoretical underpinnings of a culturally situated perspective in investigating lived experiences, it was adamant to employ qualitative methodologies in understanding health meanings among marginalized populations (Dutta, 2008). Additionally, it is evident that qualitative research methods help us gather deep knowledge on issues that are not well understood (Fossey et al., 2002), and these methods help us understand the lived experiences of individuals and their involvement with mental health diseases (Gewurtz et al., 2016). Crowe et al. (2015) highlight that qualitative research aims to comprehend the context of experiences by exploring ideas expressed in words, unlike quantitative research, which focuses on hypothesis testing while disregarding contextual depth. Thus, qualitative research methodology was adopted to study the mental health perceptions and behaviors among Indian immigrant women living in the U.S.

Phenomenological Research Approach

In the effort to study lived experiences, phenomenological research methodology is effective in inviting participants to share their experiences on perceived mental health and

counseling-seeking behaviors. This would primarily include the role of culture in shaping their understanding of mental health diseases and treatment, how their families and communities view mental health issues such as depression and anxiety, as well as their perceived benefits and barriers to seeking help. Investigating sensitive topics such as mental health arguably requires approaches that are personal, more subjective, and can explore the contextual meaning behind experiences. Phenomenology can explore shared experiences and meanings to understand the phenomenon explaining the role of culture in shaping mental health perceptions (Creswell et al., 2016). Moreover, in clinical psychology, Kutney (2006) emphasizes the relevance of using phenomenology for clinicians to understand the subjective experiences of mental health clients to serve them more effectively. Similarly, Picton and colleagues (2017) have argued that phenomenology is a strategic approach to learning about the complexities of mental health through a subject's lived experience.

Phenomenology seeks collective significance by reducing multiple subjects' lived experiences to combined descriptors of universal "essence" (Creswell et al., 2016, p. 121). Seeking realities from participants' lived experiences and producing thorough descriptions of the phenomenon are the main objectives of a phenomenological study (Moustakas, 1994). By examining people's lived experiences, researchers can then interpret their "clusters of units of meaning" (ideas, perceptions, and feelings) to generate "themes" and get deep insights into the phenomena being studied (Groenewald, 2004, p. 50). Picton and co-authors' work (2017) on phenomenology's use in mental health nursing research contributes significantly to my case for using phenomenology in mental health. Although the authors reflect on the use of phenomenology in understanding mental health patients' experiences with diseases, it highlights the importance of qualitative research approaches in mental health research, more specifically,

the use of phenomenology to give control of the interaction to the subject to share their experiences (Picton et al., 2007).

Being a qualitative methodology, phenomenology captures information in its environment and is presented in the meaning people give to their experiences (Creswell et al., 2016). Data collection processes in phenomenology are conducted in a lengthy interview style to gain the utmost understanding of the essence of the experience. Moustakas (1994) advocates that the researcher must create a comfortable environment for participants to share their experiences and develop semi-structured questions to provide much room for full story development. Located in the interpretivism research paradigm, phenomenology research can be conducted using in-depth interviews, focus group discussions, and participant observations that can help facilitate meaning-making and sharing (Sale et al., 2002).

Phenomenology has been widely used in the inquiry of health topics. For instance, Emaliyawati et al. (2020) conducted phenomenological research to gain insight into the lived experiences of Intensive Care Unit nurses to understand the communication gap between doctors and patients. They conducted in-depth interviews to better understand the issues that arise, causing the gap. Similarly, Shamsaei et al. (2015) conducted a phenomenological study investigating the experiences of caregivers of chronically mentally ill patients and the factors that affect their practices. Through semi-structured in-depth interviews conducted among 16 carers, the results concluded stress, educational and information needs, socioeconomic outcomes, and physical exertion to be the most prominent challenges among participants. Likewise, among many phenomenological researchers, interviews are the most favorable methods used for data collection (Bevan, 2014)

Hermeneutics Phenomenology in Understanding Experiences

Qualitative philosophers have developed several approaches to phenomenology. Among them, two approaches are widely used among researchers, which include transcendental and hermeneutics phenomenology, wherein the former extracts descriptive experiences and brackets the researcher's presuppositions of their own experience aside from the interpretation (Moustakas, 1994), and the latter emphasizes the role of a researcher and her experiences play in the interpretation of the text (Sloan & Bowe, 2014). "Hermeneutics phenomenology is the science of interpretation of texts, whereby language, in its written or spoken form, is scrutinized to reveal meaning in phenomena" (Rapport, 2005, p. 125). Meanwhile, in transcendental phenomenology, "the phenomenon is perceived and described in its totality, in a fresh and open way" (Rapport, 2005, p. 6). Among transcendental and hermeneutics phenomenology, I find hermeneutics phenomenology to be most relevant to my approach to understanding the lived experiences of research participants simply because, as a researcher from India who has personally known the influence of culture in understanding mental healthcare and prevention, I believe that my interpretation of the research fosters context-building and meaningful representation of the 'text.' Heidegger envisioned that the observer resides alongside the phenomena and the essences and cannot dissociate himself or herself from the studied phenomena (Sloan & Bowe, 2014).

Being an interpretive framework, the epistemology of hermeneutics phenomenology dictates that knowledge is gained through the interaction between the investigator and the essence. "Denzin and Lincoln viewed the investigator and the investigated as interactively linked in the creation of findings, with the investigator as a passionate participant" (Laverty, 2003, p. 26). Ontologically, reality is created locally and is unique to the experiencer (Laverty, 2003).

Moreover, hermeneutics phenomenology attempts to understand how people and communities see their world, and how researchers interpret these phenomena is the crux of the study (Kafle, 2011). Therefore, I employed hermeneutics phenomenology to explore the lived experiences of my subjects and provide my interpretations of the collected data to complement the understanding of Indian culture and its role in shaping mental health perceptions and help-seeking behaviors. I will now provide my positionality in the inquiry in the following section.

Subjectivity Statement

Unlike transcendental phenomenology, where the role of the researcher is bracketed to avoid biases and preconceived beliefs, as informed by Husserl (1970), hermeneutics phenomenology repositions researchers at the crux of the interpretation of lived experiences (Kafle, 2011). Therefore, the researchers need to outline their subjectivity to display transparency toward the subject matter, especially when using hermeneutics phenomenology, to provide readers with information regarding why the researcher is invested in exploring the lived experiences through phenomenology.

> I identify myself as an international/ immigrant woman in the United States. Growing up in India, my understanding of mental health was far from the Western 'linear' definitions. In my family, mental health diseases such as depression were stigmatized and often labeled as "stress." I came across a mental health disease at the age of 14 when my neighbor was diagnosed with manic depression. She was highly suicidal and mainly unaware of her attempts to end her life and other activities that were seen as abnormal in our society, such as unnecessary laughing. My father would help her parents find her every time she disappeared, and whenever I asked my parents about the incidents, I was told that she had cancer. Meanwhile, my neighbors would spread misinformation and

false rumors about her condition, associating her depression with a spiritual experience and suggesting her parents see a priest before a mental health specialist. Over the years, I realized that a lot of people in India are either unaware of mental health diseases and treatments or are unwilling to acknowledge such diseases as severe. More importantly, these perceptions are a result of the cultural determinants that help shape the meanings societies give to health and wellness. For example, collectivistic countries rely on strong family ties and communities to treat mental health problems. Similarly, growing up as a Hindu, a lot of treatments for health problems were not only sought by medical experts but also spiritual practices such as burning a piece of cotton (dipped in mustard oil) to get rid of the evil eye. Religious and spiritual practices often defined how our health problems were treated. When I was in high school, my aunt (maternal uncle's wife) was diagnosed with manic depression and suicidal ideation and was admitted into a psychological care facility in Delhi. When the extended family members found out about her inpatient admission to a psych ward, family members talked my uncle out of it and got her discharged from the facility, saying that she needed to be taken to a temple instead of a hospital. My other aunt (mother's sister) told me that being admitted into a psych service was shameful for the family. She also said that she is just acting crazy to get attention, and praying and attending to God would help her behave normally again.

As a phenomenological researcher, my aim is not to focus only on the negative aspects of the cultural determinants that shape mental health meanings. Rather, I have provided a comprehensive understanding of how culture shapes mental health perceptions consisting of positive and negative influences of the determinants.

Research Methods

Since the study aims to fulfil two main purposes; the lived experiences of the Indian immigrant women and the recommendation I intend to make based on experts' knowledge and experience, two sets of data collection methods were employed with two different set of audiences; Indian immigrant women and mental health experts. This section provides detailed information regarding the research design that was employed to conduct the data collection with the audiences in pursuit of the achievement of the goals.

In-depth Semi-Structure Interviews

In exploring the lived experiences of culturally shaped mental health perceptions among Indian immigrant women, the following research design provides information on participants' recruitment, informed consent, data collection, and an interview guide.

After receiving approval from the Institutional Review Board, I recruited 10 participants for this study. Creswell (2013) emphasizes that phenomenological research must focus on gaining clarity on the phenomenon among participants who have lived the experiences and thus considers a sample size of 10 individuals influential since the underlining factor is the quality of essence extracted from the data. Before data collection, informed consent was obtained from each subject to ensure they were participating voluntarily and had the liberty to disengage at their will. Ethical considerations relating to confidentiality were addressed before the start of the interview process. Participants were assured that their identity and personal information would be kept confidential, especially knowing that their friends and co-workers invited some of them to participate. Participants were encouraged to turn off their video feature and use a pseudonym of their choice before the start of the interview process. This was done to ensure that participants would feel safe while sharing sensitive information about their experiences and mental health

perceptions, which they may not be open to discussing in the presence of others (Corbin & Morse, 2003; Englander, 2012; Picton et al., 2017). By the tenth interview, data saturation was reached when no new information or themes were emerging. All recorded files were identified only with pseudonyms and stored in my password-protected computer.

The subjects were chosen using the snowball sampling method, a popular choice among qualitative researchers who investigate health among marginalized communities mainly due to its ability to reach subaltern populations kept aloof from mainstream health deliberations (Yehya & Dutta, 2010). Snowball sampling is a nonprobability sampling technique wherein the researcher identifies potential information-rich subjects and encourages them to make recommendations for other possible subjects for the study (Creswell, 2013). This sampling strategy has been widely used among hard-to-reach populations in the health communication scholarship. For example, in their attempt to advocate for effective qualitative sampling strategies for holistic scholarship, Woodley and Lockard (2016) emphasized that researchers must consider this snowball sampling method to take advantage of social networks and their ability to attract data-rich participants. More importantly, they highlight this sampling strategy's ability to provide platforms for historically marginalized, culturally diverse women to prevent them from further marginalization (Woodley & Lockard, 2016). Initial participants were recruited through the collection of contacts of potential participants from the K-State Office of Data, Assessment and Institutional Research, Pitt State Alumni Center Resources, LinkedIn, and the Association of India Kansas City (AIKC).

I used semi-structured interviews for data collection among Indian immigrant women participants. This research tool is particularly fitting since it lets qualitative researchers get an in-depth understanding of the experience of mental health in Indian culture. Suggestive of the

theoretical framework established in Chapter 2, which aims to investigate profound, meaningful, culturally centered perceptions of mental health, an open-ended platform must be provided to the participants to express their experiences freely. Yehya and Dutta (2010) promote semi-structured, in-depth interviews since they open spaces for participants to negotiate health meanings rooted in their symbolic culture. The interviews were conducted in English, with hints of Hindi words used by the participants to create a better context for the lived experience. Having grown up speaking in Hindi and English, I translated any Hindi words or sentences the participants used during the interview into the transcribed data. Participants were asked for permission to audiotape the interviews. The interviews were held online using Zoom conferencing audio calls and lasted between 1 and 4 hours. After delivering introductory guidelines and receiving verbal consent, the interviews were recorded. To minimize participants' doubts regarding the purpose of the study, the researchers assured participants that the interview was neither a diagnosis nor a therapy session and that at no point would the researcher ask them about their mental health diagnoses. The audiotaped interviews were transcribed, sorted into data points based on each research question, and coded using In Vivo and Pattern Coding methods.

Interview Guide

An interview guide (see Appendix A) was utilized to organize responses to achieve goals and encourage participants to reflect on their lived experiences that shaped their mental health perceptions. This guide consists of interview questions targeted toward each research question to provide a systematic flow of data recording, analysis, and reporting. For example, to explore how Hofstede's cultural dimensions are associated with mental health perceptions among Indian immigrant women and their help-seeking behavior (RQ1), several semi-structured, open-ended questions, including the impact of collectivism, masculinity, power distance, and uncertainty

avoidance were asked to gain an in-depth understanding of the subject matter. Other research questions were also investigated in a similar fashion (See Appendix A). Furthermore, the guide—following an RQ-based system of inquiry -- allowed me to sort the collected data and identify themes based on similar experiences, which ultimately worked towards answering the established research questions. In the following section, I have provided information on the demographics of the Indian immigrant women participants in the in-depth interviews.

The Participants

The study participants were women, 18 years and older who were born in India and are currently living in the U.S. All participants had at least one graduate degree and were working in public and private settings. Research participants in the study represented a wide range of age groups, with the lowest age being 27 and the highest being 53. The most common religion among participants in the study was Hinduism. Participants either had one or more master's degrees or doctorate degrees. Five participants interviewed for the study were married, and 3 had children. Participants indicated various states and union territories they belonged to in India, including Assam, Chandigarh, Chhattisgarh, Gujarat, Mumbai, New Delhi, Tamil Nadu, Telangana, and West Bengal. An overview of the demographics is depicted in Table 3.1.

Table 3.1. Demographics of Indian Immigrant Women Participants

Pseudonyms	**Age**	**Religion**	**Education Level**	**Region of India**
Adhira	28	Hindu	Master's Degree	South
Fragrance	36	Muslim	Master's Degree	West
Jane	28	Hindu	Doctorate Degree	North
Jiaa	29	Hindu	Doctorate Degree	East
Jordan	27	Hindu	Master's Degree	South

Krizza	40	Hindu	Master's Degree	South
Mona	32	Hindu	Master's Degree	Northeast
Surbhi	41	Hindu	Doctorate Degree	North
Tamanna	29	Hindu	Master's Degree	West
Diamond	53	Agnostic	Doctorate Degree	Central

Semi-Structured Focus Groups

As previously mentioned in Chapter 2, agency in CCA is the ability of the subaltern population being studied to come together to act for social change initiatives (Dutta, 2008). The culture-centered approach questions Western-based medicine, which erases cultural values and the meaning people give to health topics and diseases (Dutta, 2008). Dutta and colleagues (2013) accentuate the role of academics and health communication scholars in questioning the structural barriers and addressing them through the communicative process. They further emphasize that to form agencies, communities (participants of the CCA research) build influential networks that bring changes in how health facilities are delivered to them by questioning policy and programs in place (Dutta et al., 2013). These avenues of change become increasingly crucial in exerting solution-oriented research frameworks that place marginalized populations in leadership roles to highlight the importance of their culturally centered health meanings and values.

While CCA uses a unique methodological approach of inviting community members to analyze the collected data in focus groups to deliberate health meanings with dominant structures (Dutta et al., 2013), research on stigmatized health topics such as mental health may not attract participants to discuss their perceptions, experiences, and barriers with other members of the community due to hesitancies and culturally infused shame attached to diseases such as

depression and anxiety. In such conditions, it is essential that the researcher play an active role in communicating significant barriers and perceptions to generate change initiatives (Dutta et al., 2013). As stated before, I have taken a similar methodological approach to communicating significant help-seeking barriers and perceptions with mental health experts to initiate discussions that promote recommendations based on the experiences of the marginalized population (Indian immigrant women) in this study. In the following section, I have provided detailed information on the research method used to collect recommendations from mental health experts.

After analyzing data from the in-depth interviews, I gathered information on the identified barriers and benefits Indian immigrant women perceive in seeking mental health help in the U.S., as well as how they envision mental health services to look in the future. In the second data collection phase, I invited mental health experts to share their wealth of knowledge and expertise in offering recommendations for enhancement in the current mental health interventions. The barriers and benefits of help-seeking and the vision for better mental health outreach were communicated with the mental health experts well in advance to explore new strategies for inculcating identified information in their current mental health practice and treatments.

A purposive sampling method was utilized to identify potential participants for the focus group. Recruitment occurred through email invitations sent to mental health experts in the Riley County and Greater Kansas City communities. After successfully receiving acceptance of the invitation, information about the barriers and visions discussed by the Indian immigrant women in the first data collection phase (in-depth interviews) was shared with the experts to provide context for the focus group discussion topic. Purposive sampling was well suited for recruiting

mental health experts in the study's solution-focused phase due to the topic's relevance and the richness of the data collected through this process (Ames, 2019). Four mental health experts participated in the research with pseudonyms: Expert A, Expert B, Expert C, and Expert D. Expert A works as a Therapy Services Director for Pawnee Mental Health at the Manhattan, Kansas branch. Expert B is a licensed therapist at K-State Counseling and Psychological Services (CAPS). Expert C serves as a practicing therapist at K-State Family Center. Finally, Expert D is a licensed social worker and currently serves as the Director of the K-State Student Wellness Center. Before the discussion, informed consents were obtained from each participant, ensuring their voluntary involvement in the study and addressing ethical considerations related to confidentiality and the right to withdraw. After securing permission to record, the focus group discussions were recorded onto my computer. I then transcribed the recorded data for analysis.

One semi-structured focus group with the four participants was conducted to facilitate the discussion on identifying opportunities for improvement in mental health interventions. Focus groups have been identified as a practical approach to community-based research (Tindana et al., 2015). Focus groups are a common strategy used by qualitative researchers to gather data since they allow for the representation of many viewpoints while also realizing that they can learn important information from the consensus or disagreements among participants (Kitzinger, 1995). Bush and colleagues (2019) have utilized focus group methods in interpretive phenomenology methodology to study community-centered health needs. This strategy of utilizing focus groups was adopted from Wu and colleagues' work (2009), where focus groups were conducted with community members and counselors to facilitate discussions regarding how Korean American immigrant women perceived mental health barriers and elicited potential enhancements. A focus group guide was incorporated to encourage participants to share

recommendations based on the current research data. This guide was structured to answer the two research questions developed for the solution-focused research phase (see Appendix B).

Focus Group Guide

The focus group guide was approved by IRB and played a vital role in directing the discussion. For example, since the questions in the guide generated answers for the two research questions established to account for agency and collective leadership in the theoretical framework, it provided a system of inquiry in investigating responses to RQ 5 and 6, which informed variables such as mental health access improvements and enhancements opportunities offered by the experts. The focus group guide was built to answer the RQs, wherein the semi-structured, open-ended discussion questions were established based on the RQ being studied. It also labels the variables that were being studied in that particular question. For example, for RQ5, open-ended discussion questions included: What are some practical ways of improving mental health services access to immigrant populations in our communities? Moreover, how can we improve linguistics and communication barriers among immigrants seeking mental health help?

Further, after discovering several new factors that act as barriers to mental health in the interviews with Indian immigrant women, such as their visa status as students, service outreach at the collegiate level for international students, and contextual barriers in the patient/therapist interaction (discussed in Chapter 4), additional questions targeted to address these factors were also asked during the discussion. Examples of these additional questions include: How can universities create more inclusive spaces to generate awareness about mental health services for international students? Moreover, how can we overcome cultural/contextual barriers among Indian immigrant women and American service providers? Including these questions helped to

get a deeper understanding of how our structures could address these cultural differences. Findings reflect on these significant issues identified by Indian immigrant women and solutions elicited by experts in Chapter 4. The following section presents the data analysis method adopted to gather the essence of the experiences.

Data Analysis

The data analysis method used in this study was guided by van Manen's (1990) thematic analysis strategy that encompasses the role of the researcher in understanding and interpreting qualitative data to communicate the essence of the lived experiences. Through hermeneutics phenomenology, the role of the researcher is to actively immerse in the data with the participants' experiences to attend to health meanings embedded in their culture (Ajjawi & Higgs, 2007). Human experiences are articulated using communicated 'text' and the essence of linguistics in developing context for effective data analysis (van Manen, 1997). The data analysis process can be one of the most essential aspects of phenomenology since researchers pay close attention to meanings participants give to their experiences, and the interpretation helps build context-based knowledge about the phenomena.

In developing the framework for analysis, the thematic analysis method has been adopted to attend to multiple research methods used in the study. Thematic analysis also opens doors for informing and interpreting data to answer the established research questions. van Manen (1990) also highlighted that pre-suppositions of the concept and new knowledge gathered through data collection can be represented through a hermeneutic circle, which attends to the enrichment of deeper consciousness of the phenomena. In the following section, the data analysis frameworks are listed and applied in the theme-based analysis, which includes 1) searching for 'structures of experience,' 2) describing how structures of the phenomenon are thematic, 3) searching for

essential and incidental themes, and 4) explaining and interpreting essential and incidental themes (van Manen, 1990, p. 79). Additional coding schemes have been utilized, building thematic structures to study the essence of this hermeneutics phenomenology study.

Searching The 'Structures of Experience'

For van Manen, structures of experiences refer to phenomenological themes derived from hermeneutics phenomenology (1990). Therefore, to establish these structures, a process inquiry needs to be conducted to extract meaningful and rich data that will help us understand the phenomenon. Post-data collection, the recorded data were translated into verbatim transcripts and were stored on my personal computer under each participant's pseudonym. To organize the data, I listened to each audio recording and read the respective transcript side-by-side to make micro-edits, which included deleting repeated words, adding missing text, and removing unnecessary fillers. After cleaning the data, these textual experiences were read and reread to immerse them into the transcripts and develop a sense of the phenomenon. Known as hermeneutics conversations, immersiveness occurs between the researcher and the text to build a strong foundation for interpretation (Ajjawi & Higgs, 2007; van Manen, 1990).

Based on each set of interview questions focused on acquiring answers to specific research questions, structures of experiences (van Manen, 1990), that is, sentences across transcripts that specifically pointed to experiences that contribute to RQs, were identified and copied onto MS Excel Spreadsheet under that RQ label. These structures worked together toward the formation of themes. For example, structures that informed the effects of collectivism on mental health perceptions were the results of responses to the open-ended interview guide questions that provided participants with the space to share their personal experiences. These structures were then accumulated together to be coded into themes. This categorization process

was consistent across both research methods in the study, wherein the interview and focus group guides helped sort data into variables being studied. Within this, “a category is a collection of similar data sorted into the same place, and this arrangement enables the researchers to identify and describe the characteristics of the category” (Morse, 2008, p. 727).

To categorize, excerpts that specifically informed the role of religion in influencing mental health decision-making were accumulated together to investigate answers to RQ1. Similarly, categories informing the role of cultural determinants (RQ1), including collectivism vs. individualism, masculinity vs. femininity, power distance, and uncertainty avoidance, were each sorted separately. RQ2 informed mental health perceptions and understanding among Indian immigrant women, and responses to interview questions pertaining to this variable were accumulated together. To inform lived experiences of acculturation and its influence on Indian immigrant women’s perceptions and well-being (RQ3), data answering questions about acculturation were brought together to be coded. Likewise, RQ4 was sorted together, focusing on barriers to seeking help. RQ5 sought to investigate mental health access and communication improvement opportunities categorized under the same label from the focus group discussion transcriptions. Finally, the same approach to categorizing responses to questions contributed to RQ6 was sorted together to establish further themes. The following sub-section explains the coding methods used to articulate thematic structures (van Manen, 1990).

Informing How Meanings Are Sought Through Themes

van Manen (1997) asks researchers to focus on the research question being studied. To develop the essence of the experiences, the In Vivo Coding method was utilized to locate phrases used by the participants to give meaning to their experiences (Saldana, 2013). In Vivo Coding method not only helped in surfacing rich and meaningful excerpts in participants’ own words but

also facilitated narrowing the data to valuable sentences that could be coded further. This coding technique helps encapsulate "behaviors or processes" that explain how the participants' experiences are processed (Strauss, 1987, as cited in Saldana, 2013). The In Vivo Coding is also known as natural coding since it identifies participants' naturally spoken words for the coding scheme (Saldana, 2016). This coding method is extensively used in examining social interactions in cultural settings (Manning, 2017), thus justifying their use in the current study to articulate the meanings that Indian immigrant women and their culture give to mental health topics.

To initiate the In Vivo Coding process. I read through each category of the sorted data and highlighted phrases that spoke specifically to the related variable and research question. For instance, in understanding the effects of acculturation on Indian immigrant women's mental health and outcomes, I highlighted phrases that spoke to acculturative factors, challenges, and their impact on their mental well-being. It is crucial to note that the literature review in Chapter 2 was imperative in informing these factors and challenges that guided me into selecting such meaning units. An example of the In Vivo Coding method from the verbatim transcripts is presented in Table 3.2 to provide contextual information on how meaning units were gathered. In this table, meaning units informing immigration struggles and their impact on the mental well-being of two participants have been recorded.

Table 3.2. Generation of In Vivo Codes from Transcription

Transcript Excerpt from Fragrance	Meaning Units
I have been in the US for eight years. So, the first two years were fine because I was doing my master's. Then there was a lull for six months where I could not get a job. Again, because of the immigration challenges that we face, a lot of companies don't want to sponsor visas. So that happens. So, after around one and a half years, again, I started facing immigration issues, because companies are not very friendly towards it and you again start feeling anxious, anxiety, everything kicks in. But it's just that you have to be very mentally strong and at that time your friends and family are the most needed and they are the ones who can help you and bolster you to move ahead in life. So that's how important mental health is.	• immigration challenges • A lot of companies don't want to sponsor visas. • facing immigration issues • start feeling anxious, anxiety, • So that's how important mental health is
Transcript Excerpt from Surbhi	
I now have a lot of anxiety around immigration because I've had really poor experiences transitioning into this job with my visa. And so, I procrastinate on anything that has to do with immigration. And that is really hard on my mental health. Not so much because I wanted an American passport, but just the sheer emotional violence of the process.	• a lot of anxiety around immigration • poor experiences transitioning into this job • hard on my mental health • the sheer emotional violence of the process

Uncovering Thematic Aspect

According to van Manen (1990), themes are like "knots in the webs of our experiences" (p. 90), which are surrounded by lived phenomena. These themes help articulate the meaning of phenomenological study participants assigned to the text. They have the power to immerse researchers in curiosity to extract the essence of the experience (van Menon, 1990). It is worth noting that uncovering statements is not powerful enough to reflect on the essence of the experience. Therefore, coding strategies need to be further developed to accumulate what van Manen (1990) called thematic statements that can capture the richness of the data. This can be achieved through the second cycle coding method wherein data from In Vivo Coding is further categorized to form meaningful themes. "Theme gives control and order to our research and writing" (van Manen, 1990, p. 79). To establish patterns of themes, in the second cycle of coding, the Pattern Coding method was utilized to group similar phrases together into themes. Pattern Coding is one of several second-cycle coding methods used on the qualitative data refined from the transcripts in the first cycle. Pattern Coding helps assemble previously coded data into rich constructs or themes representing life experiences (Saldana, 2013). This coding method is effective for data representing causation and explanation and can help examine social interactions and relationships (Miles & Huberman, 1944, as cited in Saldana, 2013).

As the name suggests, Pattern Coding helped identify common constructs and patterns in refined phrases from the In Vivo codes that could be grouped together to form a theme. These themes are discussed in Chapter 4 and aim to answer the established research questions. Table 3.3 provides an example of the Pattern Coding method based on the In Vivo codes generated in first-cycle coding (see Table 3.1). To elaborate, in the second coding cycle, the In Vivo codes from the initial coding were studied to find commonalities in the experiences of Indian

immigrant women as they expressed their challenges during acculturation. Establishing summary constructs from the excerpts helped synthesize meaning units into patterns. In the example provided in Table 3.3, summary constructs established in the second column found similar codes or patterns of challenges, jobs, immigration, and impact on mental health. For this, I reflected on several pattern codes or themes and chose 'challenges with jobs and immigration' as the theme since it reflected their acculturation challenges, which contributes to answering RQ4. Memoing or reflections can help researchers brainstorm ideas to identify emerging patterns or constructs, establish themes, define code, and answer research questions (Saldana, 2013). Throughout the data analysis, I reflected on how my pattern themes emerged from the In Vivo codes and how they complemented each other to answer my research questions.

To respond to my research questions comprehensively, I developed themes and sub-themes from my data analysis process. According to Creswell (2013), themes are "broad units of information" and are a "family" to various subthemes (p. 187). These themes and subthemes then provide a thorough response to research inquiries. For instance, in articulating the effects of acculturation on Indian immigrant women's mental health and well-being, I informed a theme that provides insights into acculturation discomfort and its impact on their mental health and participants' positive outlook on mental health topics. Within this, I informed subthemes that further broke down several discomforting factors (see Chapter 4). This method of organization helped achieve research goals and provided complete responses.

Table 3.3. Example of Pattern Coding Conducted in Second Cycle Coding

Meaning Units from in vivo codes	**Summary constructs from excerpts**	**Generated Pattern Code**
Fragrance (36) • The immigration challenges that we face, a lot of companies don't want to sponsor visas. • I started facing immigration issues, I again start feeling anxious and everything kicks in • That's how important mental health	Immigration challenges Impact of visa on job Mental health hindrance Importance of mental health	Challenges with Jobs and Immigration
Surbhi (41) • a lot of anxiety around immigration • poor experience transitioning into this job with my visa • Really hard on my mental health • the sheer emotional violence of the process	Immigration anxiety Impact of visa on job Poor experiences due to visa Mental health hindrance	
Tamanna (29) • getting a job is stressful • It's very tough on mental well-being • Challenges with laws	Impact on job Mental health hindrance Immigration challenges	
Krizza (40) • Cannot take a break from job • Strict immigration rules and regulations • Immigration system is rough on us	Immigration challenges Impact on job Mental health hindrance	

Explaining and Interpreting Themes

At this point, the interpretation of phenomenology researcher is imminent in expressing lived experiences. At this point, we address themes to "make sense of the data" (Creswell, 2013, p. 187). Hermeneutics phenomenology states that the researcher's role in interpreting the themes

is crucial to the nature of the methodology (Kafle, 2011; Rapport, 2005; van Manen, 1990). To articulate comprehensive meanings of the text, "a researcher's theoretical and personal knowledge" and her ability to conversate with the data becomes pivotal (Ajjawi & Higgs, 2007; p. 616). Interpretation also involves reflecting on reviewed literature to test developments and inculcating the researcher's decoded understanding of the essence (Ajjawi & Higg, 2007). For now, the analyzed themes, subthemes, and their interpretations leading to answering the research questions are informed in Chapter 4.

Establishing Rigor

One of the most important aspects of qualitative data collection is the findings' validity and trustworthiness. Therefore, I focused on conducting quality interviews that covered significant aspects of the research questions to get a deeper understanding of the subject matter. The length of my questions remained succinct to ensure that the interviewees' responses were built upon their own meanings and experiences. I repeatedly encouraged participants to dive deeper into excerpts from their responses (Kvale, 1996). The study used audio recordings and transcriptions to facilitate research documents' validity and credibility (Burhans & Alligood, 2010). Further, in Chapter 4, I have included excerpts extracted from the refined transcripts to showcase the richness and transparency of the data (Moravacsik, 2020).

Member checks were also conducted among study participants, where the refined transcriptions were shared to correct any errors and comment on the accuracy and resonance with their lived experiences. Member checks are "the method of returning an interview transcript or analyzed data to a participant (Birt et al., 2016). Members checks speak to the trustworthiness and internal validity of the qualitative research. In the current study, apart from minor sentence structure errors and grammatical suggestions, the participants reported no significant changes in

this process. For Beck (1993), credibility can be achieved by articulating the vividness and faithfulness of the description presented by the subjects during data collection, which can be tested by member checks. Moreover, Lincoln & Guba (1985, as cited in Creswell, 2013) find member checks as "the most critical technique for establishing credibility" (p. 252). Credibility is exemplary in the organization of the inquiry and the communication of the objectives, findings, and interpretation presented in the study. Finally, transferability was achieved by simplistic interpretation so that readers could find context-rich relations with the essence of the data (Koch, 2006). Further, thick descriptions of each theme leading to answering the research questions have been provided to attend to the transferability of the experiences in shared settings (Creswell, 2013).

Summary

This phenomenological study investigated the lived experiences of Indian immigrant women to understand their culturally shaped mental health perceptions and help-seeking behaviors. The study employed semi-structured in-depth interviews and focus groups to gather vital data about the participants' lived experiences and mental health experts' elicited recommendations for improvement in mental health access, respectively. I used thematic analysis, informed by van Manen (1990), to analyze my qualitative data. Throughout the research study, I played an active researcher role in building agency (Dutta, 2008) for the participants. I collected, analyzed, and communicated essential data points from the interview to my mental health experts to create collective and deliberative spaces for exploring enhancement opportunities. I also implemented research strategies and standards for qualitative research validity and reliability.

Chapter 4 - Findings

This chapter explains how participants describe their experiences with culturally centered mental health perceptions and help-seeking behaviors. It also informs how mental health experts shared their recommendations about better mental health opportunities for Indian immigrant women in the U.S. The literature review in Chapter 2 explored the intricacies of topics of mental health in the Indian culture and how people with mental health diseases perceive and are treated by society. Using hermeneutics phenomenology and van Manen's data analysis methods, the themes presented in this chapter explored answers to the research questions established in Chapter 2.

The purpose of the study was to understand the role of culturally shaped mental health perceptions among Indian immigrant women and their help-seeking behaviors. It also aimed at eliciting practical recommendations from mental health experts regarding enhancements in the current mental health intervention. Findings from the thematic analysis help the research accomplish its purposes. Several themes emerged from the thematic analysis conducted with the collected data that provide insights into the lived experiences of the study participants and mental health experts' contributions to a solution-oriented inquiry. The results are organized in the following manner: subheadings stating the research question followed by analyzed themes and their subthemes that answer the question, along with my interpretations of the analyzed data to summarize the meaning of each studied variable.

Cultural Determinants and Mental Health

The first research question (RQ1) investigated how cultural determinants influence mental health perceptions and decision-making among Indian immigrant women in the study. The following themes emerged in response to RQ1: collectivism and social support network,

masculinity and mental health expression, power distance and mental health topics, uncertainty avoidance, and women's mental health. These themes are further elaborated by subthemes that provide a deeper understanding of the phenomenon. Among the four determinants identified across literature in Chapter 2, the first discussed is individualism vs. collectivism. Across literature and the collected data, India has been identified as a collectivistic nation that prioritizes overall community welfare, harmony, and interdependence (Chadda & Deb, 2013). Additionally, collectivism serves its benefits in coping with diseases but only in silence. The following theme and subthemes provide insight into collectivism's role in shaping perceptions and behaviors. These themes from the participants' experiences for RQ1 are as discussed:

Collectivism and Social Support Network

India has been identified as a collectivistic nation that prioritizes overall community welfare, harmony, and interdependence. In addressing the effects of collectivism on mental health perceptions and help-seeking behavior, participants expressed their lived experiences that forefront issues of stigma, lack of knowledge, and distrust in medicinal treatments while seeking help. Moreover, members of the Indian community tend to value community harmony and reputation over individual concerns. In contrast, collectivism also serves its benefits in coping with diseases but only in silos. The following subthemes provide insight into collectivism's role in shaping perceptions and behaviors.

Collectivism and Stigmatized Mental Health

During the interviews, the word 'collectivism' was received rather negatively by the participants in terms of mental health topics. They were unwelcoming to the notion of collectivism in Indian society due to society's collective power over individual belief systems. Indian immigrant women shared their experiences of growing up in a collectivistic society that

stigmatizes mental health topics. Due to a general lack of awareness about mental health diseases, people with depression and anxiety are often labeled as “crazy” and are considered unfit for society. For example, when asked about the effects of collectivism on perceptions of mental health diseases, Adhira, a 28-year-old engineer, said,

> Let's say a young kid is seeking help, and people know about this. Then society will label her as difficult; the kid is crazy; nobody should talk to her or stay away from her and don't engage with her. When somebody in high school or college is seeking help, then the narrative is that nobody should engage with them because they almost think it is contagious, or they think it's not good to be around them.

Stigma and society’s need to maintain collective harmony often lead to Indian families resolving mental health problems within the household due to the fear of being judged. Tamanna, a 29-year-old accountant from a small town in India, reflected on the impact of collectivism on people’s inability to seek professional help and listed factors that impact negative beliefs, saying,

> If there is a certain issue or if somebody really needs help, the family tries to resolve it within the circle. They wouldn't want to go out there and seek help right away. They become victims of social stigma and judgment.

Stigma tends to cause families and community members to disacknowledge symptoms of depression and anxiety. Fragrance, a 36-year-old engineer, pointed out that women are horrified by judgment, which plays an intense role in how they seek help and face society. She said, “the fear of being judged and how it is going to affect their future, not only concerning their mental health, but after they are judged in the society, they just feel that they cannot face society anymore.” The word “judgment” came up in every interview referencing to the taboo in Indian society related to mental health topics pointing out the great depth of terror it has caused within

the culture. Judgment also tends to shut down conversations in a society wherein a family no longer addresses depression and anxiety as serious issues. These stigmatized collective conversations about mental health and the lack of deliberative spaces thereof have been reported to be the reason why many participants never talked about mental health while growing up in India. When Jane, a 28-year-old Indian immigrant woman, was asked what conversations about mental health were like among family members in the culture, she responded,

> I don't think the term depression ever existed in their thought process and then I have seen some friends who had gone through mental health issues while I was growing up and I think sometimes their families just wanted to cover that part, thinking nothing happened and she's just sad because she didn't get a materialistic object.

Lack of awareness regarding symptomology and treatment of mental health is a significant driver for stigmatized beliefs in the Indian culture. For instance, Mona, a 32-year-old mother of one, shared that since most people are unaware of depression, they often misinterpret symptoms such as lethargy, excessive sleeping patterns, and overeating as a sign of laziness which are major behavioral patterns leading to worsening conditions. Similar sentiments about lack of awareness among people about mental health were noted across interviews.

In articulating the extent of the role of collectivism in shaping perceptions, participants were asked about the benefits this orientation serves to the culture. The following subtheme provides excerpts from the study highlighting the identified benefits of collectivism.

Benefits of Collectivism in Mental Health Expression

Collectivism dictates community harmony and collaborative decision-making, which can serve benefits for people suffering from depression and anxiety. Several members of the study pointed out that knowing your family and community members are around you to support you in

hardship provides a sense of belongingness that helps in coping with depression and anxiety. However, participants indicated that to create this supportive outlook of collectivism, there needs to be more acceptance among family members to provide support rather than diminish the disease's severity. While sharing her experiences about this benefit of collectivism, Adhira (28) said,

> Let's say I just showed up to my family and said I'm not doing okay and that there's something wrong with me. Instead of judging me, let's say they accept the fact and I have several people who worried about me in the room and show support. This creates a safe circle for us. They give this much positivity, and I will reassure myself that I have people supporting me.

Nevertheless, these scenarios are predicted only if the family is open-minded about accepting mental health diseases as severe. There are contingencies upon which collectivism can benefit someone seeking support from family and friends: more awareness and less judgment. Participants went on to share instances where family or communal support was only possible if people were aware of the mental health issues in the first place. To this, Jane (28) shared that if there were awareness and willingness to talk among family, neighbors, and relatives about mental health diseases, then people who are suffering would not need therapists due to increased support from their surroundings. Similarly, Jiaa, a 29-year-old researcher, provided insight into the current situation wherein this contingency (more awareness, less judgment) has not been met and outlined its effects on mental health well-being, saying, “I would say that the number of supportive people is less. It depends on the demography, family, culture, and state you belong to, but that number of supportive people is less, which negatively affects you, especially in terms of mental health.”

Gaining support in times of need can help a person become more optimistic about overcoming mental health challenges. To answer the question regarding what benefits collectivism serves to suffering individuals, participants consistently used the word "can" to attend to the hopefulness of supportive collectivism in Indian culture. For example, Tamanna (29) expressed her optimism about social support, saying that communities can motivate suffering individuals to gain a positive outlook if done correctly, hoping that perceptions become more favorable toward mental health in the culture. Aside from the effects of this determinant on mental health perceptions, collectivism tends to impact an individual's ability to seek professional help in India. Throughout the study, the impact of cultural determinants on help-seeking behavior was investigated. The following subtheme provides insights into the role of collectivism in shaping mental health decision-making processes.

Collectivism and Help-Seeking Hindrances

Collectivism tends to negatively impact people's tendency to seek professional help. Since family and relatives tend to make decisions collectively, a family member suffering from depression or anxiety needs to discuss these issues with their parents before they can seek help. Adhira (28) examined the role of family members and how they seek help by explaining that they contact family doctors and skew the diagnosis results. In the case where the doctors provide a different diagnosis than expected, the family overlooks it and eventually declares the patient to be normal. She said that the family seeks out doctors or family physicians who are supposed to say, "You are fine, don't worry about it." If the doctor does not say that or diagnose it differently than anticipated, then the doctor is probably not a good one.

Collectivism shows up in conversations that parents and family members have about how to deal with diseases. Strong ties among family members often create expectations for family

discussions about significant decisions, especially for women who may need medical attention, physical or mental. When asked which factors affect decision-making, Jane (28) said that in a society where families are closely connected, if the support system lacks knowledge and open-mindedness, it could hinder women's getting help since the decision-making power has shifted to adults in the household. In Indian families, community well-being takes precedence over individual well-being, transferring decision-making power to adults, primarily men, in the family. Similarly, when Surbhi, a 41-year-old architect, was asked about how collectivism affects mental health decision-making in their society, she responded,

> I think collectivism harms it. I think that because there are different generations of people with different belief systems who are making decisions together, it could lead to decisions that are not the best, at least regarding mental health. My married friends want to see a therapist, but they must discuss it with their husbands. If they live with their in-laws, it is something they discuss with them, and to me, this is a medical decision. If this person needs medical attention, I don't understand why this must be shared (Surbhi, 41).

Additionally, Indian families have alternatives to therapy that are suggested to people suffering from mental health diseases, which diminishes the value of seeking medical help. Several participants shared that families suggest alternatives such as physical activities, home remedies, and keeping minds busy as ways to avoid diseases and therapy. To this, Jiaa (29) shared that friends and family often "brush off topics by suggesting home remedies, taking a walk in the morning, or praying to different gods of Hindu religion to feel better. They often suggest meeting an astrologer to seek out help as well." These attempts to drive an individual away from professional help contribute to increasing symptoms, which negatively impact overall well-being due to the sheer lack of acceptance and attached shame in the culture. The negative

perceptions about mental health that create stigma around seeking help often isolate people. When asked about the consequences of seeking support and assistance from society, Fragrance (36) mentioned that,

> It's sad that there are still a lot of people who do not take any mental health support or help because they feel that people will judge the whole family that they are not mentally stable, and they would be kept aloof from society. This is one of the general norms in Indian society. So, people still do not go to doctors, therapists, or counselors because they are always fearful of being judged (Fragrance, 36).

With the adverse effects of collectivism on help-seeking, women in India often do not reach for professional help. Participants pointed out that regardless of where you are located in the country, collectivism follows and hinders a woman's ability to decide for her health. So far, it is evident that community harmony, familial respect, and collective decision-making are crucial to Indian culture, which hinders mental health mainly because of stigmatized beliefs and perceptions, judgment and shame, and lack of awareness about diseases and treatments.

Since RQ1 aims to investigate the association between cultural determinants and mental health perceptions among Indian immigrant women and their help-seeking behavior, I will now provide evidence on the second determinant: Masculinity/ Femininity. Throughout the interviews, this cultural dimension has been reported to have a significant impact on how Indian immigrant women perceive mental health. Moreover, the positionality of women in mental health decision-making is heavily impacted due to this dimension. To provide a detailed account of the lived experiences of the participants, the following theme and its subthemes deliver insights into masculinity's role in mental health topics among Indian immigrant women.

Masculinity and Mental Health Expression

Masculinity and mental health expression are another theme that emerged while understanding the cultural determinants and their role in shaping mental health perceptions and help-seeking behavior. To embark on the impact of masculinity vs femininity on well-being, participants provided deep insights into the weakened position of women in Indian culture with respect to mental health. For many, the power and authority to make decisions lay in the hands of either their husbands or parents (primarily fathers). Masculinity, predominantly the uneven distribution of power among genders in the country, shows up in nuanced dynamics that exist due to cultural norms and family traditions. Throughout the interviews, this cultural dimension has been reported to have a significant impact on how Indian immigrant women perceive mental health. Moreover, the positionality of women in mental health decision-making is heavily impacted due to this dimension.

To provide a detailed account of the lived experiences of the participants, the following subthemes: gender differences and mental health perceptions and gender roles and mental health decision-making, deliver insights into masculinity's role in mental health topics among Indian immigrant women. Participants made it clear that Indian culture is masculine. For example, when asked about the power dynamics among genders in the family and community, all 10 participants indicated that men are more powerful in society. To this, Mona (32) said, "I think society as a whole was very male-dominant." To reflect on this determinant's impact, in the following subthemes, I provide excerpts from the study that discuss the interplay of masculinity and its effects on mental health perceptions and help-seeking behavior.

Gender differences and Mental Health Perceptions

Findings from this research have indicated that India is a male-dominant society. Throughout the interviews, eight participants shared incidences that pointed toward masculinity being suppressive of women's rights for generations. Men are seen as the head of the family, hold decision-making power, and, as Adhira (28) said, "can get away with a lot because they are men." Similarly, when asked about the positionality of women in the culture, Jordan, a 27-year-old engineer, said, "In Indian culture, we do have some kind of setbacks for women from the hierarchy, the dominance, and extra pressure a person upholds to fit into the daily norms." Similarly, Surbhi (41) instigated that, in terms of mental health, the pressure to wear several hats and complete several tasks always falls on women in India, which impacts their well-being.

From an early age, gender roles play a significant role in determining women's duties and responsibilities toward their families and the well-being of the house. Often, there is little to no room for them to express their needs and desires, let alone seek help. When Krizza, a 40-year-old accountant, was asked about how conversations about making decisions were played out in her household, she replied,

> Most of the time I used to think that I wanted to do something, I wanted to give some suggestions, but men of my household were not ready to take it. For example, if I want to buy a house or if I want to travel somewhere, I can't because it's what they decide, and we must follow that. That's it (Krizza, 40).

Compared to men, women are expected to showcase strength, which is considered pivotal to the well-being of the family. Women are expected to suppress their negative emotions and present themselves as happy and collected for the smooth functioning of their household. For

instance, Adhira (28) shared that men and women were treated differently if they showed emotions, saying,

> If a guy messed up, the guy did something, he was excused for his behavior, but as a female, you should be more patient, that means you're not allowed to get frustrated, you should always be cheerful and smiling because in my culture I was told multiple times that a woman shouldn't cry because it's not good for the household. Unfortunately, society sees in a way that it's a woman's fault if she cries (Adhira, 28).

The family and society often neglect women's mental health. There is also an added pressure to portray yourself as happy for the positive well-being of the family. This pressure to adhere to gendered role expectations often also affects how an individual would seek help in a time of need. The following subtheme discusses the influence of masculinity on women's mental health help-seeking behaviors.

Gender Roles and Mental Health Decision-Making

Across interviews, women established a direct connection between men having decision-making power and women's inability to seek mental health help. Essentially, men are considered the household's decision-makers, and they often decide whether a woman can seek professional help. For example, when asked who decides whether women can seek therapy, Diamond, a 53-year-old professor, said, "The men decide, the brothers decide, the grandfathers decide if they can spend money on help-seeking. This is regardless of any corner of India" pointing out that the power to take decisions about a woman's medical treatments lies in the hands of men.

The lack of authority to make decisions can contribute to depression and anxiety a woman may be experiencing. Oftentimes, the frustration lies in their inability to fight for their

personal well-being. When Tamanna (29) was asked about the impact of decision-makers' authority in the household on mental health perception and decision-making, she said,

> I always perceived difficulty that if he would get permission, then my dad and my uncle would make decisions, and then it came to my mom, and then it came to me. It was very hard for us kids to approach the elders. We were always scared of them because that's how the dynamics were in the family. So, my perception about deciding for myself was that anything I would put my point across would never be heard. There's no way that I would be given a chance (Tamanna, 29).

To a similar question, Fragrance and Krizza, in their interviews, indicated that men are always the decision-maker of the house in Indian families, which hinders their ability to show authority to decide for their mental well-being. Women are often confined to portraying a strong persona. Below is an excerpt from a conversation with Fragrance (36),

> **Researcher**: What do you think is the positionality of women when it comes to mental health help-seeking decisions?
>
> **Fragrance:** One thing that I know is that women are not even allowed to get mental health help for the simple reason that we were always told to be strong because we are women, and we must take care of everything in the house. So, you must be strong under pressure, even if you are going through any mental or emotional turmoil. You can never bring it out or discuss it with the closest family members.

The distribution of power among genders has placed women in the fragile role of caretaker and peacemaker in the household, which eliminates spaces for them to express their negative emotions. Family values and gender roles have dictated that regardless of whether a woman is going through a mental disease, she must always portray a happy face for the harmony

of the household. Moreover, they are not deprived of seeking treatment since the decision-making power is not in their hands.

High Power Distance and Mental Health Topics

High power distance and mental health topics is the third theme that corresponds to cultural determinants that influence perceptions and behavior among Indian immigrant women. The Indian culture is high in power distance, meaning that authority is unequally divided among the population. In the current study, when asked about power structures, patriarchal families were the most identified structures, which indicated that the power lies mainly in the hands of families run by men, which interplays with women's health and decision-making. Additionally, religion as a power structure holds the utmost authority to determine how individuals must lead their lives and how mental health would be defined. The following subthemes, patriarchal families and women's positionality and the influence of religion on well-being, provide evidence from the study highlighting the experiences that define power distance in India. The first subtheme embarks on the familial pressure on women in the Indian culture that commands their lifestyles and its impact on their mental health and well-being is discussed as follows:

Patriarchal Families and Women's Positionality

Parental and gendered pressure often plays a crucial role in defining the lifestyle of the children in Indian culture, especially for girls and women. They are usually pressured to lead their lives on their parent's terms, including their lifestyle, education, professions, and marriage. Adhira (28) describes the positionality of women under the pressure of the patriarchy, saying,

> By the time we are even born, they [parents] already have decided what a woman should do or who a woman would marry. We grow up and all our responsibility is to take care of

children or take care of somebody so you're responsible for somebody all the time that's how we grew up (Adhira, 28).

Indian families tend to adhere to societal norms that command women's positions to remain in the household and to take care of the offspring. Moreover, their tendency to make personal decisions is often minimized by parents to prevent the family from shame, which adds negatively to their overall mental well-being. For example, when Jane (28) was asked about how women's lives play out in a patriarchal society, she responded,

> Women must do things in a certain way, we must get married in a certain way, and I think I am kind of coming close to that age where there's a lot of societal pressure. Even if you don't find a nice, decent guy to live your life with, you are still pressured to get married before 30, which is basically the deadline for most of us. There's a lot of societal pressure just to behave in a certain way, and even if you're struggling after your marriage, you must bear it because there's another taboo: Divorce. So, you cannot do that because it's frowned upon. So that all leads to depression and just not being aware of what's going on in that person's mind (Jane, 28).

Several participants in the study shared similar experiences where patriarchal families play a dominant role in defining what is best for women in the household. Beyond dictating their duties and responsibilities, patriarchy forces women into submissive roles in the hierarchy where the expectation from them is to listen. To this, Jiaa (29) pointed out that if women are not earning money, their purchasing power is diminished and transferred to male members of the family who will neglect women of professional help. Diamond (53) also elaborated on the difference in how finances are distributed among genders regarding medical treatments. She pointed out that even for physical ailments and treatment, families tend to spend less money on women with diseases

as compared to men. For example, “if a boy is sick, the family will drain their financial resources to keep him alive since he is the future of the family name compared to a girl, who is married into a different family” (Diamond, 53). Similar sentiments were noted across interviews where nuanced behaviors reflected on the pressure of patriarchy in defining mental health severity, contributing to women’s mental health diseases being perceived as secondary or relatively unimportant.

Power distance is reflected in the dominant religions’ role in shaping how people perceive diseases and seek treatments for mental health. Religion can have both healing and detrimental effects on people with mental health diseases. The following subtheme provides excerpts on these perceptions.

Influence of Religion on Well-being

Religion is deeply rooted in Indian culture when it comes to mental health and well-being. When asked about the role of religion and spiritual practices on mental health perceptions and seeking help, many participants separated religion and spiritual practices. They saw this as an opportunity to reflect on the benefits of spiritual practices on mental well-being and the harmfulness of religion in understanding mental health. For them, spiritual practices lead to self-awareness and healing, which they believe are helpful for mental health. For instance, Krizza (40) mentioned that “yoga and meditation can contribute to calming depression and anxiety.” At the same time, Tamanna (29) said that “turning to God, visiting the temple, practicing spiritual prayers helped soothe their anxiety.” However, they mentioned that these may not be enough to treat the diseases completely.

To distinguish religion from spiritual practices, Fragrance (36) provides a more precise context of how the two play separate roles in dealing with mental health in India. She said,

“Being spiritual is a healing practice for me; being religious is not because I noticed that when people become very religious, there is a fanaticism that comes from within, and I don’t appreciate that.” She further explained that religious people tend to push their beliefs on others, while spiritual practices help individuals heal during suffering. In the attempts to establish religion’s role in defining mental health and treatment, participants reflected on how religious leaders and astrologers play a crucial role in misguiding people about mental health diseases. For instance, Jiaa (29) shared,

> There will always be narratives like you pray you will get over with it. If you're facing a problem mentally, you pray to special gods. Go to this town and pray to this god, your problems will be solved. Whatever anxiety or tension you are feeling, will be gone. And there's a huge exploitation from the astrologers too, that you wear this pearl or that gem, your problems will be solved (Jiaa, 29).

Adhira (28) shared a similar statement about the exploitation of religious leaders who mend diagnosis based on the amount of donation a person makes by saying, “According to the Babas (religious and spiritual gurus), if you make a huge amount of donation, all your diseases would be cured, I mean that right there says that that's a scam.”

Lack of knowledge and the infused fear among people often leads them to believe that mental health diseases are supernatural and can be cured through religious gurus. Diamond (53) argues that the culture is confused between biophysical mental health and deep spirituality. To this, she said, “They are confused, in my opinion, and they begin to claim things like Bhoot Pret (ghosts) are overwhelming an individual or their Buri Nazar (evil eye) on them” rather than attending to their mental disorders, which may be worsening.

The dominant role of religion in India forces impressionable people to perceive mental health as supernatural forces rather than treating them as biomedical. Religious gurus and astrologers mainly push these ideologies to charm people into believing that they have the solution (in the form of prayers, rituals, and gemstones) to their mental illnesses. Fear of disease or supernatural forces often coerces mental health patients to adopt these practices, which can negatively affect their well-being.

Power distance in India plays a scary role in women's mental health perceptions and their decision-making. Not only are they positioned in a docile role in families where their gender roles are pre-defined, but they often lack the ability to make decisions for themselves when it comes to seeking professional help for mental illnesses. Patriarchy dictates that women are meant to portray themselves as content and untroubled for the well-being of the household, and men and parents have the power to decide how the finances of the family will be spent on women's healthcare. In times of need, participants discussed that while spiritual practices like praying, yoga, and meditation can be beneficial in calming anxiety and depression, they are certainly not the remedy to these diseases. Moreover, the dominant power structure of religion spreads misinformation about mental health diseases and distributes superstitious healing practices due to a lack of knowledge and fear of diseases.

Uncertainty Avoidance and Women's Mental Health

Uncertainty avoidance and women's mental health are the fourth emerging themes identified from the lived experiences of participants. In attempts to keep collective harmony, the culture tends to avoid uncertain situations that may invite mental health conversations simply due to stigmatization and lack of awareness and acceptance. The following subthemes discuss the elimination of spaces for women to express their mental health issues and reflect on the

behavioral codes set up by society to be considered mentally fit. I have provided excerpts from the interviews to give context to these subthemes.

Absence of Deliberative Spaces for Mental Health

Indian society tends to avoid or shut down conversations about mental health diseases. Throughout the research, participants pointed out words like depression and therapy do not exist in people's vocabulary due to the taboo attached to people with mental illness being abnormal and contagious. Due to this, people with severe symptoms and mental illnesses are shunned by their families. For example, when asked to reflect on conversations about mental health among families and relatives, Adhira (28) said,

> Depression, the way it was labeled to me, it's just you feel sad about something, and you don't show it, you just get over it and it's like "Everybody has problems. It's okay to have it but just don't brag about it, don't cry." If I say I'm sad, then I will be told to get over it, and it was so drained into our society that if some kid is being difficult and constantly being sad, they are labeled as an unhappy kid (Adhira, 28).

Conversations about mental health are mostly unwelcome in Indian families. Surbhi (41) also shared how conversations about mental health are minimal due to the fear of more and more people being exposed to information about symptoms and self-diagnosing with depression or anxiety, saying,

> So, I think that there's a fear that if we actually start talking about these things, we will discover that there are a lot more people [with mental health problems] and there are things about our culture that make things really hard on people (Surbhi, 41).

Further, the Indian society collectively boycotts a person with severe symptoms of mental health illnesses to avoid explaining to people in the community about their diagnosis. This can

often lead to hindrances to patients talking about their symptoms with family members in the first place. For instance, Fragrance (36) reflected on the fear among people with diseases, saying,

> If people suffer from depression or anxiety, they are not considered to be mentally fit and at the same time, they don't want to believe that they can be ostracized from society. So, the fear of being ostracized is more harmful to their mental health. That is one of the reasons I feel that a lot of people are not very open about their mental health issues (Fragrance, 36).

Adhira (28) shared an example of a family member being ostracized due to her family member rejecting her mental health condition saying,

> It was a time when one of my uncle's daughters opted for divorce. It's after the divorce she was trying to talk about how difficult life has been or how it's been it took a pretty little on her and then when she was trying to share how difficult it was to make a decision on it and how it affected her mentally for a couple of years to get back on it, the people around them tried to ignore her and completely change the topic. But in the next ceremony, my mom was told that no one really invited her and that it's not good to be around people that she's emitting these negative vibes and she's talking about these things and infecting other people (Adhira, 28).

Other participants in the study also agreed that Indians tend to avoid discussing matters related to mental health to remain a part of society. Diamond (53) shared,

> Once you start to say that something is mentally wrong with you, your life is pretty much doomed from then on. Society can shun you; society can start by labeling you, and it could really be the in-group and out-group biases that get established. And you would

> really want to be embraced, even within extended families, within nuclear families, sometimes siblings don't want to acknowledge their siblings if they have any condition. So, the support systems are so weak despite so many people (Diamond, 53).

Coinciding with the results of collectivism and its effects on mental health perceptions, the absence of deliberative spaces for women in the culture is an attempt to avoid the uncertainty of being judged in society. The culture eliminates possibilities of open discussions about mental health among family and community members and, upon revelation, has the capacity to ostracize individuals in order to protect the family from shame. The factors that drive this behavior are stigma, judgment, and lack of awareness about diseases, which have also been noted in Theme 1. In the following subtheme, I have highlighted how strict behavior to act "normal" is an expectation in the culture.

Behavioral Codes to Act Mentally Fit

Another subtheme contributing to the uncertainty avoidance that emerged from the collected data focuses on strict behavioral patterns and codes regarding how people, especially women, should present themselves as "normal." This is often done to overshadow mental health symptoms and keep up a healthy image of the family to avoid the uncertainty that may come from symptom recognition and diagnosis. When asked whether Adhira (28) believes that Indian culture has strict behavioral codes about how a person must behave to be considered a part of the culture, she responded,

> I think the culture or society initially tried to hide it as much as it could so that it wouldn't break open in the air. They believe it's contagious. I was told to always surround myself with happy people, don't spend more time with moody people, or don't spend time with

people who always have this emotional volatility, a few people who speak out of their minds (Adhira, 28).

Behavioral codes are mostly in place for women to portray a perfect image and to be considered mentally stable. For instance, when Mona (32) was asked about the strict behavioral codes about how society seeks mental health, she shared that the behavioral codes are in place mostly for women expected to dress and speak mannerly. She expected to do well in school, be a wife, and be a mother. In this process, a woman talking about mental health takes her away from being a perfect woman. In the context of mental health, Surbhi (41) also mentioned that "women's behavior is policed a lot more than men's behavior in India. Moreover, Tamanna (29) pointed out that if people actively smile and have a healthy conversation, their behavior is acceptable. It changes when a member of a group is feeling low and starts to discuss their stressful, depressive episodes, where people around them get uncomfortable and start avoiding them altogether.

Conclusively, the cultural norms dictate that mental health conversations are not embraced in society. Moreover, people willfully choose to shut down conversations about mental health either due to the shame attached to the diseases or the fear that more people would be exposed to the disease symptomology and diagnosis. The position of women in being able to express their psychological needs is weaker than that of men since there is a lack of deliberative or safe spaces. They are also expected to behave "normally" so that their perfect image and familial respect are kept intact in the eyes of the community.

Mental Health Perceptions and Meanings

To investigate the answer to RQ2, which attends to how Indian immigrant women understand mental health perceptions amid cultural influence, two major themes emerged that

point to their perceptions based on their experiences with the disease and its interaction with the Indian culture. The perceptions varied, depending upon their exposure to mental health topics while living in India. The cultural determinants significantly influence how these perceptions emerge and change. Moreover, personal and familial experiences with mental health diseases played a vital role in the formation of perceptions. The following themes provide thorough insights into how culture and experience led to the development of mental health meanings among Indian immigrant women.

Variations in Exposure to Mental Health Topics

Indian immigrant women in this study described a diverse perspective on knowing mental health. While some participants had been well-informed and well-equipped since their teenage years, others did not know or discuss mental health until they arrived in the U.S. The reasons behind the drastic differences in exposure to mental health topics are embedded in personal experiences from living in Indian society.

Among the ten participants in the study, three women, including Fragrance (36), Surbhi (41), and Diamond (53), informed that growing up, the conversations about mental health were normal, which generated their curiosity to read and learn about mental health diseases and treatments themselves. Fragrance (36) shared her experiences of getting exposed to mental health diseases, saying,

> As a child, I saw my father deal with many mental health issues. When I was around 17 years old, he was finally diagnosed with bipolar disorder. Speaking to doctors and more learned people, we understood that this cannot cured, but with medication, it can be controlled, and we even tried to understand the root cause of it. So, my understanding of

> mental health was that if you support them, understand their emotions, talk to doctors, and therapists, and get more knowledge about these things, that would be more helpful.

Similarly, when asked about her experiences of knowing mental health topics, Surbhi (41) shared that it was the diagnosis of a family member that led to her researching and being open about such topics. She said,

> I think most of what I know about mental health is from having to address issues of mental health for myself or having family members and friends do that. I think most of what I know comes from learning that somebody has some issue, looking it up, and trying to do research on it. Once I discovered that there were these things, then I would go look things up or talk to people about them.

On the contrary, Jordon (27), Krizza (40), Tamanna (29), and Adhira (28) indicated that they had minimal to no knowledge about mental health before migrating to the U.S. When asked about recalling the first time they heard or discussed topics of mental illnesses, Krizza (40) responded that it was not until 2013 when she moved to the United States and suffered with mental health challenges herself that she became aware of mental health and diseases. Similarly, when Jordon (27) was asked the same question, she responded, "Well, only after coming here I understood how important mental health and anxiety is on a day-to-day basis on the courses of actions and how I react to situations" (Jordon, 27).

Meanwhile, other participants, including Jiaa (29), Jane (28), and Mona (32), indicated that they were knowledgeable about mental health and illnesses while in India; however, they became more aware after coming to the United States. Interestingly, most participants indicated they became more knowledgeable about depression and anxiety after suffering through these diseases or encountering a loved one going through a mental health illness. Mona (32) described

her experiences with post-partum depression increased her perceived severity toward diseases and made her more vocal, saying,

> I had a very difficult pregnancy, and postpartum depression was horrible. Even before pregnancy, I struggled with infertility for a few years. So, I think now I'm more vocal about the things I went through so that people feel safe talking about these things with me, as opposed to earlier, I was just blissfully ignorant.

The lived experiences of these Indian immigrant women reflect the diversity in knowledge distribution among families and individuals. For most, personal experiences with diseases create exposure to knowledge about mental health issues, while for others, sheltered lifestyles dominated by power entities and eliminated spaces for discussions refrain them from knowing and exploring stigmatized health diseases. It is peculiar to discover that Jordan (27) was never exposed to the term ‘mental health’ before coming to the United States. Throughout the interview, most of her responses indicated that this topic was not under her radar while living in India, nor did her family or community talk about such matters, pointing out a lack of awareness and acknowledgment.

In discovering how participants in the study articulated meanings of mental health diseases and treatments, social and cultural factors played a vital role in shaping their perceptions. In the following theme, I provide insights into how social factors contributed to Indian immigrant women’s mental health knowledge and perceptions.

Mental Health Meanings Among Women

While investigating how mental health meanings were generated, most participants shared that culture and social determinants are crucial in defining their knowledge and perceptions of mental health. Social factors such as family orientation, socioeconomic status, and

exposure to mental health information in school or lack thereof significantly contributed to how perceptions were built. Socioeconomic status defines familial knowledge and acceptance of diseases; for Jane (28) and Surbhi (41), socioeconomic status, level of education, and hailing from a privileged family have exposed them to open conversations about mental health topics. To Surbhi (41), education is also a defining factor that has helped her perceive mental health as salient. However, they also pointed out that differences prevail regarding knowledge distribution across the country, meaning that low economic groups may have different perceptions of the diseases.

Several other social and cultural factors, such as gender at the workplace and personal experiences, have helped participants develop perceptions about mental health. For Tammana (29), social factors of judgment, stigma, and fear of shame played a significant role in shaping negative perceptions while she lived in India. As previously stated, for Jordon (27) and Krizza (40), mental health topics were never discussed around them, indicating having no perceptions about the diseases. However, both developed their mental health perceptions after personally experiencing symptoms of depression and anxiety post-migration. To this, Krizza (40) said,

> In India, I was not aware of depression or anxiety and never thought about it. But in the United States, when I was alone, far from family, and unable to go out and work, I started to feel depressed. When I heard in my circle that most of the women were undergoing anxiety treatment, that's when I realized that I had never known about all this in India. (Krizza, 40).

For these women, mental health meanings have been created by social and cultural factors around them. Dimensions such as socio-economic status, level of knowledge and education, personal experiences, stigma, judgment, and exposure to conversations have shaped

how Indian immigrant women perceive mental health diseases. Women in this study hail from all walks of life in terms of mental health topics, wherein while some participants were exposed to such issues from an early age, others were completely unaware of psychological well-being up until they immigrated to the U.S. For many, personal experiences and cultural determinants have shaped how they perceive diseases and treatment and dictated their comfort level regarding communicating about this topic with people.

To recollect a response for RQ2, cultural meanings, and lived experiences speak to their understanding of mental health and well-being. Their interaction with their self, families, genders, and communities have shaped their meanings of depression and anxiety. In the following section, to further articulate culture and its role in the construction of health meaning, I have developed a comprehensive understanding of Indian immigrant women's acculturation process.

Acculturation Process among Indian Immigrant Women

Across interviews, Indian immigrant women shared how their mental health and perceptions about mental health have been affected by the acculturation process (RQ3). The participants provided insights about the challenges and effects of acculturation on how they see mental health now. Two themes emerged from the data: acculturative discomfort causing mental distress and a positive outlook toward mental health. These themes are discussed in the following sections and collectively respond to RQ3.

Acculturative Discomfort Causing Mental Distress

The acculturation process brought several challenges for the female Indian immigrant participants in this research. Acculturation challenges tend to cause mental health problems among immigrants settling in the U.S. To understand the discomfort experienced by the

participants, three sets of challenges (subthemes), including loneliness, lack of support, and hurdles with jobs and immigration processes, were the most common. Some excerpts from the data are provided below.

Loneliness in a Foreign Country

Several participants in the research pointed out that being away from the family caused loneliness and depression after moving to the United States. Among participants, Adhira (28), Jordon (27), Jane (29), and Mona (32) reflected on their experiences of feeling alone. According to Jane (28), loneliness caused depressive symptoms during her acculturation process. To this, she said,

> A lot of times, you don't have a lot of people around you. So, when you're feeling low or sad, or you had a bad day, and then you can relate it to different stages of depression, but then you don't have people around you. So yes, it was very difficult (Jane, 28).

Similarly, another participant shared that being alone caused anxiety symptoms in their acculturation phase in the United States.

> Once I got my job, I needed to move to a different city where I had nobody. Like I knew nobody. I needed to show up at work, be graceful, work, and do everything, and that's when the problem started. I first realized something called loneliness and how everybody in my office goes home to somebody. That's the first time I realized what I'm going through is called anxiety. I started experiencing heavy breathing, sweating, and not understanding what it was and how to control it (Adhira, 27).

Acculturation brings loneliness for those who come to the U.S. alone. Lack of social networks hinders a person’s ability to share their thoughts, emotions, and experiences, which often causes depressive symptoms and anxiety among participants feeling lonely.

Lack of Social and Familial Support

This subtheme describes another challenge caused by acculturation: the lack of support, especially for foreigners migrating alone. The pressure of handling responsibility for oneself, along with managing work and livelihood, causes mental distress among Indian immigrant women. For instance, when Jordan (27) was asked about the challenges of acculturation, she mentioned that being away from family and taking care of everything alone is depressing. Similarly, other participants shared that lack of familial support is a significant challenge for most of them. When discussing her challenges, Mona (32) said, "Moving to the U.S. is almost like you lose your support system. So, I think my biggest problem or biggest challenge was that I knew if something happened, it would take my parents maybe a week to get to me." This reflects their realization of the side effects of acculturation. Moreover, Tamanna (29) reflected on how their struggle made her realize how she is susceptible to mental health diseases after facing challenges herself, saying,

> The whole process made me realize something about mental health, depression, and anxiety: yes, you need to be socially active. You need somebody because, obviously, you don't have your family around, so you need some thick friends, very close ones with whom you can share anything and everything (Tamanna, 29).

Challenges caused by lack of social and family support negatively affect mental health outcomes among participants. Along with the absence of close family members, taking care of oneself and not having friends or companions to communicate with add to the burden of distress caused by acculturation.

Challenges with Jobs and Immigration

Another major challenge caused by acculturation identified in this research is getting a job, especially for those who first come to the States as international students. The process of securing a job after graduation causes mental distress. Tamanna (29) said, “Getting a job is stressful. I cannot ignore that fact because that’s very tough. Initially, we felt like we had graduated with a master’s degree, and we were out there, and anybody would hire us. But now that’s a challenge.” Similarly, the rigid immigration system tends to cause mental distress. For instance, Krizza (40) shared her struggles with finding and keeping a job and how it leads to mental health problems. She said, “You cannot take a break from your job. You can’t just take a break. The immigration rules and regulations that we have in the U.S. are tough and need to be more friendly towards our mental health issues because there is so much uncertainty in the whole design and process.”

The immigration process has also caused anxiety among participants due to the uncertainty of the visa applications and processing outcomes. For instance, when Surbhi (41) was asked about the effects of immigration challenges on her well-being, she responded,

> I now have a lot of anxiety around immigration because I've had poor experiences transitioning into this job with my visa. And so, I procrastinate on anything that has to do with immigration. That was hard on my mental health, not so much because I wanted an American passport but just the sheer emotional violence of the process (Surbhi, 41).

A similar excerpt was shared by Fragrance (36) when she was asked about the challenges she faced after coming to the U.S., to which she said,

> I started facing immigration issues because companies are not very friendly towards sponsoring visas, and you again start feeling anxious, and everything kicks in. But it's just

> that you have to be very mentally strong, and at that time, your friends and family are the most needed, and they are the ones who can help you and bolster you to move ahead in life. So that's how important mental health is (Fragrance, 36).

Acculturation tends to bring an ample number of challenges for Indian immigrant women when they relocate themselves. Women often find themselves lonely when starting their new lives in the U.S. since their immediate families are left behind in India, and they rarely know anyone around them. Moreover, they often lack social support in hardship and have to deal with challenges alone, which worsens their mental well-being. As they move toward securing jobs and visa sponsorships from their organizations, they incur additional challenges due to rigidity in obtaining employment and visas, which causes them anxiety.

Positive Outlook Toward Mental Health

A positive outlook toward mental health also emerged as a central theme in investigating the response to RQ3. In articulating the effects of acculturation, participants also discussed their changing perceptions about mental health diseases and their ability to communicate about them after their migration. Acculturation has caused Indian immigrant women to become more vocal about mental health topics in the U.S. as compared to India. The increase in acceptance and normalcy in communicating about mental health diseases in the U.S. has provided participants with a new outlook and confidence to address mental health openly. To elaborate on the positive outlook post-acculturation among participants, I have discussed the following subthemes, providing insights into their openness to discuss mental health topics and improving perceptions below.

Feeling Safe to Discuss Mental Health Topics

All ten participants indicated that they feel safer about sharing about their mental health in the United States than in India. The major reasons behind this belief are less judgment and more awareness about mental health topics among people in the United States.

> I feel safer here discussing depression or being mentally upset than in India just because people are more accepting of the concept, and they understand that this can happen and that it is okay and not being as judgmental as back in. So, yes, it's easier to discuss here than (Jane, 28).

Being open about mental health issues is a result of a safe and welcoming environment where people are not judgmental, and, as discussed before, the fear of being shunned is removed. Surbhi (41) shared how she feels safer sharing about her mental well-being at the workplace, saying,

> It's definitely safer than it is in India, particularly in the work context. I think in India, you can't be sure it's going to be taken neutrally, not even positively. If I share and then there's a retaliation, I have some protection here. I think in terms of sharing mental health, I am more open with my students than I am with my colleagues (Surbhi, 41).

The essence of feeling protected both at work and in their social environments is important to the participants in the study. Moreover, initiating conversations about mental health allows others to share their experiences without being judged. Fragrance (36) shared her experiences saying,

> I have realized that since I started speaking about mental health and seeking help for mental health, people who are suffering from mental health issues come up to you and

ask you more questions and ask your experiences and they then go and seek help, which is a very good thing (Fragrance, 36).

Acculturation has opened doors for previously unwelcomed conversations while living in India. Women also tend to develop more spaces for others to express their mental health due to shared experiences and understanding about the severity of the diseases and their negative impact on well-being. The following subtheme furthers context regarding positive outlooks post-acculturation.

Improving Perceptions and Behavior

The process of acculturation has also shown positive effects on Indian immigrant women's mental health perceptions. Several participants discussed the openness about mental health topics in the U.S., which has provided them with a positive outlook toward being more vocal about mental health topics. When asked about her acculturation process and its effects on mental health perceptions, Jane (28) said, "I think I've become more aware here than I was in India. Although we used to discuss certain things back home, still [the] awareness about going to a therapist or talking to people online like through helplines was lacking. It's a mindset that has definitely changed or grown or developed over the years in the United States." A similar statement was provided by Jordon (27), who said, "The awareness has increased since mutual experiences among you and your friends open doors for more conversations about mental health."

Similar excerpts from other participants, including Tamanna (29), Krizza (40), and Jiaa (29), help conclude that immigration to the U.S. improved mental health perceptions among Indian immigrant women. Moreover, the openness of the topic and availability of resources also encourage mental health help-seeking behavior. To this, Jiaa (29) said,

> "One thing here is people can talk openly about it. Like if somebody is seeking mental health, they can tell it, people will not bat an eye about it. So, I think that was something I learned from observing here. Secondly, accessibility. Everywhere, there is a mental health facility. So that's one thing that's very different and we should learn from it." (Jiaa, 29).

Additionally, Adhira (28) shared, "There is a little bit of freedom of choice. I don't have to share this with even my friends. If I just decide to take therapy, I can just book an appointment." The acculturation process has been reported as a bittersweet experience for the participants in the study. On the one hand, they indicated that migration had brought individual challenges; they also gained a positive outlook on mental health topics as they discussed feeling safe to communicate about diseases and treatment.

In concluding the response to RQ3, the process of acculturation comes with challenges for Indian immigrant women but also leads to a positive outlook toward mental health and help-seeking. Among the challenges discussed, loneliness, lack of support, finding and sustaining a job, and immigration issues have been identified as major stressors and causes of depression and anxiety. However, migration does come with the freedom to express mental health concerns openly due to increased awareness in the U.S. Participants indicated that the absence of judgment also helps them to discuss such matters with ease. Additionally, the vast availability of mental health resources and easy accessibility help them to seek help.

Perceived Barriers to Therapy

Addressing structural barriers in the study highlights the gaps in mental health help-seeking among Indian immigrant women in the United States (RQ4). The following theme, contextual barriers in patient-therapist interactions, cost of therapy causing hindrances, and lack

of awareness and openness among Asian Indians, provide a detailed understanding of the identified perceived barriers among Indian immigrant women when seeking mental health therapy.

Contextual Barriers in Patient-Therapist Interactions

The cultural and contextual differences between Indian immigrant women and therapists often seem to create a barrier for the former to reach out to the latter in the U.S. Several participants shared their hesitancy in seeking help from non-Indian therapists. For instance, Jiaa (29), when asked to describe her dubiousness regarding seeking help from a non-Indian therapist, said,

> Indian context is a very huge thing. Like, I think understanding the family dynamics or the collective society back in India or the religious beliefs is very difficult to explain to a person who is not from my country or my culture. Suppose I'm talking about my family or have three uncles and aunts like I grew up with so many people in my life. When I talk about things like, "Okay, I have to think about their feelings too," it's very difficult for a person who does not have this family dynamic. I think this society is more individualistic, so explaining to them why their opinions matter in my life is very difficult (Jiaa, 29).

Seven of the ten participants indicated cultural and contextual differences as barriers for Indian immigrant women to seek help. A therapist's ability to acknowledge and articulate cultural meanings embedded in their personal experiences is essential.

Cost of Therapy Causing Hindrances

Another significant barrier identified among Indian immigrant women seeking mental health help in the U.S. is the cost associated with therapy sessions. While most participants shared that they are still determining whether their health insurance covers it, some pointed out

there are limitations regarding how many sessions would be covered by insurance. Moreover, therapy-seekers who attend more than one session a month may have to cover a more significant portion of the co-pay or pay out of pocket. When asked about the financial constraints therapy causes, Adhira (27) said,

> Not everybody has health insurance that covers therapies. For some insurance, we just have to co-pay, but especially considering problems like immigration and all this cultural stuff, you can't just look anywhere and everywhere. You have specialized online platforms, but the price is high. It's not easy for us to reach out [for help] because it's expensive. I can't afford to do it two times a month because I have other things. So, let me just do it once a month, and I cut my therapist appointments from I started with three and then I did 2, and then I'm like doing once a month (Adhira, 27).

The cost associated with mental health therapy was a barrier perceived by other participants, including Tamanna (29), Krizza (40), Jordon (27), Fragrance (36), Jane (28), Mona (32), and Surbhi (41).

Lack of Awareness and Openness Among Asian Indians

Several other participants identified barriers, including a general lack of awareness regarding access and resources among Indian immigrant women. Tamanna (29) shared that not knowing where to get help, information about whether you go for sessions first or get prescribed medication directly, and procedures to schedule appointments can be a significant barrier since nobody taught Indian women how to reach out for help. Jane (28) also addressed that lack of awareness about available resources is a barrier for many.

Lack of acceptance and conversations in the Indian community residing in the U.S. has also been identified as another barrier since it points to judgment and isolation for women who

are suffering. Diamond (53) shared how Indian/South Asian community members often confuse economic prosperity with mental prosperity, saying,

> The barrier itself is in economics. Their [Indian immigrant women] stratification of themselves means that they should not have any issues with mental health. So, they get confused about what they have versus how they feel. That's a huge barrier. The South Asian women that I have been exposed to, in general, have this expectation that they would rather be seen amongst a group of people, like partying or dressing up and doing things the way that they want to be seen with a social media presence on their side, as opposed to doing the real work of taking care of self. It's a stigma (Diamond, 53).

On the other hand, Adhira (28) stated that believing that mental health is a Western concept often leads to a lack of acceptance and conversations among their own community members, saying, “They think it's not for our culture people, it's for Americans. That's the kind of label they give. I think they feel like stopping themselves from seeking help in preserving their culture. It makes them feel more Indian” (Adhira, 28).

To summarize the response to RQ4, this research has identified several barriers sought by Indian immigrant women in the U.S. These barriers include contextual, financial, a general lack of awareness about resource availability, increased judgment, and minimal awareness among fellow Indian immigrants. Cultural and contextual differences between Indians and therapists prevent seekers from reaching out for help. They fear that the difference in context would hinder the counseling experience and may not generate any results. Additionally, the cost associated with getting therapized is also a barrier for Indian immigrant women. Participants also discussed that there is a general lack of awareness about mental health diseases among Indian immigrants that often leads to confusing symptoms of depression and anxiety with stress. This self-diagnosis

often prevents them from getting professional help. Moreover, the lack of awareness also leads to increased judgment among South Asian community members, which often hinders people's mental health decision-making. These barriers were presented to the non-profit mental health and community experts to provide strategic solutions and enhancement opportunities in focus group discussions.

Major findings from the focus group discussion conducted with several mental health experts, practicing counselors, and wellness experts led to the discovery of various approaches to foster public mental health service outreach. To provide context of the lived experiences and barriers Indian immigrant women perceive while seeking mental health help, results from the in-depth interviews were accumulated and shared (anonymously) with focus group participants well in advance. Additionally, Indian immigrant women were asked about how they envision the mental health care system to look in the U.S. for their community. Results gathered from the responses were also communicated to the experts to provide further context for gathering the expectations of the Indian immigrant women. The following themes provide information regarding how focus group participants contributed to improving the mental health care system.

Improving Mental Health Access and Communication

In the attempt to improve mental health access and communication among immigrants in our communities (RQ5), the following themes and subthemes provide a comprehensive response to effective strategies shared by mental health experts in the focus group discussion. Among the future visions shared in the interviews, several Indian immigrant women indicated that there is a need to communicate about mental health challenges and resources at the initial stages of migration, primarily at the arrival at the university level. Participants shared that engaging international students with mental health topics and communicating symptom identification,

available resources, and potential barriers can be helpful tools to reduce the uncertainty of facing challenges later in life as an immigrant. This sentiment, wherein mental health information and resources become a part of the conversation at the college level, was also shared by mental health and wellness experts during the focus group discussion. Experts working closely with international student communities acknowledged similar challenges. The following theme provides insights from the experts on the matter.

Engaging with Immigrant Communities

To improve health access and communication among immigrants, participants in the focus group suggested that it's essential to engage with our international students and immigrant communities early enough for immigrants to navigate their mental health journey and to become more accessible. The following subthemes provide context regarding building engagement among communities.

Experts pointed out that to initiate conversations, they must build trust among international students so that they are considered approachable in times of need. They emphasized the essentiality of community mental health facilities becoming a part of the cultural communities by simply showing up. To this, Expert D said,

> I think we need to concentrate on and do a better job at being part of international communities and groups before we need to communicate the services needed. If my well-being staff shows up and shows curiosity within those communities to begin with, when we do have some communication, it may carry the message a little bit differently. It builds trust in a familiar face. If they see our well-being center there regularly, whether it's a student or immigrant family, they might then be able to contact the wellness center

more freely. I think it's becoming involved within these communities before we have something that we want to communicate with them (Expert D).

Similarly, international student organizations were identified as crucial spaces for interactions among experts to engage with students about their mental well-being. A licensed therapist working at the K-State Counseling and Psychological Services (Pseudonym: Expert B) said mental health practitioners across universities should participate proactively in cultural gatherings to build community with international students. Using student organizations like the Indian Student Association and other international student associations can be crucial touchpoints for experts to develop "one-on-one contact" and build a "steady face to resonate with."

To inculcate knowledge and information about mental health diseases and resources among international students, Expert D addressed that topics of mental health must be separated from other information sessions and must be given their own space for discussion. He said, "At K-State, we do a one day where it's like 120 slides of a PowerPoint and that there are very few other opportunities," which are not enough to create safe avenues for international students to reach out for help. He further mentioned that instead of providing too much information at once, experts should take the time to educate students about mental health and diseases.

Use of Technological Advancements in Creating Access

Effective use of technology can help create better service outreach for the immigrant community, especially among those who are new and hesitant to reach out. To this, Expert B shared that mental health apps can help develop how services can be made more accessible. He continued to share that apps such as TELUS Health, which has been adopted by K-State Counseling and Psychological Services, "provides therapy at no cost," making them affordable

to most international students seeking therapy. Furthermore, He said that “it is a multilingual service that's offered. So, if English is a secondary language, students can have a service where they can be accommodated.” Other participants also emphasized that useful tools for mental health treatments are available online for students and immigrant community members to use.

Further, to accommodate bilingual immigrant populations, Expert B pointed out that newer online video-conferencing tools are being utilized at their mental facility that allow active translations, which can enhance accessibility among immigrant women seeking help. He further added that since video conferencing is virtual, it can reduce hesitancy among patients to open up about their symptoms and experiences.

Throughout the focus group discussion, experts reinforced the essentiality of building community with students and immigrant populations. They emphasized that mental health facilities must create their presence among community members to develop trust and reliance and fight stigma and hesitancy. To answer RQ5, experts pointed out that they need to strengthen their community presence to establish access to mental health services for the immigrant populations. Similarly, accommodations relating to translations and effective use of technology that enhance service outreach must be on the radar for mental health institutes in the communities. Effective utilization of mental health apps can not only improve linguistic accessibility but also enhance the ease of delivery of the services.

Enhancement Opportunities to Modify Services

To articulate enhancement opportunities in the current mental health intervention for Indian immigrant women, experts in the focus group discussions negotiated several strategies to reduce barriers and improve mental health outcomes (RQ6). The central theme approaches to reducing barriers and the subthemes that emerged in the discussions collectively provide a comprehensive understanding of what enhancement opportunities can help modify the current service outreach.

Approaches to Reduce Barriers

Indian immigrant women discussed perceived barriers of cost, context, and lack of conversations and awareness among Indians living in the U.S. As experts addressed these barriers, several approaches emerged that can help promote inclusive service outreach. These approaches are discussed using the following subthemes: cost-effective strategies to seek therapy, breaking contextual barriers in patient-therapist communication, and approaching the Indian community through leaders. The following sub-themes provide a comprehensive outlook on these opportunities.

Cost-Effective Strategies to Seek Therapy

As discussed in Theme 16, cost has been identified as a major barrier to mental health help-seeking among Indian immigrant women. Participants raised issues about how their health insurance covers only a section of the therapy cost and how the co-pay patients incur is unaffordable. To address this barrier, our experts pointed out that several community mental health clinics are available to all, regardless of an individual's ability to pay. To this, Expert A shared that "a lot of immigrants tend to be very unaware about publicly funded assistance that

can be used towards those services." To this, another expert provided further context about how these community service funding work, saying,

> Where I work, which is a community mental health facility, we are a state-funded agency, and a portion of our funding comes from the counties we are assigned to cover. So, my organization covers ten counties in Northeast Kansas. Each of those counties put forth money designated to help people in their county without health insurance. So, because those counties have a fund, we are required to see anyone regardless of their ability to pay (Expert A).

Regarding issues related to the cost of the services, another expert provided vital information about resources available at zero or minimal cost to the help-seekers. When asked about cost-benefiting strategies for community members and international students, Expert C, a licensed therapist working at a community mental health institute, said,

> We have opportunities for people to come and work at our agency. They provide services for free so so students who are in training for any licensed profession can intern with our organization and we can have our patients see those students for free and they are under supervision from our staff and from their universities as well, but it's also a way to access care at no cost (Expert C).

With the intention to provide crucial information about the resources, experts were eager to communicate the utmost information that could be used to educate Indian immigrant women in our communities about the accessible facilities. Since a major aspect of Indian immigrant women's acculturation process has been their experiences as international students, Expert B shared pivotal information about the role of collegiate-level mental health facilities, saying,

> The services that are available in colleges are minimized rates because they are therapists in training under a lot of supervision. These services could be availed at any university because most universities have their own training centers. So, if immigrant populations, not only in Kansas but across the board, want to access minimized-rate services, they can always reach out to their universities (Expert B).

The cost inflicted on mental health help-seekers has been identified as a hindrance in procuring therapies. Experts in this study have acknowledged that immigrant populations often need to be made aware of the services that are available to them, mainly due to the assumptions that they may not qualify for such services. Regardless of whether an individual's health insurance covers the cost or not, experts have provided several minimal-cost services that our Indian immigrant populations across the country can avail themselves of. Conclusively, there are cost-effective options available for both international students and immigrant community members seeking therapy.

Breaking Contextual Barriers in Patient-Therapist Communication

Another barrier discussed in Theme 15 is contextual differences between therapy providers and patients, which impedes help-seeking. Indian immigrant women shared that therapists in the U.S. may not understand the contextual meanings they associate with their lived experiences, leading to depression and anxiety due to differences in the cultures. In addressing contextual barriers between a patient and her therapist, several participants in the discussion exclaimed about the essentiality of cultural competence among practicing therapists. To this, Expert A said, "I think that a way to overcome this is just having more diverse therapists that already understand some of the cultural context." However, there is a greater need for graduate

and training programs to involve cultural attunement and competence within the curriculum for future therapists. To add, she said,

> Our hope for the training program setting is that we have diverse students talking about their experiences and using sociocultural attunement to really train therapists and help them to understand how to use what is in the room to their advantage (Expert A).

Recommendations to enhance mental health therapists' cultural competence were marked essential in the discussion. Expert C also pointed out that graduate programs that are training students to become therapists must engage with cultural presentations that can bring students closer to learning different cultures and contexts. To provide references from her own experience, the participant (Expert C) mentioned that "cultural presentations such as the international student and scholar services' events like the Coffee Hour from different cultures. With a grad student who is going through training, it would add value for them to learn about diverse clients." However, she emphasized that these presentations would be useful if they were mandated in the curriculum to motivate students to attend since graduate programs are often rigorous and time-consuming.

To further provide recommendations, one expert pointed out that practicing therapists must stay connected with other practitioners from diverse backgrounds and experiences to stay attuned with culturally varied clients. This strategy can be useful for therapists to learn about new cultures to serve their clients more effectively. To this, Expert A said,

> I think therapists must seek consultation from other therapists. I'm surrounded by a bunch of therapists, and I also personally am connected to a lot of different practitioners. So, when I have questions that come up about cultural context, working with LGBTQ populations, or anything that I don't have enough experience in, I have access to reach out

> to people and to ask my questions and gather resources. So, I think as therapists, we must be responsible for staying networked in order to reach out to people who have more information than we do (Expert A).

In an attempt to reduce contextual barriers among mental health professionals and help-seekers, available linguistic accommodations for non-English speakers were also addressed as recommendations for immigrant populations. A practicing therapist (Expert C) in the discussion shared,

> There are new telephone and video interpretation services, which usually allow people to communicate across those different language barriers. So, I think making people a little bit more aware of all these kinds of services that are out there that you can use to get access to the care that you need is important and something that I am hoping to do as well (Expert C).

In summary, to break contextual barriers among patients and therapists, graduate programs must inculcate training with cultural attunements and competency building to prepare therapists who can handle diverse clientele. Communicating these recommendations has also been identified as vital so that the next generation of therapists can provide effective services. Moreover, new technologies that accommodate diverse languages and interpretations must also be introduced and communicated with immigrant help-seekers.

Approaching Indian Community Through Leaders

To address contextual barriers and challenges associated with lack of awareness and conversations among Indian communities, several strategies were introduced that can be implemented and are becoming a part of the agenda for the experts. One of the strategies was to

target nation or ethnicity-based organizations at university and community levels and build trust among them as service providers. To this, Expert D said,

> There are organizations for ethnic communities that invite and welcome immigrant family members, including spouses, children, or any family members. These organizations usually come together for festivals, celebrations, events, etc. At that point in time, mental health providers having one-on-one contact with the group can translate to having a steady face with which to resonate. I think that makes a difference because you genuinely then start believing that this person is invested in your well-being. So that lack of awareness gap can be reduced (Expert D).

Participants in the focus group discussions emphasized that to reach out to Indian community members about mental health topics, an effective strategy can be identifying community ambassadors or leaders who could potentially communicate positive messages about mental health among the members and encourage them to seek professional help whenever needed. To this, Expert A said,

> Hiring and bringing on cultural ambassadors, especially those from the community who are respected and revered and people went to for counsel and support, can already be effective. We can bring them into the community mental health center world and explain how we can offer them the resources. Then, these leaders can help disseminate this information to people in their community. So, they can then create those bridges to build those relationships. We currently don't have any cultural ambassadors for the community to encourage them to seek our services and help them understand what our services are (Expert A).

Consistently, other experts in the discussion emphasized that identifying these community leaders can be an effective strategy to build trust and disseminate useful information with Indians in the community. To this, Expert D shared,

> Suppose a community or organizational leader who is also Indian is advocating for mental health and starts talking to other Indian people. In that case, they'll assume that if the leader believes in it, then it's okay to believe in it as an Indian, and they may also take that step to better mental health outcomes. Then we can fall back on that safe, consistent pace that genuinely someone who believes in mental health diseases is invested in their well-being, and that can make a difference (Expert D).

In eliciting enhancement opportunities about building strong community ties to initiate mental health deliberation, participants also shared that places of worship can be another effective cultural site for mental health conversations and communication of resources to the target group. To this, an expert said that places of worship like Mosques, Hindu Temples, and community gathering spaces can help communicate mental health information. They also mentioned that "becoming a part of their norms by visiting regularly, doing presentations, and sticking around to answer questions" can be a functional strategy to engage with Indian communities. Therefore, identifying community leaders and deliberative spaces can help mental health facilities disseminate necessary information about services to hard-to-reach Indian populations in the communities. Identifying community-appointed leaders can assist in developing conversations about stigmatized topics of depression and anxiety with the hope of reducing hesitancy and increasing service utilization.

The mental health experts effectively addressed the identified barriers in the data collection process with Indian immigrant women to provide crucial insights that can help develop positive mental health outcomes. In investigating responses to RQ6, focus group participants offered strategies that can be implemented to make mental healthcare more affordable and accessible for Indian immigrant women in the U.S. They addressed helpful strategies to overcome financial barriers by providing information about cost-effective services, emphasized the importance of cultural leaders and their role in creating more spaces for communicating about mental health more positively to build awareness and reduce hesitancy towards help-seeking. They also indicated the relevance of cultural competency among mental health experts in providing adequate services.

The analyzed themes and subthemes in this chapter have provided a detailed account of Indian immigrant women's lived experiences through mental health perceptions and help-seeking behaviors. This chapter also provided themes that discuss recommendations from mental health experts in the focus group discussion. A summary of the themes and sub-themes is presented in Table 4.1. In the following chapter, I offer a discussion of the findings of the existing literature. Additionally, I will elicit recommendations based on the findings from conversations with mental health experts.

Table 4.1. Summary of the Themes and Subthemes

Research Questions	Theme (Pattern Codes)
RQ1: How are Hofstede's cultural dimensions associated with mental health perceptions among Indian immigrant women and their help-seeking behavior?	1. Collectivism and Social Support Network o Collectivism and Stigmatized Mental Health o Benefits of Collectivism in Mental Health Expression o Collectivism and Help-Seeking Hindrances 2. Masculinity and Mental Health Expression o Gender differences and mental health perceptions

	o Gender Roles and Mental Health Decision-Making 3. High Power Distance and Mental Health Topics o Patriarchal Families and Women's Positionality o Influence of Religion on Well-being 4. Uncertainty Avoidance and Women' Mental Health o Absence of Deliberative Spaces for Mental Health o Behavioral Codes to Act Mentally Fit
RQ2: How do the participants understand mental health and diseases?	5. Variations in Exposure to Mental Health Topics 6. Mental Health Meanings among Women
RQ3: How has acculturation affected Indian immigrant women's mental health and well-being?	7. Acculturative Discomfort Causing Mental Distress o Loneliness in a Foreign Country o Lack of Social and Familial Support o Challenges with Jobs and Immigration 8. Positive Outlook o Feeling Safe to Discuss Mental Health Topics o Improving Perceptions and Behavior
RQ4: How do the participants describe common barriers perceived in help-seeking?	9. Contextual Differences in Patient-Therapist Interactions 10. Cost of Therapy Causing Hindrances 11. Lack of Awareness and Openness Among Asian Indian
RQ5: How can we improve mental health access and communication among immigrants in our communities?	12. Engaging with Immigrant Communities 13. Use of Technological Advancements in Creating Access
RQ6: What are some enhancement opportunities offered or identified by the experts regarding the current mental health interventions?	14. Approaches to Reduce Barriers o Cost-Effective Strategies to Seek Therapy o Breaking Contextual Barriers in Patient-Therapist Communication o Approaching Indian Community Through Leaders

Chapter 5 - Discussion, Recommendations and Conclusion

The purpose of this qualitative hermeneutic phenomenological study was to explore culturally shaped mental health perceptions among Indian immigrant women and identify opportunities for enhancement in the current mental health interventions. This chapter summarizes significant findings from the study that address research questions and responses. It will also provide a summary of the recommendations elicited by mental health experts, along with their relevance to current literature. Further, the implications of the study are also discussed. I provided the study's implications on the current health and leadership communication theories and practices. Additionally, I have provided the dissertation conclusions and limitations incurred during the research process to guide future researchers investigating cultural perceptions of mental health diseases.

Although previous studies have highlighted common barriers and effects of acculturation among Indian immigrant women in the U.S. (Mann et al., 2017), there is a limited understanding of the role of Indian culture in shaping mental health perceptions and help-seeking behaviors among this population. This research addressed this gap by analyzing how cultural determinants shape Indian immigrant women's perceptions about mental health, how Indian immigrant women describe their acculturation process, and the common barriers they perceive in seeking mental health help. Culture plays a vital role in how health meanings are formulated and become the basis of how communities and families tackle diseases (Dutta, 2007). It has a moderating effect on how mental health is perceived and its impact on an individual's ability and actions to seek mental health help (Dressler & Oths, 1997). This stands true regarding how Indian immigrant women describe their knowledge and perceptions about mental health and the central role of culture in defining diseases and treatment (Roberts et al., 2016). Findings from this

research significantly highlight the central role of culture and its determinants in influencing Indian immigrant women's perception of mental health and their help-seeking behavior.

Major findings from RQ1 promote the presence or lack of cultural norms and practices that shape mental health awareness. The identified theme: **collectivism and social support network**, informs that the dominance of collectivism in suppressing issues of mental health for women due to stigma and hesitancy, mainly due to a severe lack of understanding about mental illnesses and diagnoses (Scull et al., 2014; Roberts et al., 2015). Previous research has also pointed out that stigmatized beliefs about diseases in a collectivistic society tend to suppress issues to reduce judgment (Papadopoulos et al., 2012; Han et al., 2017).

The subtheme: **collectivism and stigmatized mental health**, addresses the stigma that affects mental health perceptions. Collectivism, where parents, extended family members, and neighbors are often a part of the health-related conversation (Hofstede, 2011), eliminates conversations about mental health overshadowing initial symptoms. Due to this, several participants in the study indicated that they were unaware of mental health diseases until they immigrated to the United States. Moreover, there is shame attached to sharing mental health conditions with the extended family and community members. This finding is consistent with de Groot and colleagues (2021), who pointed out that "In collectivistic nations, shame and guilt of disappointing the community are socially oriented consequences" (p. 1201). Additionally, Indian immigrant women in the study indicated that judgment among community members is often a result of a lack of general awareness and stigmatized beliefs among Indians regarding mental health diseases and treatments. Meghrajani and colleagues (2023), in their analysis of mental health problems in India, also pointed out that a dearth of awareness results in stigma and judgment among people in India.

Collectivism also impacts help-seeking behaviors among Indian women, which is also linked to highly stigmatized beliefs regarding diagnosis and treatment (Chen & Mak, 2008). On the other hand, results from subtheme: **benefits of collectivism in mental health expression,** dictates that collectivism can promote communal support through positive messaging around diseases and for patients to feel supported in tackling illnesses. However, there is a need for more awareness and less judgment among people to make collectivistic support possible. To this, Tse and colleagues (2015) highlight the importance of family support in collectivistic societies such as China for people with mental illness to recover. Collectivism serves as the driving force of decision-making; wherein family members are consulted to decide whether help will be sought unanimously. The identified subtheme, **collectivism and help-seeking hindrances,** indicated that help is sought from the immediate family members rather than going to a therapist. This finding is consistent with Kim and Hogge's (2015) study of help-seeking behaviors among Asian Indians. Similarly, (Scull et al., 2014) conducted a study on the perceptions of mental health among adults in Kuwait. Results showed in collectivistic cultures, there is an obligation to consult family members about mental health diseases before seeking professional help (Scull et al., 2014). Overall, collectivistic cultural orientation has negatively affected women’s mental health and their ability to seek help for diseases.

As pointed out earlier, India is a masculine country (Juhasz, 2014). Findings from the research, including the theme: **masculinity and mental health expression,** highlights that this macro-level gender-dominant trait suppresses women's ability to discuss topics of mental health and seek help. Moreover, gendered role expectations lead to depression among women due to high societal pressure to fulfill their responsibilities. Participants in the study discussed a chain of command among family members wherein fathers and grandfathers decided whether the

women of the household would seek treatment for diseases or not. Additionally, results from the subtheme: **gender differences and mental health perceptions** indicates that men and women are treated differently in the culture wherein men have more privilege and dominance over women. Findings show that this dominance negatively impacts women's well-being. Previous research has also concluded the harmful effects of masculinity on women's mental health and their ability to seek help (Gupta et al., 2023; Hapke, 2013; Mann et al., 2017). Hapke (2023) highlighted that despite the increase in female literacy levels in Kerala (a state in India), the prevalence of mental illnesses among women remains high mainly because of dominant masculine power. Moreover, men and women with mental health illnesses are perceived differently from one another, wherein men's conditions are more tolerable than women counterparts.

Results from the subtheme: **gender roles and mental health decision-making** provides evidence that masculinity dictates mental health decision-making for Indian women in the culture. Moreover, gendered role expectations from women to take care of the family and to present a happy, cheerful face suppress their ability to share their challenges in the family openly. Bhattacharya and colleagues (2019) also reflected on the adverse effects of gender role expectations on Indian women's overall mental well-being. Additionally, men also tend to decide whether women would seek help for mental health or not, hindering their ability to make decisions (Bhattacharya et al., 2019; Mann et al., 2017). Previous studies have also reported gendered role expectations as a hindrance in women’s ability to communicate mental health needs and help-seeking behaviors (Varghese & Jensen, 2009).

The third theme in the findings highlights the **high power distance and mental health topics** in Indian culture. High power distance contributes significantly to how Indian immigrant

women perceive mental health and treatment-seeking in India and the U.S. Through the exploration of the subtheme: **influence of religion on well-being**, it was noted that religion and spiritual practice play an influential role in perceiving and managing mental health among Indians. For the participants, religion and spiritual practices have distinguished roles in treating mental health diseases. Spiritual practices such as yoga, meditation, and praying are perceived as healing practices. Several participants indicated that spiritual practices are alternative health practices to many in India and can help with diminishing depressive symptoms and anxiety. This finding is consistent with Telles and colleagues' (2021) study investigating the effects of yoga on mental health. Results from the study indicated that more than 90% of participants in India indicated yoga as being beneficial for reducing depression and strengthening mental well-being. Dutta (2008) has also embarked on the importance of spirituality in cultural communities, saying, "Offering a window into the nature of human existence and its fundamental basis, spirituality provides a framework for understanding human health, illness, pain, and suffering (p. 133).

Meanwhile, religion has been viewed as a dominant power structure that hinders help-seeking. Religious leaders often associate mental health diseases with supernatural conceptualization, such as ghostly spirits and evil eyes, to get donations and promote their ritualistic treatments that are sought through a series of prayers and gemstones. O'Mahony & Donnally (2007) have also noted the association of the evil eye with mental health illnesses among Indian immigrants living in Canada. They take advantage of people's spiritual beliefs and fear to mend their attitudes toward mental illnesses. Being a high-power distance culture, Indian society relies heavily on religious and spiritual practices to resolve health diseases (Chakraborty et al., 2013). Mental health treatments are often sought through religious leaders and priests

before seeking help from professional experts (Sharma et al., 2020; O'Mahony & Donnally, 2007). This often leads to people being misled due to their desperation to become mentally fit and the stigma around medical treatment.

In addition to finding about power distance, the subtheme: **patriarchal families and women's positionality,** depicts the power differences between parents and children, especially girls. Patriarchal families tend to suppress women's ability to make their own decisions in general. In terms of mental health, women are expected to fulfill gendered expectations towards parents and spouses, which affects their mental well-being. Moreover, parents and male spouses tend to decide whether a woman with mental illness would get treated or not, which adds to their psychological distress, worsening their symptoms. These findings are consistent with those of Chandra and colleagues (2015), who pointed out that the role of parents and male spouses is central to Asian Indian women's decision-making process. Other studies have also indicated that patriarchal cultures have adverse effects on how women make mental health decisions and their overall weakened positionalities in families (Gupta et al., 2023; Singal, 2023).

The fourth theme in the study: **uncertainty avoidance and women's mental health,** contributes to understanding the role of culture in mental health perceptions and behavior. Due to elevated stigma and high societal judgment (Kumar & Nevid, 2011), Indian culture tends to avoid any uncertainty caused by shutting down conversations. Findings from the subtheme: **absence of deliberative spaces for mental health** indicates that the culture has failed to create spaces for family and community members to discuss their mental health needs. For example, if a person with mental illness attempts to communicate their symptoms or conditions with their family members. In that case, they are often told that all they have is generalized

stress, diminishing the severity of their illness and avoiding any uncertain situation wherein society judges the family for being unhealthy.

Participants in the study shared that Indian families ostracize people with mental illness due to stigmatized beliefs about them being dangerous, contagious, incompetent, and, for most women, unmarriable. This finding is consistent with Han and colleagues (2017), wherein collectivistic societies like Korea tend to cut people with mental health out to protect familial respect in society. Additionally, participants also shared that people fear that exposure to information about mental health symptoms might lead to more people getting diagnosed.

Furthermore, results from the subtheme: **behavioral codes to act mentally fit,** indicated that India has strict behavioral codes and norms about people presenting themselves as "normal" to be considered a part of the society. This is practiced in order to avoid any uncertainty that may bring shame to the family (Warn et al., 2013) or cause risk of symptom recognition and treatment-seeking. Families tend to be more vigilant about hiding women's mental health symptoms from society, mainly due to the fear of rejection from possible marriage suitors. In analyzing the role of Hofstede's cultural determinants on Indian immigrant women's mental health perceptions and help-seeking behavior (RQ1), it is evident that collectivism, masculinity, high power distance, and uncertainty avoidance are influential factors. Indian culture diminishes the severity of mental health problems, especially for women, due to increased stigma and judgment around diseases. These determinants collectively negatively impact the health conditions, perceptions, and behavior of women in society.

RQ2 investigated the current cultural perceptions and understanding of mental health among research participants. Results from the fifth theme: **variation in exposure to mental health topics** indicated a diverse perspective about mental health among participants, as some

were well-informed about diseases and treatments while others did not possess any knowledge while living in India. A significant factor explaining this difference is the participants' lifetime exposure to diseases. Several participants had parents and family members struggling with psychological diseases, which motivated them to learn more about mental health. Others were never exposed to diseases, diagnoses, or conversations about the topic in their surroundings. Other studies have also indicated that knowledge about mental health diseases, prognosis, symptoms, and treatments remains poor among Indian communities (Ganesh, 2011; Gaiha et al., 2020).

Additionally, evidence from the sixth theme: **mental health meanings among women**, highlighted that Indian immigrant women's current perceptions are socially and culturally informed. Factors including socio-economic status, level of education, personal experiences, migration, and exposure to information are vital in developing perceptions about health topics (Bhattacharya et al., 2019). Others informed that stigma and judgment contributed to the development of negative mental health perceptions as experienced and informed by their family and community members. Stigma and judgment have long been associated with mental health across many cultures and greatly impact how people perceive diseases and treatment (Mascayano et al., 2015; Shrivastava et al., 2011; WHO, 2022). To respond to RQ2, Indian immigrant women's lived experiences have shaped their perceptions. Due to differences in upbringing and exposure to mental health topics, their knowledge and perceptions are distinct but are informed by their external environments, including social and cultural factors. This points out the inference that Indian society and culture shape mental health perceptions.

Results from RQ3 provide significant insights into how the acculturation process has impacted Indian immigrant women's mental health and well-being. The theme discussed in the

findings: **acculturative discomfort causing mental distress,** addresses several factors that negatively impact the participants' mental well-being. Indian immigrant women perceive discomfort when they migrate to the United States. Subthemes emerging from the results, including **loneliness in a foreign country**, **lack of social and familial support** caused by migrating alone, and **challenges with jobs and immigration**, are major causes of depression and anxiety among Indian immigrant women (Guruge et al., 2015; Joseph et al., 2020; Prabhakar, 1999). These findings are consistent with Ryan et al. (2021), who concluded that immigration and law-related stress contribute to mental illnesses. Several other studies have also pointed out how major challenges can cause mental distress among immigrants (Delara, 2016; Wu et al., 2009). These findings are different compared to Mann and colleagues' (2017) research among Indian immigrant women who were primarily domesticated and perceived linguistical barriers in seeking help, concluding that Indian immigrant women perceive unique barriers caused by acculturation based on socio-cultural factors such as marital status, English-proficiency, and occupation.

Despite the challenges that follow immigrant women after settling in the host country, one of the themes identified in the findings indicates that acculturation also promotes a **positive outlook toward mental health**. Among many advantages, the majority of participants in the study shared that they **feel safer discussing mental health topics** in the host country than in India, which has been indicated under a subtheme, mainly due to increased awareness and reduced judgment and stigma among people (Rodriguez-Reimann et al., 2004). Acculturation has also **improved positive perceptions and help-seeking behaviors** due to the U.S. culture's being more vocal and accepting about mental health topics and the increased availability of resources. These findings are consistent with Joseph and colleagues (2020), who reported that integration

into the host culture promotes positive mental well-being and higher self-esteem among Asian Indian women in the U.S. Conclusively, while acculturation brings stressors and challenges for Indian immigrant women, it also tends to promote positivity and acceptance toward topics of mental health and help-seeking behaviors.

In the quest to identify the barriers Indian immigrant women perceived while seeking help in the U.S. (RQ4), several themes were discussed that respond to this research question. Results indicated that **contextual barriers in patient-therapist interaction** have been the most common barrier identified in the study. Participants discussed how differences in culture and context between therapists and patients can hinder the quality of service. They explained that the challenges Indian immigrant women go through often tend to lie outside American therapists' scope of experience and context, making it difficult for both the patient to openly discuss and the therapist to articulate cultural meanings behind experiences. Previous research has also pointed out cultural differences in perceiving psychological diseases to be a significant barrier to mental health help-seeking post-acculturation among Asians (Leong & Kalibatseva, 2011; Sue et al., 1991).

Another significant barrier identified as a theme is the associated **cost of therapy hindrances** among participants. Several participants indicated that they immigrated to the U.S. as international students and faced several barriers as students at the collegiate level. Despite health insurance coverage, the financial burden of regular therapy sessions can hinder international students and Indian immigrant women from seeking help. Online and in-person counseling are expensive and are often an out-of-pocket affair due to low coverage by health insurance companies (Wu et al., 2009; Leong & Kalibatseva, 2011). Additionally, **lack of awareness and openness among Asian Indians** resulting in absence of discursive spaces for

mental health topics among Indian communities in the U.S. have also been reported as barriers. This can cause hindrance for Indian immigrant women to build community, share their mental health experiences, and seek help. Prabhakar and colleagues (1999) also discussed the effects of social rejections and conflicts that cause mental health disturbances among immigrants. Lack of awareness and openness among Indian communities in the U.S. was also discussed as a significant barrier for Indian immigrant women to reach out for help from other Indians and openly discuss topics with them (Karasz et al., 2020).

The culture-centered approach has informed the theoretical and methodological underpinnings of this study. By understanding the central role of culture in mental health topics among Indian immigrant women and providing a platform to discuss their perceptions and barriers they face in seeking help, I have attempted to advocate for this subaltern population in the U.S. to create opportunities for enhancement in how mental health resources can be communicated, accessed, and utilized. Through agency and collective leadership efforts, an academic researcher worked collaboratively with community health experts toward the fulfillment of the shared goal of advancing health outcomes, capitalized on cultural knowledge and perceptions, and established supportive networks of communication to build new approaches and opportunities for mental healthcare development (Magrab & Bronheim, 2018). Through collective leadership efforts, this study built bridges by communicating problems and eliminating barriers and differences with experts, reframed discourses by attending to marginalized voices, and unleashed human energies in working toward shared goals and success (Ospina et al., 2012).

In the attempt to identify cultural influences, structural barriers, and the power of agency in negotiating change initiatives in mental health interventions, this health communication

research provides recommendations for our experts in the communities and Indian immigrant women to navigate available resources and overcome barriers.

Recommendations to Improve Mental Health Outcomes

In this section, I will provide detailed information about the recommendations acquired from the focus group discussion with mental health experts to improve service outreach and reduce barriers. Major findings from the discussion in this research consist of recommendations for mental health facilities and experts to create better accessibility for Indian immigrant women to seek help. The recommendations, targeted toward mental health facilities and immigrant populations, are collectively discussed while also attending to the final two research questions. Response to RQ5 provides recommendations regarding improvement in mental health access and communication among immigrants in the community, while RQ6 attends to enhancement opportunities that can improve current interventions. These recommendations are a result of agency (CCA) formation and collective leadership initiatives taken by research subjects, the researcher, and mental health experts to develop avenues for social change in advancing mental healthcare delivery.

Experts in the study repeatedly emphasized the essentiality of mental health experts **engaging with immigrant communities** about mental health topics by getting involved in participative spaces. They indicated that to develop trust, credibility, and familial relationships among Indian communities and mental health experts, it is essential to actively engage in deliberations and normalize conversations about diseases and treatment options by showing up at cultural gatherings. This can help develop knowledge and positive perceptions towards diseases to reduce stigma and judgment. This is consistent with Lansing and colleagues' (2023) study that illuminates the essence of trust in building community empowerment for overall health and well-

being. They highlight that communities contribute to positive health outcomes by building relationships and avenues of engagement, trustworthiness, and shared autonomy (Lansing et al., 2023).

Further, they discussed that experts can effectively utilize places of worship like Temples, Mosques, and Churches to build communities with immigrant populations. Another useful recommendation for mental health institutes is to approach cultural groups by identifying the community leaders and ambassadors who are respected and well-established within the group. Experts can build trust and disseminate helpful information by approaching leaders to build community with the larger group. Participants shared that a trusted leader has the potential to develop venues of change, so experts must take advantage of these resources. These leaders can include faith and religious leaders like priests since communities tend to rely on faith and spiritual practices for mental well-being (Vaidyanathan, 2021). With the help of religious leaders, mental health experts can effectively interact with immigrant populations to build community and communicate about mental health.

Another helpful recommendation provided by the experts is the effective **use of technological devices to improve access** among Indian immigrant women and international students. Participants discussed that online mental health services rendered through websites and mobile applications could be helpful for mental health institutes and universities to provide services at minimal cost and accommodate language and virtual accessibility (Krausz et al., 2019). The use of mobile apps can also improve the quality of service and reduce hesitancy among students and immigrant women seeking help. This also extends to the effective utilization of websites to disseminate mental health information and develop language accessibility options for non-English speakers seeking information (Mason et al., 2021). Hilty and colleagues (2017)

have also emphasized the importance of using E-mental health services rendered by telemedicine, mobile apps, and web-based mental health service deliveries in improving mental health outcomes among users.

In response to RQ6, the theme: **approaches to reduce barriers**, developed recommendations for immigrant communities, mental health experts and community health workers. In the efforts to break **contextual barriers in patient-therapist communication**, participants emphasized that graduate programs offering mental health therapy and counseling training must equip their students with cultural competence and experiences with counseling diverse clients to develop context understanding. Moreover, students must also be exposed to international and intercultural curricula and presentations throughout their training. Through this, future therapists will be culturally attuned to attend to immigrant clientele, which may help reduce barriers among immigrants seeking mental health help in the U.S. Cultural competence has been identified as an integral component of mental health treatment delivery. Alegria and colleagues (2010) have also highlighted the importance of diverse learning and cultural attunement in attending to multicultural clientele.

With the intent to provide a better service experience and valuable resources, results from the subtheme: **cost-effective strategies to seek therapy,** provided information on affordable service options available in communities. To overcome cost-related barriers, experts shared that several community clinics have publicly funded assistants available to all, regardless of an individual's ability to pay the cost. These funds come directly from the counties and do not require an individual to have health insurance. To further address cost-related barriers, experts also shared that community facilities provide training facilities to graduate students to practice counseling delivery, which is at zero cost to clients being therapized. This cost-effective option is

a viable choice for immigrant community members who perceive the cost of the therapy as a barrier. Additionally, services provided by university clinics across the country are often at minimized rates since the therapists are students in training, which are also affordable options for immigrant women and international students seeking mental health help.

Additionally, the findings from the subtheme: **approaching Indian community leader leaders** was another recommendation made by the experts for mental health institutes and community health workers. Experts in the discussion encouraged Indian immigrant community members to act as community ambassadors to become leaders of change. Since an identified barrier among Indian immigrant women was a lack of awareness and openness about mental health in Indian communities, these experts invite Indians to become cultural ambassadors and leaders who can create space for transformative deliberations about stigmatized mental health diseases. Through this, experts and leaders can collaboratively develop avenues of information dissemination and positive perception building among Indians in the community, which can improve mental health access and reduce barriers. This can also promote empowerment and advocacy efforts among immigrant communities that help community experts develop effective avenues of mental health outreach. To communicate valuable resources with the Indian immigrant women, experts willfully shared helpful resources in the Riley County community, which provides low-cost services. This resource is listed in Appendix C.

In summary, this study has explored responses to the six research questions by delving into the lived experiences of Indian immigrant women. By exploring the effects of Hofstede's cultural determinants, the study highlighted the influence of Indian culture on participants' mental health perceptions and behaviors. It further investigated participants' acculturation processes and their effects on their mental along with barriers they perceive in seeking mental

health help. Further, after communicating these barriers with experts, the focus group discussion rendered useful recommendations that can improve mental health outreach for Indian immigrant women. Both community mental health experts and immigrants seeking mental health help can benefit from the recommendations elicited in this chapter.

Implications

This research has theoretical and practical implications for future research investigating mental health topics focusing on marginalized populations. The theoretical underpinnings inform unique research practices that create spaces for health communication researchers to invite minority populations to share their context-rich health meanings. Culture influences mental health perceptions among immigrant groups. To understand health meanings, practitioners need to take cultural foundation into account. Through a culture-centered approach, which serves as both a theoretical and methodological framework, health communication praxis can be extended to conduct inquiries that invite community members to interact with agencies of health. Moreover, it encourages future scholars to practice interdisciplinary research that can provide a solid theoretical foundation that offers several entry points to investigating health topics.

The agency in CCA is the research participants' capacity to participate in research in further communicating their health meanings with structures (Dutta, 2007). However, due to hesitancy among communities about mental health topics, the current research offers methodological enhancements that forefront the role of the academic researcher in playing an agentic role in communicating marginalized populations' health needs to health structures. This has implications for future researchers investigating mental health among subaltern populations who may need to adopt collaborative data collection processes. Further, by developing effective theoretical frameworks inviting collective learning and decision-making, health communication

practitioners must collaboratively work with community leaders to implement solution-oriented research designs to enhance healthcare practices.

Further, Hofstede's cultural determinants develop a guiding framework to investigate culturally embedded health meanings. Using this framework can help researchers get a deeper understanding of how dominant power structures dictate health perceptions and behaviors and silence marginalized voices. Women around the world continue to tackle mental health diseases and are often overlooked by these power structures, which hinder their help-seeking behaviors. More research investigating the positionality of women in mental health topics across cultures is needed to provide spaces for them to express their experiences and develop adequate campaigns that enhance their decision-making processes.

This study also has practical implications for policymakers in developing advocacy and funding opportunities for future mental health programs and services for immigrant community members. As immigrant populations grow, community strategists must advocate for the minority groups' personal and social welfare and collaboratively work with nonprofit mental health facilities to provide adequate service outreach. Additionally, mental health institutes must incorporate cultural competence into their practice to effectively treat immigrant clients. Further, there is a need for mental health practitioners to engage with immigrant communities to build trust, which then facilitates mental health information dissemination and a pathway for immigrants to communicate their health issues in times of need. Moreover, community leaders and organizations must actively participate in initiatives to address mental health topics to reduce stigma and build awareness through campaigns, workshops, cultural events, and places of worship. Immigrants rely on their communities and leaders for support and communication. Therefore, community-based organizations and mental health practitioners must take the

initiative to create awareness among immigrant populations to reduce judgment and stigma. These social change initiatives are a result of collective leadership efforts that community members and service providers are engaged in to create better health outcomes.

Despite offering a wide range of potential research directions, this study significantly contributes theoretical and critical-culture knowledge to the existing literature on the cultural meanings of health diseases. This study also has implications for cross-cultural understanding of mental health topics erased from dominant health structures. Research designs such as this can help health communication scholars broaden their understanding of the cultural meaning of health topics. By developing a research framework that amplifies the marginalized population's voices, the study empowers women to freely express their mental health knowledge and experiences, which may have been overshadowed in dominant cultural spaces. This empowerment extends to broader immigrant communities and diverse populations to foster openness, resilience, and positive reinforcement toward mental health diseases.

Using hermeneutics phenomenology to understand the lived experiences of cultural communities can benefit researchers who are invested in and familiar with that culture. Martin Heidegger states that researchers cannot perform phenomenology without having any background information and experience with the culture they are studying and cannot separate themselves from the phenomena (Laverty, 2003). As future practitioners use this methodology, their reflexivity and measures to establish rigor can help approach cultural topics more profoundly. Additionally, employing snowball sampling techniques can invite hard-to-reach cultural community members. Practitioners must capitalize on their initial subjects' ability to recruit other cultural members to participate in research. Further, it is crucial to approach data collection with cultural members with open-mindedness and composure since sensitive topics like mental health

can be triggering to subjects. Researchers must provide enough time and space for participants to communicate their experiences without feeling threatened. More importantly, it is suggested that researchers reassure subjects about data confidentiality to gain their trust before, during, and after data collection.

Limitations

Several limitations were noted throughout the research that can help future health communication research investigating mental health topics among marginalized communities. Despite being suitable for a phenomenological investigation, attracting a larger sample can help ensure generalizability and greater context-building. However, the data collection process reached saturation since no new information or patterns were emerging towards the end. Additionally, most women in the study were highly educated and working professionals since they all had advanced degrees. Therefore, their experiences can differ from those of less educated and nonliterate Indian immigrant women who may not be proficient in English and rely entirely on family members for communicative support (Robert et al., 2015). Also, since most of the women hail from urban cities in India, the results are generalizable to all women living in India.

Further, due to the sensitivity of the subject matter, the participant recruitment period was time-consuming since many potential subjects were hesitant to share their perceptions due to stigmatization and fear of judgment. This hesitancy was also noted among participants recruited in the study since many of them repeatedly ensured that no identifiable information was used in the final draft of the research during interviews and member checks. The video recording was eliminated to ensure participation and minimize hesitancy since participants indicated discomfort

in their faces being recorded. This eliminated the opportunity to collect data through observations and journaling to articulate the nonverbals of the participants.

Since the study is explanatory in nature, the results from this small sample cannot be generalized to other immigrant women's mental health perceptions and experiences. It is also worth noting that social desirability bias may persist since participants' hesitancy with discussing sensitive topics such as mental health may affect the accuracy and depth of the data. It is worth noticing that hermeneutic phenomenology acknowledges subjectivity in interpretation, which may introduce bias in the data analysis and interpretation. Finally, findings from this research are context-specific and may not be transferable to other cultures and geographical contexts. Moreover, acculturation findings are also unique to experiences in the U.S. and may not apply to Indian immigrant women traveling to a different geographical location since every country has distinct healthcare interventions, structures, and environments wherein migrants acculturate.

Conclusion

In conclusion, this phenomenological study understanding Indian immigrant women's lived experiences underscores the significance of culture in shaping mental health perceptions and help-seeking behaviors. Through the exploration of Hofstede's cultural determinants and communication dynamics, this study has elucidated rich insights into the role of culture in shaping and defining health meanings among marginalized populations. Cultural determinants influence Indian immigrant women's mental health perceptions and help-seeking behaviors. This has implications for health communication scholarship and practice, program and intervention development, and collective leadership efforts. The diverse experiences among Indian immigrant women in the study illuminate the uniqueness of how they articulate meanings for mental health in the context of community orientation, gender, and power. Despite limitations, this research

highlights the complexities of help-seeking behaviors by exploring the nuanced dynamics of culture. Additionally, insights from the effects of acculturation have uncovered bittersweet experiences among Indian immigrant women and negatively impacted their overall mental well-being.

Participants perceived several barriers and benefits as hindering their decision-making. Several effective strategies were communicated by employing mental health experts to elicit recommendations. This includes engagement with immigrant communities, online mental health options, and identifying community leaders. Experts also provided enhancements and opportunities to overcome barriers identified by Indian immigrant women. Moreover, this study highlights the crucial role of researchers in communicating problems to structures of change due to increased hesitancy among marginalized populations in disclosing their mental health experiences publicly. Significant findings and discussions served to accomplish study goals. More importantly, with the help of a culture-centered approach, this study looks beyond linear Western biomedicine, which has historically eliminated the importance of culture in understanding health topics.

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Appendix A - Interview Guide

Research Question (s)	**Form of Data Collection**	**Interview Questions or Other Protocol**	**Anticipated pages of data**
How do the participants understand mental health and diseases?	*One-to-one interviews with Indian-immigrant women located in the United States (6-10 participants)*	On a scale of 1- 10, how much do you think you know about depression and anxiety? Do you think depression and anxiety are severe diseases? Do you think depression and anxiety require medical attention? Do you think depression and anxiety can be cured? In your experience, what social factors have defined your mental health knowledge?	1 interview x 3 pages each

How do the participants describe common barriers perceived in help-seeking	*One-to-one interviews with Indian-immigrant women located in the United States (6-10 participants)*	How would you define depression and anxiety? What challenges (if any) did you face growing up as a woman in your culture? How would you define the position of women in your society when it comes to mental health help-seeking?	1 interview x 5 pages each
How do the cultural dimensions contribute to shaping their mental health perceptions?	*Collectivistic*	In your experience and knowledge, how have society, community, and family connections contributed to your perceptions of mental health? What do you think are some benefits and barriers associated with the nature of the society being collectivistic compared to the U.S.?	

		How do you think mental health is similar or different from the U.S. culture?	
	Masculinity vs Femininity	What were the power dynamics among genders in your family and community growing up? Who was the decision-maker of the house and how did that impact your mental well-being or perceptions of mental health?	
	Power Distance	What was the role of religion and collectivistic community orientation in defining mental health? Do you believe that religious leaders push misinformation or stigma about mental health diseases? Why and why not?	

	Uncertainty-Avoidance	Do you think that your culture has strict behavioral codes and beliefs about how they see mental health? During your upbringing, how often did you talk about mental health? Were there instances where your family or community members avoided or changed the subject to avoid uncertainty? If you self-diagnose or are diagnosed with mental health, do you think you can openly discuss it with your family back home? Why or why not? -how about family, friends, and community in the U.S. Why and why not?	

	**The identity of the participants will remain confidential due to the sensitivity of the data being collected.*		
	One-to-one interviews with Indian immigrant women (10-12 participants)	What barriers do you think Indian women face while seeking help in India? What barriers do you think Indian immigrant women face in the U.S. (this may include cost, transportation, stigma, judgment, lack of awareness, etc)	1 interview x 5 pages each
How do the participants describe their acculturation process concerning mental health?		How do you think your migration to the U.S. has changed your perceptions about mental health? What are some challenges you faced coming to the U.S.? How did these challenges contribute to your mental health?	1 interview x 5 pages each

		Do you feel safe[r] here to discuss topics of mental health? How do you think it's different from India? How do you think your personal experiences define your mental well-being? How do you envision mental health care systems to look like for Immigrant women in the U.S.? How do you envision mental health care systems to look like for women in India?	

Appendix B - Focus Group Guide

Research Question (s)	**Form of Data Collection**	**Interview Questions or Other Protocol**	**Anticipated pages of data**
How can we improve mental health access and communication among immigrants in our communities?	*Online focus group discussions with mental health experts (4-5 participants)*	What are some effective ways of improving mental health service access to immigrant populations in our communities? How can we improve linguistics and communication among immigrants seeking mental health help?	
What are some enhancement opportunities identified by the experts?	*Online focus group discussions with mental health experts (4-5 participants)*	What are some important considerations when dealing with a culturally diverse clientele? What are some ways to ensure that the identified barriers are addressed?	

		What methods have you implemented to ensure that you're tailoring your services for culturally diverse/immigrant help-seekers? What are new/innovative ways experts can ensure that they are providing the utmost level of care and therapy to someone who identifies as an immigrant?	

Appendix C - Mental Health Resources in Riley County

Name	City	Payment Amount	Availability
Pawnee Mental Health	Manhattan	$13-52 per session	8-10 weeks
Cornerstone Family Counseling	Manhattan	$25 per session	
Curtis-Baker Therapeutic Services	Junction City	$50+ per session	3-4 weeks
T4 Therapy	Manhattan	$30-60 per session	
365 Days 365 Chances	Manhattan	No sliding scale	1-3 weeks
Evergreen Therapy & Wellness	Manhattan	$0-60 per session	1-3 weeks
Healthy Connections	Manhattan		
Infin8e Counseling Connections	Manhattan	$50-210 per session	
Avenues For Change	Manhattan	$30-200 per session	1-3 weeks
Beyond Ideas Counseling	Manhattan	$75-120 per session (Can also do $50 for special cases)	No availability currently
Firebrand Wellness Initiative Therapy and Movement	Junction City	0.01% of annual income	4-6 weeks
Ethos Therapy and Life Coaching	Manhattan	No sliding scale	1-3 weeks
Hope Harbor Therapy	Manhattan	No sliding scale	1-3 weeks
ALP Counseling Services	Manhattan	No sliding scale	1-3 weeks

Appendix D - IRB

KANSAS STATE UNIVERSITY | University Research Compliance Office

TO: Nancy Muturi
AQ Miller School of Media and Communication
Manhattan, KS 66506

FROM: Lisa Rubin, Chair
Committee on Research Involving Human Subjects

DATE: 03/20/2024

RE: Proposal #IRB-11734, entitled "Let's Talk Mental Health: Analysis of Indian Immigrant Women's Culturally Centered Mental Health Perceptions and Identifying Modifiers in Interventions."

MODIFICATION OF IRB PROTOCOL #IRB-11734, ENTITLED, "Let's Talk Mental Health: Analysis of Indian Immigrant Women's Culturally Centered Mental Health Perceptions and Identifying Modifiers in Interventions"

EXPIRATION DATE: 07/17/2026

The Committee on Research Involving Human Subjects (IRB) has reviewed and approved the request identified above as a modification of a previously approved protocol. **Please note that the original expiration remains the same.**

All approved IRB protocols are subject to continuing review at least annually, which may include the examination of records connected with the project. Announced in-progress reviews may also be performed during the course of this approval period by a member of the University Research Compliance Office staff. Unanticipated adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB, and / or the URCO

It is important that your human subjects activity is consistent with submissions to funding / contract entities. It is your responsibility to initiate notification procedures to any funding / contract entity of any changes in your activity that affects the use of human subjects.

Electronically signed by Heath Ritter on 03/20/2024 5:18 PM ET
On Behalf of IRB Chair