HINDU INDIAN AMERICAN CONCEPTIONS OF MENTAL HEALTH

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Abstract

The Hindu Indian American community is an integral piece of America—contributing to the economy, diversity, and culture of the United States in many different ways. However, this community has rarely been studied, and evidence through the broader Asian American community shows that this population has been underutilizing mental health resources. Hinduism offers a perspective on psychology, mental health, and treatment that may offer insight into how to better engage this community. To this end, the present exploratory study used a qualitative research design based on grounded theory (Corbin & Strauss, 2014) to investigate the attitudes of Average Hindu Americans, Hindu American Clergy, and Hindu American Mental Health Providers on mental health. Interviews were conducted with 6 participants in each of the three groups, with 18 total participants. Vignettes on schizophrenia and depression were used to assess how participants understood the illnesses; and differences in how they thought about friends and family, the vignette character, and themselves in relation to the illness were identified. Open ended questions were used to explore definitions of mental health and mental illness; conflicts felt between faith, psychology, and practice; and thoughts about barriers to treatment. Interviews were then analyzed to identify themes and important findings. Results indicated that participants in the Average Hindu American and Clergy groups showed more understanding of depression than schizophrenia, but were more likely to recommend help-seeking for schizophrenia than depression. The participants of these two groups were most likely to recommend help to the vignette character, less likely to recommend help to their friends and family, and least likely to seek help themselves. They defined mental health as balance, which aligns with Hindu views, but had disparate definitions of mental illness. They acknowledged stigma as a barrier for the community at large, but said they themselves did not seek help because they "didn't need it." Mental Health Professionals accurately assessed schizophrenia and depression, and uniformly

recommended seeking help, though they showed more hesitation about seeking help themselves, an indication that this group also felt stigma. Overall, expressed conflict between Hinduism and ideas of mental health for Clergy was limited. Mental Health Professionals similarly expressed little conflict between Hinduism and professional practice. The Clergy demonstrated the most adherence to Hindu ideas of psychology. These findings have many implications for the training of mental health professionals who may work with Hindu Indian Americans, as well as for psychoeducational material that is created for better outreach to this community.

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Introduction

This dissertation aims to begin illuminating the Hindu American conception of mental health and mental illness. While Hindu Americans account for just about .7% of the population of the United States, they have made an impact on American society—residing in top positions across industries such as finance, tech, fashion, government, etc. (Pew Research Study, 2014). Given Hindu Americans' current contributions, as well as their steady growth as a community, it is important for those in the mental health field to understand this population and their needs, particularly as part of culturally competent practice (APA, 2017). There is a dearth of literature on Hindu Americans (Magan, Siddiqi, & Shafiq, 2016) and they are underserved by current systems, making it important to understand both why and how to better serve them.

Much of the research that has been done on understanding minority conceptions of mental health has been divided by ethnic group rather than by religious affiliation. Many Hindu Americans are also Indian American, and there are answers to be found by looking at the research that does exist on Indian Americans. However, the groups do not overlap completely – aside from India, Hindus also come from the Caribbean, parts of Africa, South America, the UK, and Canada, as well as the United States (Hatcher, 2015). Indian Americans are predominantly Hindu, but many of them are also Muslim, Christian, Jewish, Buddhist, Sikh, Jain, Zoroastrian, or of some other faith (Pillari, 2005). Furthermore, ethnicity shapes identity in different ways than religion. Both ethnicity and religion impact culture, but religion impacts worldview in a unique way that makes it important to separate the two. This is a difficult endeavor in any community, and is particularly a challenge with the Hindu community, as it is so tied to India and the Indian community. However, the challenge does not mitigate the necessity of this task.

Though data on Indian Americans could be used to begin to understand the related Hindu American community, the Indian American community is not researched particularly well either.

In fact, even the broader South Asian community has only been found to have a presence in between 2-11% of relevant samples (Kim & Omizo, 2003; Miville & Constantine, 2007; Ruzek, Nguyen & Herzog, 2011; Shea & Yeh, 2008; Zhang & Dixon, 2003). While the lack of existing scholarship itself demonstrates the need for greater research, looking at characteristics of the broader Asian American community further supports this assertion. The Asian American community is a vast and heterogenous grouping of many distinct communities, and generalizations in the literature should not be applied uniformly to all Asian Americans. Despite similarities in cultural values and histories of oppression in the communities embodied by the "pan-Asian" identity label, the differences in ethnicity, history, culture, religion, socioeconomic indications, etc. make the label controversial (Suzuki, Ahluwalia, & Alimchandani, 2012). South Asians' inclusion in this label has been shown to be particularly challenging (Shankar & Srikanth, 1998) given that the label does not account for the variations in patterns of acculturation, conceptualizations of mental illness, and openness to mental health services that are markedly different for South Asians (Farver, Narang, & Badha, 2002; Rao, 2006). Nevertheless, given the lack of literature on Hindu Americans and South Asian Americans, it becomes necessary to use statistics on the broader pan-Asian community to understand how to frame the research within this particular community so that a relevant body of data can be gathered. Additionally, it will be important to use dynamic sizing concepts—flexibly generalizing culture specific knowledge where appropriate—to understand where large-group generalizations are applicable to Hindu Americans and where individualized cultural and group understanding is necessary (Sue, 2006).

Mental Health Concerns in Hindu American Populations

Prevalence rates of mental illness by religion were not found for either the United States or worldwide. Prevalence rates by ethnicity (such as Indian) in the United States were also not

available. Nevertheless, some studies have looked at South Asian Americans as a conglomerate. For example, Masood, Okazaki, and Takeuchi (2014) found a 20.8% lifetime rate of any DSM-IV diagnosis in the South Asian American population. This is lower than the 50% lifetime prevalence rate of any DSM-IV disorder in the United States (CDC, 2011). However, caution must be taken while analyzing the implications of this data. Some research has shown that the manifestation of pathology is distinctly different in Asian and American cultures. For example, South Asians tend to report more physical symptoms than Western populations (Hoge et al., 2006). South Asians also tend to have a different course of schizophrenia—their hallucinations tend to be more relational, i.e. positive and playful, than caustic, or bitter and troubling, and the overall course is more benign (Gangadhar and Thirthalli, 2009). Social anxiety also seems to be associated with different core fears—with Eastern culture leading to a social fear of offending others and Western culture leading to a fear of being perceived as inferior (Hofmann et al., 2010).

While these differences are seen when comparing Asian countries to Western countries, it is likely that individuals from these countries bring the unique cultural manifestations of mental illness with them when they emigrate to the United States. Indeed, when looking at mental healthcare underutilization rates, Abe-Kim et al. (2007) demonstrated that patterns seen in Asian countries remained applicable for individuals emigrating to the United States. They found that only 2.2% of first generation Asian Americans utilized mental health service, but that second-generation Asian Americans fared better, with 3.5% utilizing services. Though this is higher, it is only slightly so, showing that the potential barriers to proper access rates are not only immigrant specific, such as being related to language or knowledge, but are also related to cultural factors that must be explored. Furthermore, researchers looking at findings related to the prevalence rates of mental illness for Asian Americans confirmed that cultural bias resulted in flawed

statistics, and that high rates of distress experienced by this community were masked by these statistical errors (Nguyen, Shibusawa, & Chen, 2012; Sue, Cheng, Saad, & Chu, 2012).

The U.S Department of Health and Human Services published a landmark report in 2001 that brought national attention to the mental health needs and service disparities among ethnic minority groups. With regard to Asian Americans, they found that there was a dearth of knowledge about their mental health needs, historic underutilization, and need for culturally competent mental health service delivery to increase health outcomes for this underserved group (U.S. Department of Health and Human Services, 2001). Decades of research on Asian Americans followed, and have consistently shown low prevalence rates of diagnosed mental illness among Asian Americans (Substance Abuse and Mental Health Services Administration, 2012; Takeuchi et al., 2007). An abundance of research studies on Asian Americans have all discovered that Asian Americans, on average, participate in mental health treatments at comparatively low rates, even in comparison to other ethnic minorities, with a large percentage of participating individuals terminating prematurely (Abe-Kim et. al., 2007; Bui & Takeuchi, 1992; Cheung & Snowden, 1990; Kinzie & Tseng, 1978; Loo, Tong, & True, 1989; Snowden & Cheung, 1990; Sue & McKinney, 1975; Sue & Morishima, 1982; Uba, 1994). Abe-Kim et. al. (2007) found that Asian Americans still used mental health services at less than half the rate of the general US population (8.6% versus 17.9%), but that the level of service use was less disparate when the participant had a probable DSM-IV diagnosis during the 12-month period prior to their seeking of help (34.1% versus 41.1% sought services). However, overall even Asian Americans with psychiatric conditions did not seek help, as the U.S. Department of Health and Human Services (2001) found that only 17% of these Asian Americans sought help and less than 6% used mental health programs.

Factors Influencing Service Underutilization. Several researchers have examined the impact of help-seeking attitudes and the willingness to meet with a practitioner in an effort to identify the factors associated with lower mental health service utilization and compliance rates among Asian Americans, and have universally found that stigma is a large obstacle to seeking resources (Lee et. al., 2017; Hwang & Ting, 2008; Shea & Yeh, 2008; Atkinson & Gim, 1989; Gim, Atkinson, Whitley, 1990).

Kim and Zane (2016) looked more deeply at the factors behind service underutilization in order to better understand this stigma. They found that the perceived benefits of treatment were lower among Asian Americans when compared to White Americans, and that this partially accounted for lower intentions to seek help. Asian Americans also perceived more barriers, but the researchers found that this was not a significant factor in explaining differences in help-seeking intentions. Perceived severity of distress was also a factor in underutilization, with Asian Americans perceiving their distress as less severe than their White American peers, which appeared to lead to the conclusion that they did not need help (Kim & Zane, 2016). Additionally, traditional beliefs and the experience of mental distress as somatization, not only masked prevalence statistics, as shown before, but also precluded help-seeking (Nguyen et al., 2011).

In examining where Asian Americans go for mental healthcare, given that they underutilize professional psychological services, several studies have found that they are most likely to seek support from their family members and friends when they are incapable of managing mental issues on their own (Lee et. al., 2009; Akutsu, Snowden, & Organista, 1996; Lee, 1988; Narikiyo & Kameoka, 1992). However, it has also been found that Asian Americans are less likely than other groups to speak to their family or friends when in distress, meaning that the group is particularly isolated and inhibited from seeking help—having trouble seeking help

even through their most preferred option (Chang, Chen, & Alegria, 2014). Studies have shown that when their efforts do not ameliorate the severity of their issues, Asian Americans may seek the support of community figures such as elders and spiritual leaders (John & William, 2013). A last resort tends to be considering professionals outside of the family (Akutsu, Castillo, & Snowden, 2007), with medical doctors overwhelmingly preferred and somatic complaints accounting for the majority of all problems reported (Chun, Enomoto, & Sue, 1996; Zhang, Snowden, & Sue, 1998). Overall, research has shown that Asian American families and individuals may look within for solutions until faced with legal or social services requirements to seek professional services (Hsu, Davies, & Hansen, 2004).

Stigma, or "a mark of shame or discredit; a stain, or an identifying mark or characteristic" (Merriam-Webster Dictionary, 1990, p.506) is commonly encountered when exploring mental health service utilization, and is a phenomenon seen broadly throughout U.S. culture. A survey of nationally representative public attitudes towards mental illness in the U.S. found that only 42% of Americans aged 18–24 believe that people with mental illness can be successful at work, 26% believe that others have a caring attitude towards the sufferers, and 25% believe that people can recover from their illness (National Alliance for the Mentally Ill—Greater Chicago, 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). Individuals with mental illness suffer, not only from their illness, but also within society. There is evidence that they experience discrimination in nearly every domain of their lives, including employment (Farina & Felner, 1973; Link, 1987; Stuart, 2006), housing (Corrigan et al., 2003; Farina, Thaw, Lovern, & Mangone, 1974), and medical care (Thornicroft, Rose, & Kassam, 2007). Additionally, experiences of stigma are associated with increased symptom severity (e.g., Boyd, Adler, Otilingam, & Peters, 2014), decreased treatment seeking (e.g., Corrigan, 2004) and treatment nonadherence (e.g., Sirey et al., 2001).

Stigma manifests in many ways. Public stigma is felt through prejudice, belief in negative stereotypes, and discriminatory actions based on prejudice (Sue, Sue, Sue, & Sue, 2015). In fact, the prejudice and discrimination can be more devastating than the illness itself (Stuart, 2012). Self-stigma occurs when prejudice and discrimination are accepted and internalized based on an individual's belief in or acceptance of negative societal beliefs or stereotypes. These negative societal beliefs, such as feeling different, dangerous, unpredictable, or incompetent, become incorporated into an individual's self-image and lead to decreased self-worth and self-efficacy, hindering recovery (Corrigan and Rao, 2012; Sue, Sue, Sue, & Sue, 2015). Another manifestation is social stigma, which comes from people believing that those who are mentally ill are responsible for their conditions (Sue, Sue, Sue, & Sue, 2015). Pescosolido et al. (2010) explored the idea that stigma would be reduced if the public could better understand the biological roots to mental illness in the same way that they understand the biological roots of medical illness. They found that between 1996 and 2006, beliefs about the causes of severe mental disorders did shift towards recognizing biological causes for mental illness rather than blaming families or personal characteristics. However, they also found that this shift did not result in less prejudice and discrimination, as measured through public perceptions of the dangerousness of suffering individuals or degree of social distance. Instead, it has been found that highlighting biogenetic reasons can lead to increased attitudes that those who are mentally ill are dangerous and unpredictable, rather than decreased negative attitudes (Kvaale, Haslam, & Gottdiener, 2013). Ultimately, researchers have had difficulty finding a consensus on the best approach for combatting stigma, given that effects differ widely depending on context; however, education and contact with people with mental illness have been identified as important (Krafft, Ferrell, Levin, & Twohig, 2017).

As such, advocates have continued to increase public awareness and provide information about mental illness to combat stigma. For example, the National Alliance on Mental Illness (NAMI) began the "You Are Not Alone" campaign, which used first hand written and video testimony of individuals and families affected by mental illness in order to combat stigma (Corrigan, Sokol, & Rusch, 2013). In response, organizations are recognizing and commending those in the entertainment industry who are working to present those with mental disorders in a humanizing and accurate way as a move towards public education to reduce stigma. It is also largely regarded as a helpful counter to social stigma when talented individuals in the public eye come forward to discuss their own journeys coping with and recovering from mental illness (Sue, Sue, Sue, & Sue, 2015). It is thought that this may be effective due to research showing that participants who know someone who has received treatment have more positive attitudes, and individuals often feel that they "know" celebrities (Walker & Read, 2002). Though there are many questions and uncertainties in the field on how to reduce stigma, Fox et al. (2017) found that research on stigma has been progressing rapidly, with the amount of research on the topic increasing steadily each year. However, they point out that while the there is a great deal of literature looking at mental health stigma broadly, there is a need for greater focus. For example, they assert that it will be important to keep researching how "race and ethnicity impact people's conceptualizations and experiences of mental illness stigma as it has important implications for individuals' overall health and well-being," (Fox et. al., 2017, p. 21) especially given the findings that racial and ethnic minorities are more likely to have unmet health care needs (Wang et al., 2007).

Research on Asian American manifestations of stigma has shown that individuals feel that experiencing mental health problems and receiving treatment for them may bring shame to individuals as well as to their families (Augsberger, Yeung, Dougher, & Hahm, 2015). Others

have found that for Asian Americans this shame comes particularly from feeling that mental health disorders are due to a lack of willpower, which makes it difficult to seek help or to even admit that one has a mental health problem (Lee et al., 2009). Others found support for different cultural beliefs that led to increased stigma in the South Asian population particularly, such as mental illness being a punishment from God (Fogel & Ford, 2005) or the result of bad deeds in a previous life (Raguram, Raghu, Vounatsou, & Weiss, 2004). Gender also appears to play a particular role in the South Asian community, as Arora, Metz, and Carlson (2015) found that men had more negative attitudes about help-seeking than women. They also confirmed that for South Asians, higher levels of personal stigma led to more negative attitudes about help-seeking.

Given that education is an important way to combat stigma, and certainly the most feasible of the approaches, it is necessary to understand what Hindu Americans do know about mental illness. Ogurchukwu et. al. (2016) did an enlightening study in South India that begins to offer a picture of mental health literacy for the Hindu American community. They surveyed pre-university adolescents, 79% of which were Hindu, and gave them a vignette describing depression, and a second vignette describing schizophrenia. Less than 30% were able to correctly identify depression, and less than 2% were able to identify schizophrenia. While the generalizability of the study to Hindus in America is limited, given that the study was conducted on largely rural Indians, the startling lack of mental health literacy is telling. Furthermore, the help-seeking attitudes assessed in the second half of the survey showed that the participants were unlikely to look outside of their family for help with either condition, and were particularly less likely to seek help for themselves in comparison to seeking help for a friend. They were instead likely to advocate steps such as exercising or finding a distraction.

Given the service underutilization and seeming lack of literacy on mental health, it is clear that the Hindu American community needs to be better served. In order for mental

healthcare providers to begin serving this community properly, it is important to start with understanding how Hindu Americans understand mental health. To do this, this dissertation first looks at average Hindu Americans who are potential consumers of mental health services. Interviews with this group explore and clarify how they think about mental health as well as help-seeking. A closer look is then taken at religious leaders, including both ordained clergy and community leaders, to whom Hindu Americans may be going to for help instead of mental health professionals (John & William, 2013). The goal with this group was to understand how those who may be counseling troubled Hindu Americans respond to their mental and emotional distress, and how they regard help-seeking. Third, to further understand the relation between mental health and Hindu philosophy, Hindu mental health providers, who are versed in both and may be able to speak to any conflict that comes between their faith and their practice, are studied. By studying these three groups, this dissertation hopes to generate a cohesive picture of how Hindu Americans conceive of mental health in order to understand both the barriers to treatment and how best to bridge them. For the purposes of this study, the decision was made to focus on depression, because it is the most commonly diagnosed mental illness (World Health Organization, 2005). Schizophrenia is also explored because there are indications that it is the disorder most misunderstood by the Hindu community (Ogurchukwu, 2008; Cinirella and Loewenthal, 1999), and that views of Asians and Non-Asians are the most divergent when it comes to schizophrenia (Furnham, 1988).

Literature Review

Researching the mental health of Hindu Americans is a challenging endeavor. There is a significant lack of information, and the much of the information that does exist is filled with inaccuracies, misconceptions, and gross overgeneralizations about Hinduism and Hindu culture (Gittinger, 2015; Sanu, 2002). For example, Das and Kemp (1997) had this to say about marriage in the Hindu community in the *Journal of Multicultural Counseling*:

> The woman is usually much younger than her husband, probably less educated, and enters the family as its lowest member in the status hierarchy. She is welcomed as Lakshmi, goddess of wealth, signifying the dowry she brings into the marriage and her ability to endow the family with children, preferably boys. Under the thumb of her mother-in-law, she works at her beck and call, answering to her, to the men in the family, and to any older women. (p. 26)

More recently, Chaudhuri, Morash, & Yingling (2014) offered the statement: "Several practices for setting up marriages contribute to South Asian women's disadvantaged, devalued position in marital families" (p. 143). To see such stereotyped writing without nuance or tentativeness in a research journal is disconcerting and may serve to perpetuate conceptions among service providers that the community is "backwards, racist, and patriarchal" (Jiwani, 1992). However, it is also not difficult to understand why painting an accurate picture of Hindus is so complicated.

For example, Hindus are incredibly diverse. Most Hindus hail from India, a country that encompasses 29 states, 7 union territories, 22 official languages, and hundreds, if not thousands, of dialects (Hatcher, 2015). There are great differences in the practice of Indian Hinduism ethnically, from state-to-state and even village-to-village, as well as from one sect to another. Hindus also hail from the Caribbean, from parts of Africa, South America, the UK, and Canada as well as the United States, and have different cultural understandings of the faith based on the

environments in which they, and their ancestors, were raised (Hatcher, 2015). The differences range from superficial differences about which deity to worship, to sweeping differences in how rituals are conducted, to deeper differences in the balance between spirituality and religiosity. A Hindu in the Caribbean may spend the bulk of his or her worship in congregation, singing hymns and reciting the Ramayana in large groups (Van der Veer and Vertovec, 1991). A Hindu in the United States may spend much of his or her worship in solitary meditation or contemplation of the scriptures (Johnsen, 2009). A Hindu in a small village in India may spend much of their worship doing complicated rites in front of an altar to Shiva (Johnsen, 2009). Of course, there are those that prefer solitary reflecting in Trinidad and those that prefer ritual in Kansas; thus, further attempts to identify concrete differences in Hinduism from region-to-region would inevitably fall apart given that there is diversity in practice everywhere. Attempts to make these claims and to pin down what different sects and groups of Hindus believe leads to a great deal of inaccurate conflations. Some scholars would even argue against the utility of the label "Hindu," given the breadth of beliefs the term encompasses (Pennington, 2005). However, there are shared core philosophies, making the Hindu grouping beneficial for a general understanding of a culture and religion that is markedly different from those of other faith traditions. It simply must be wielded with an understanding of the diversity it encompasses.

An overview of Hinduism and traditional Hindu Values

Hinduism is the oldest practiced religion in the world. It has no known beginning, no known founder, and predates recoded history. It has many scriptures – the Vedas are the oldest and the Bhagavad Gita may be the most popular (Johnsen, 2009). It has 1.034 million followers around the world, making it the fourth largest religion (Pew Research Study, 2014). However, despite its age and prevalence, and in part due to its diversity in practice, Hinduism is often not well understood by those who do not consider themselves part of the religion.

Two key tenets of Hinduism are *karma* and *dharma* (Kang, 2010). *Karma* is a popular notion – the idea that every action has an equal reaction. Who one is and the circumstances in which one is born, such as being born a Saudi prince and being given a comfortable life or being born in a slum of Bangkok where some opportunities may be closed off, are thought to be determined by karmic "bank accounts" and how much good or bad *karma* has been accrued through actions. This can lead many to inaccurately believe that Hindus are very fatalistic, though in fact they believe strongly in the power of free will to determine their futures. *Dharma* is loosely translated as "duty" (Chinmayananda, 1975). In Hinduism, there is nothing that resembles Commandments, such as in Christianity of Judaism, or a strict moral code of what is right and what is wrong. Instead, a Hindu must understand his/her *dharma* in any given situation by figuring out what the right or wrong thing to do is in that particular context. *Dharma* is generally guided by three principles – *satya*, or the truth, *ahimsa*, or nonviolence, and *brahmachari*, or moderation (Chinmayananda, 1975). However, each person's duty is bound by his or her context. A teacher's duty is different than a student's, and an army soldier's duty is different than a UN ambassador's. All of these people have to value the three principles differently from one another, based on their personal context. For example, the soldier may need to lift arms and kill, the UN Ambassador may need to lie for the security of his/her people, and the teacher may need to abandon moderation for a period of time to make sure that he/she finishes his/her lesson plans.

Another key belief in Hinduism relates to the nature of God and reality itself. Hinduism is, at its core, a monist religion (Kang, 2010). God is one, a formless and quality-less abstract concept that is beyond the grasp of the human mind. In order for Hindus to understand and appreciate God, whose divinity is manifest within them themselves, they can create form and quality with their minds that they can use as devotional anchors. This is why Hinduism is said to

have millions of gods; each Hindu individual who ever existed could create his or her own personal form of God, though generally communities come together around one with broad appeal. Indeed, this may lead some Hindus to feel polytheistic in their practice, despite the core philosophy. The material world is thought of as *Maya*, or an illusion that only distracts from every individual's divine nature (Chinmayananda, 1975).

Hindu life is thought to have four goals. The first is *dharma*, or acting honorably/dutifully as discussed before. The second is *kama* or pleasure. It is expected and encouraged for Hindus to work towards experiencing material and sense pleasures. Third is *artha*, or wealth. The pursuit of wealth, material and spiritual, is again expected and encouraged for a fulfilling human life. Finally is *moksha*. *Moksha*, or liberation from the material world to be one and part of the divine, is the ultimate goal of Hinduism. Hindus move towards *moksha* through 4 main paths, though none are thought of as exclusive of each other. They follow *bhakti yoga*, a path of whole hearted love and devotion for the divine; *karma yoga*, the path of selfless service to mankind and the divine; *raja yoga,* the path of meditation and contemplation; and *jnana yoga,* the path where one studies the scriptures to find enlightenment (Chinmayananda, 1975). The process of attaining *moksha* is a difficult one, and may take several lifetimes. Hindus believe in reincarnation, and generally believe that time is both linear and cyclical. Essentially they see time as a spiral, where cycles of creation and destruction repeat themselves unceasingly. The cycle of birth and rebirth goes on until one is able to free oneself from all karmic debt and achieve *moksha.* While it is fully encouraged for Hindus to pursue the material through the early parts of their lives, the ultimate goal is to eliminate all desire and, hence suffering, by moving towards *moksha* (Johnsen, 2009). This is a paradox, but one that rarely, if ever, is thought of as such.

There are many other aspects of Hinduism as well, and scriptures that outline everything. The Ayurveda extolls what to eat, and when, where, and why; and the Kama Sutra theorizes on

how to have sex, and where when and why as well (Johnsen, 2009). Delineating every aspect here is beyond the scope of this dissertation, and has little utility to the project at hand of understanding the core philosophy of Hinduism and how it affects how Hindu Americans understand mental health. Some topics that are not addressed here may come up in the interviews with participants, but it is not possible to predict all aspects as Hinduism is also very personal and its practice varies hugely from person to person. Some topics have come up frequently in this literature review, including astrology and caste. Astrology, or *Jyotiṣa*, is defined as "the system which explains the influences of the sun, moon, and planets" (Tripathi, 2008). It is used in Hindu culture for deciding everything from when to get married to the letter with which a newborn's name should start. Hindus range from placing no value in astrology at all, to using it as the basis for every decision (Tripathi, 2008). However, is not intrinsic to understanding the general Hindu worldview, so a full description of this science is not given. Caste is a complicated social system that is not rooted in Hindu philosophy, though this misconception is spread widely. The part that is based in Hinduism is discussed in following sections.

Hindu Conception of Mental Health

Concept of the mind. The concept of God/The Divine/The Absolute, also known as *Brahman*, has been described above. Hindus believe that the Self, or the *Atman*, is identical to the Divine, and the material world with its names and forms and individualistic distinctions is illusory (Salagame, 2013). The Divine is forever true, forever unchanging, and forever blissful; in other words, it is reality (Chinmayananda, 1975). It is covered with a sheath, however, and this sheath makes the Self think it is separate from the Divine and creates a sense of "I". In other words, the Self is reality masked by the individual ego, and ignorance, or *avidya*, maintains in the Self the false idea that it is separate from the Divine (Salagame, 2013). The body is the physical body, the mind is the sense organs or perception, and the intellect is the discriminating

faculty that makes sense of all that the mind takes in – all of these things are impermanent and separate from the true Self (the Divine, and reality). Personality, likes and dislikes, sense of identification, etc., are all attached to the ego, and are thought of as illusions disguising the true Self (Chinmayananda, 2010). Mental illness then is also an illusion attached to the ego which hides the true Self. To understand the goal of treatment, it is in turn crucial to see that the goal of Hinduism, *moksha*, is to become aware and one with the Divine that is the true Self, letting go of the illusion of the material world as important (Chinmayananda, 2010).

The mind itself is studied closely and is thought to be moved by the elements—ether, air, fire, water, and earth (Frawley, 1997). It consists primarily of ether, or space, and an expansive mind is more spiritually evolved while a restricted mind shows its restriction through less space. Air is the secondary element of the mind which moves rapidly through coordination with the body and endless thinking. Fire is the element that provides light with which to perceive. Water is present in emotion, empathy, and feeling. Finally, earth gives weight to memory and attachment. Understanding the mind as beholden to the elements is crucial to understanding how treatment is conceptualized (Frawley, 1997). The mind moves with the elements, but the ultimate goal is to still it, and to find peace and spirituality in its balance. While the mind is seen as an illusion, it can also be used as a tool to move towards ultimate realization. To do this it must be stilled and controlled, rather than being allowed to do the controlling (Chinmayananda, 1975). The idea that the mind is a tool that must be controlled is an important one that will be looked at closely as the root of conceptualizing mental illness as an inability to control, and hence as a weakness.

Ayurveda, Yoga, and *Tantra* are the branches of the Hindu healing sciences. *Ayurveda* is the therapeutic branch, *Yoga* is the spiritual branch, and *Tanta* is the branch that deals with consciousness. Hindu therapies for healing the mind include elements of all three. *Ayurveda*

itself draws on the constitution of the body and food as healing. Yogic practices for spiritual growth, such as *mantra* (repeating a divine name or phrase repeatedly) and meditation are incorporated. Tantric tools of sensory remedies using gems, colors, sounds, mantras, and use of deities (often as archetypes) to heal are also used (Frawley, 1997).

Ayurvedic Constitutional Types. *Ayurveda* is based on the idea that every person is different in constitution, that one must understand an individual's constitution in order to be able to understand his or her health, and that treatment of disorder must be individualized based on individuals' unique constitutions. There are three major constitutional types (*doshas*) of which each person has a different ratio. The constitutional types are based on the biological humors that are the root forces of physical life. They are *Vata*, based on air, *Pitta*, based on fire, and *Kapha*, based on water. They are the basis of all that is organic in nature and, in humans, are responsible for every process in the body and mind. While the mind itself is not organic, it is moved by the elements, and imbalances in constitution move the mind in ways that can be seen as illness (Frawley, 1997).

Vata. This is "what blows," and it governs movement and is the force that directs and guides the other humors. It allows for agility, adaptability, and facility in action. Its power animates and makes one feel vital and enthusiastic. It also rules the basic sensitivity and mobility of the mental field by energizing all the mental functions. When life force is threatened or jeopardized, or *Vata* is somehow lessened, it results in fear and anxiety (Frawley, 1997).

Pitta. This is "what cooks," and it governs transformation in the body and the mind. *Pitta* is responsible for all heat and light from sensory perception down to cellular metabolism. *Pitta* in the mind governs reason, intelligence, and understanding; allowing the mind to perceive, judge, and discriminate. The main emotional disturbance of *pitta* is anger (Frawley, 1997).

Kapha. This is "what sticks," and it governs form and substance and is responsible for weight, cohesion, and stability. It relates to the senses of taste and smell. *Kapha* in the mind governs feeling, emotion, and the capacity of the mind to hold onto form. This gives one calm and stability. Its disturbance results in desire and attachment, which can lead to holding onto things until they result in an overburdened psyche (Frawley, 1997).

Most people are dominated by one *dosha* or two*,* and they impact a person's physique and personality. The *doshas* are constantly shifting and changing and balancing them for health looks different for each individual (Frawley, 1997).

The master forms. *Vata, Pitta,* and *Kapha* have subtle counterparts on the level of vital energy – *Prana, Tejas,* and *Ojas.* They control mind-body functions and keep one free of disease. These essences are the key to vitality, clarity, and endurance. They are built through the essence of nutrients taken into the body in the form of food, heat, and air on a gross level. On a subtle level, they are built by the impressions taken in by the senses. The key to their functioning is in reproductive fluid which is where they are contained in the physical body. The mind cannot function properly without these vital energies, so one must work to improve and harmonize the balance between these three (Frawley, 1997).

Prana- primal life force*.* This is the subtle energy of air, the master force behind mind-body functions that coordinates breath, the senses, and the mind. It governs the development of higher states of consciousness. *Prana* is also responsible for enthusiasm and expression in the psyche, and without it depression and mental stagnation occur (Frawley, 1997).

Tejas- inner radiance*.* This is the subtle energy of fire, the master force that digests impressions and thoughts. On an inner level, it governs the development of higher perceptual capacities. *Tejas* governs mental digestion and absorption so without it clarity and determination are lost (Frawley, 1997).

Ojas- primal vigor. This is the subtle energy of water, and the essence of that which has been digested. On an inner level, it gives calm and supports and nourishes higher states of consciousness. *Ojas* provides psychological stability and endurance, and when it is diminished the result is anxiety and mental fatigue (Frawley, 1997).

Three Qualities of Nature. According to Ayurveda, all of nature has three primal, subtle qualities that underlie matter, life, and mind. These qualities are *gunas*, which in Sanskrit translates to "that which binds," because they bind one to the material world if not properly understood (Frawley, 1997).

Tamas is substance, and it creates inertia. It is the quality of heaviness, and it veils and obstructs action. It is the force of gravity, and it holds things in their form. *Tamas* brings sleep and loss of awareness it the mind. It causes decay and disintegration. While this sounds negative, this is necessary for balance and to be able to create that which is new (Frawley, 1997).

Rajas is energy, and it causes imbalance. It is the quality of change, activity, and turbulence. It is stimulating and provides pleasure in the short term, but, because it is unbalanced, leads to pain and suffering. It is the force of passion and causes distress and conflict (Frawley, 1997).

Sattva is intelligence, and it upholds balance. It is the quality of virtue and goodness and creates harmony and stability. It brings about spiritual progress and provides happiness and contentment of a lasting nature (Frawley, 1997).

While *Sattva* alone brings clarity, *Rajas* and *Tamas* are factors that bring disharmony to the mind by causing agitation and delusion. *Rajas* immerses one in sensory enjoyment, creating desire, distortion, turbulence, and emotional upset. *Tamas* can create ignorance that veils the divine nature of the self and weakens perception, making one think that the physical body is all one has. *Sattva* is the balance of *Rajas* and *Tamas*. Even attachment to *Sattva* itself (by clinging

to virtue) can bind the mind, so *Sattva* must be pursued through a detached form for the sake of its balance rather than its quality (Frawley, 1997).

Each person has a balance of these three qualities within themselves. To have a preponderance of *Sattva* is to be harmonious and adaptable, to strive towards peace of mind and balance, by being considerate of all while taking care of oneself. Rajasic people have a great deal of energy, which leads to an agitated mind that looks for power over others. They can be inconsistent and impatient, but generally are able to meet their goals. Tamasic people have gravity and heaviness, which can lead to a mind with stagnant and repressed emotions. They may let others influence them rather than pushing to be responsible for themselves. Therapy through the *gunas* focuses on the Sattvic, though Rajasic and Tamasic modalities are used for balance. According to Frawley (1997),

> Ayurvedic psychology aims at moving the mind from *Tamas* to *Rajas* and eventually *Sattva*. This means moving from an ignorant and physically oriented life (*Tamas*), to one of vitality and self-expression (*Rajas*), and finally to one of peace and enlightenment (*Sattva*) (p. 37).

Personality. An individual's *guna* composition is thought to be shaped by past and present *karma* and can be influenced by every aspect of the environment, most namely diet. Food, which is organic, has constitutional elements that shape the balance and imbalance of the *doshas,* but it also has the *gunas* that can shape the balance of the mind. The compositions are loosely grouped into four groups of psychological types or temperaments, known in Sanskrit as *varnas.* The first is *Brahmin*, those who are predominant *Sattva* with some *Rajas* and the least of *Tamas*. *Kshatriyas* are those who have a preponderance of *Rajas* with some *Sattva* and the least of *Tamas*. *Vaishyas* have a high proportion of *Rajas*, some *Tamas*, and the least of *Sattva*. *Shudras* have a majority of *Tamas*, with some *Rajas* and the least of *Sattva* (Chinmayananda,

1975). These *varnas* also lend themselves to particular occupations, and Hindu scriptures expand a great deal on the significance of people "leaning into" their temperaments to create a well-balanced and well-functioning society. However, these *varnas* often get inaccurately conflated with the rigid, hierarchical, and birth-based caste system. It is important to note here that the *varnas* descriptions are simply of personality types that can be changed, and the scriptures do not advocate for any hierarchy or discrimination of any of the groups (Hindu American Foundation, 2011). While a predominance of one particular *guna* shapes an individual's personality type/disposition/temperament, each thought and emotion that passes through an individual's head, and each action that he/she engages in, will all have different qualities. Every individual can change his/her overarching *varna* by changing how he/she interacts with and reacts to the external world. This is the key to understanding Hinduism's core philosophy that every individual has the capacity to evolve spiritually. While the goal of religious and spiritual practice is to expand the sattvic, the ultimate goal of human life goes beyond even expanding the sattvic to transcend the *gunas* entirely through complete control of the mind that leads to achieving *moksha* (Chinmayananda, 1975).

Ayurvedic Healing. Given this, Ayurvedic psychology offers a path towards this lofty goal, and is conceptualized as therapy that moves an individual through a preponderance of *Rajas* or *Tamas* to a sattvic place. The goal of this psychology is *moksha*, which is also inherently free of any psychopathology or suffering.

The first stage of healing through Ayurveda requires breaking up the excess of *Tamas* in a person, to move them towards change. This is done with the element fire, which can release patterns of deep attachment, stagnation, and depression. Frawley (1997) says to do this "we must recognize our suffering and learn from it, confronting our pain, including what we have suppressed or ignored for years. A new sense of who we are and what we need to do is required,"

(p. 39) and therapy may require changing jobs, modifying relationships, or even moving to a new locale. The second stage of healing is moving from *Rajas* to *Sattva*, with the element of space. As Frawley states,

> We must surrender our pain and give up our personal seeking, letting go of individual hurts and sorrows. Egoistic drives and motivations must be surrendered for the greater good. We must depersonalize our problems and look to understand the entire human condition and the pain of others. Leaving behind our personal problems, we must take up the problems of humanity, opening up to the suffering of others as our own. This is a stage of service and charity" (p. 39).

The third stage is developing pure *Sattva*, by developing love and awareness:

> We must learn to transcend the limitations of the human condition to our higher spiritual nature. Inner peace must become our dominant force. We should no longer seek to overcome our pain but to develop our joy. At this stage we move from the human aspect of our condition to the universal aspect, becoming open to all life (p. 40).

These three stages of counseling are meant to move an individual towards *moksha*, beyond all attachment, even to personality, mind, and sense of self, which makes it very different from Western Psychology.

Ayurvedic counseling takes place in four primary areas. Physical factors, including diet, herbs, and exercise; psychological factors, including impressions, emotions, and thought; social factors including work, recreation, and relationships; and finally, spiritual factors including *yoga* and meditation. There are four levels of treatment to be considered. The biological humors – balancing *vata, pitta,* and *kapha* – happen largely through physical factors like diet and exercise. The vital essences, or strengthening *prana, tejas,* and *ojas*, can be done with *pranayama*, or breathing regulation. Impressions, and harmonizing the mind and the senses, are addressed

through sensory therapies. Finally, consciousness, and promoting the correct functions of it, occurs through increasing *sattva* with *mantra*, or repetition, and meditation. Frawley (1997) explains that Ayurvedic counseling is practical in nature and comes from the therapist and the client learning

> …how the mind and body work so that we can use them properly… Therapy is a learning process. Ayurveda looks upon someone suffering from a psychological problem not as a bad or disturbed person, but as someone who does not understand how to use the mind properly (p. 149).

Therapy is thought of as emphasizing "right association to ensure psychological well-being" (p. 150) with the goal of associating with people who both possess sattvic qualities and in turn sharing those qualities with others. In Ayurvedic psychology, the counselor is not a doctor with boundaries and distance, but a "spiritual friend and well-wisher" (p. 151) where therapy is the beginning of communion, or *satsang* in Sanskrit (Frawley, 1997). It is further recommended that making friends who are spiritually elevating is better than going to a therapist. If a therapist is necessary, they "should not play guru, but direct their clients toward genuine spiritual teachers" (p. 152).

Psychopathology. Following this model of understanding the mind, body, and soul, all disease is seen as an imbalance. "Health problems, whether physical or mental, are not merely personal problems, but energetic problems in the mind-body complex. They are not so much personal or moral failings as an inability to harmonize the forces within us," said Frawley (1997). He explains how a surge of any of the biological humors can lead to psychological disturbance. An excess of *Vata* (the air element) can create instability and agitation in the mind, leading to excessive worrying and reactiveness. It can even lead to hallucinations or delusions since an excess of *Vata* leads to feeling ungrounded and unrealistic. Insomnia, mania, and

schizophrenia are all described as incidences of extreme *Vata* imbalance. Neglect and abuse as children can predispose one for this *Vata* imbalance. *Pitta* is fire, and it can lead to an overheated body and mind that is seeking the release of tension. *Pitta* imbalances can cause the mind to be narrow and contentious, and result in hostility. People with this imbalance can be seen as self-centered and antisocial. Paranoid delusions and psychosis can result. A competitive education and too much childhood conflict can predispose one to an excess of *pitta*. *Kapha* is water, and an excess of this makes the mind dull and leads to poor perception. It can lead to attachment as well as lack of motivation, which can both result in depression or a clinging obsession. Being overly indulged as a child or emotionally smothered by parents can lead to this imbalance.

In essence, all psychopathology is imbalance, and there is a great deal of literature within the Ayurvedic tradition on how to heal by creating balance. The core idea is that all people are inherently good and divine, but that the conditioning all people go through in the physical, material world can lead to "mental indigestion" that results in a superimposition of distress on top of true nature (Frawley, 1997). Mental health is thought of as a mind that is still and in control, and anything that moves the mind out of an individual's control is mental illness. This Ayurvedic perspective is unique, though it can be compared to elements of traditional Western psychology. The idea that we are conditioned and need behavioral interventions to make change is consistent with Western behavioral theories, while the ideas of understanding suffering and confronting previous pain can be thought of as psychodynamic. Overall, Ayurvedic counseling could be conceptualized as a transdiagnostic approach which looks at each individual as unique in their pathology. While this is the Hindu perspective, directly from the scriptures, it is unclear if the Average Hindu thinks this way, and further research must be done to see if practicing Hindus approach mental health through this lens. Research has indicated that the overt influence of Hinduism on understanding psychology diminished due to the impact of colonialism (Wirth,

2002). Additionally, psychology based in Hinduism is often not considered in India due to a lack of training in Hindu psychological thought, feelings that Hindu psychology is somehow less valuable or less scientific than Western psychology, and limited access to texts on Hindu psychology due to language barriers and resource limitations (Rao, 1988). However, these factors need to be assessed in the Hindu American population and serve as part of the rationale underlying the structure of this study. Thus, in order to asses these areas, participants will be asked if they see mental illness as an imbalance, if they see illness as an inability to control the mind, if they feel that healing should be undergone with a spiritual friend rather than a therapist, and if they speak about treatment in the holistic balance of mind-body-soul way that Hindu scriptures recommend.

Therapy with Hindu Americans

From these concepts of Hindu psychology, some psychologists have also made suggestions on how to best treat Hindu clients and patients (Juthani, 1998; Madathil and Sandhu, 2008; Rastogi and Weiling, 2005). Juthani (1998) in particular outlines how to approach the healthy and unhealthy religious factors in the lives of Hindu patients. Healthy spirituality, according to Juthani (1998), involves courage, prudence, love for oneself, love for others, knowledge, and open-mindedness. When these factors work together, a person is considered well integrated and hence healthy. Unhealthy religiosity, however, involves excessive fear, lack of prudence, selfishness, self-hate, hate of others, ignorance, and close-mindedness; as well as more extreme symptoms such as delusions and hallucinations of a religious nature. Providers will of course encounter Hindu patients who are at various stages of spiritual development and cultural adaptation, and these factors may be related to psychological issues. Treatment that is sensitive to this and accurately discriminates between healthy and unhealthy spiritual development is necessary. It may even, in turn, allow patients to move to a higher level of spirituality (Juthani,

1998). While this is a useful approach driven by a conceptual understanding of Hinduism, a purely conceptual framework to guide therapy implementation can be problematic. For example, Johansen (2010) compared and contrasted Hindu belief with Adlerian philosophy to better understand how to treat Hindu clients. However, his main findings were that Hindus would find individual psychotherapy in the vein of Alfred Adler difficult given their beliefs in caste and inequality and Johansen's interpretation of Hindu scripture. Had Johansen actually talked to Hindus about their practice, he may have arrived at an alternate conclusion because the Scripture actually emphasizes that all beings are equal and divine, and this interpretation of the scripture is widely held among Hindus (Chinmayananda, 1975). As discussed before, caste is a social construct in India that is unfortunately practiced by those of all faiths, and it is inaccurate to conflate it with Hinduism (Hindu American Foundation, 2011) or with the beliefs of all Hindus. Not speaking to Hindus can lead to misconception-ridden understandings of what they should believe based on one interpretation rather than what they actually believe. Talking to Hindus about what they actually believe is an important facet of further understanding how to guide both treatment implications for providers, as well as psychoeducation for the community.

Others researchers have shown the utility of using specific Hindu concepts in therapy. The idea of *karma* can provide individuals with a sense of control during stressful circumstances (Dalal & Pande, 1988). Tarakeshwar, Pargament, & Mahoney (2003) found that Hindus who more often used *dharma* and the path of ethical action experienced greater life satisfaction, greater marital satisfaction, and a less depressed mood. These studies were limited in their scope however and did not look specifically at conceptions of mental health and the mind in assessing how Hinduism in practice affects mental health or even help-seeking.

McLean (2001), in her dissertation "A Collision of Worldviews: Theory and Implications for therapy with Hindu Indians in America," used literature and case studies to offer a picture of

how Hindu philosophy and practice forms the Hindu self, and how therapists can use this understanding to practice more competently with their Hindu American clients. She speaks about how Western culture and Western religion inspire a self that has been studied closely – the integrative self that seeks individuation and autonomy. She contrasts this with the assimilative self, a self that can appreciate the multiplicity of meaning, contextualism of phenomena, and accommodates paradox, contradiction, and ambiguity without anxiety. She shows effectively that understanding of this assimilative self is necessary for therapists who wish to work with Hindu clients. She also writes about how Hindu philosophy impacts the Hindu worldview and how one interacts with the world every moment. This is particularly salient when thinking about how this impacts those Hindus who are living in a context where the majority of people come from an opposing, integrative worldview. For example, Hindus are appreciative of the multiplicity of meaning behind everything. In its most concrete, that would mean that a therapist should be careful when interpreting a Rorschach to assess personality structure and whether or not the individual is suffering from psychosis. McLean (2001) illustrates this through a case example of a Hindu American woman who saw multiple images simultaneously in a card. This could have been a sign of psychosis, but the woman was clearly a functional and well-adjusted woman, who simply felt no conflict at the multiplicity of the image, likely because of her comfort with the Hindu worldview. Of particular importance is the idea of contextualism of phenomena (McLean, 2001). Through their comfort with the idea of *dharma* and context bound duty, Hindus may shift the way they behave from situation to situation, for example with family, with peers, and at work, without feeling disingenuous or insincere. Furthermore, they may feel distressed when they feel the clash of worldviews. For example, a Hindu may expect his/her superiors to act in a *dharma* bound way – eliciting great respect and deference from those who work under them, but also obligated to do their part to ensure and encourage the growth of those for whom they are

responsible. Working with an ambitious boss who looks only for his or her own gain could be jarring and upsetting to a Hindu employee in a way that one who comes from a worldview that encourages individuation and autonomy may not understand (McLean, 2001). She shows that understanding these differences can help therapists do more effective work with Hindu clients. Overall, McLean (2001)'s study was an important piece of work in understanding Hindu Americans which was driven by a conceptual understanding of Hinduism and personal experience with a limited number of cases. Further corroboration of her findings, as well as further research on how Hindu Americans define mental health and use those definitions towards help-seeking, is important and is a goal of the present study.

Evidence-based practice with Hindu Americans

There is a dearth of research on what treatments have been used to effectively address mental illness in Hindu Americans, as no studies of evidence-based treatment for South Asians exist (Aisenberg, 2008). The literature abounds with arguments in favor of the evidence-based practice (EBP) mandate, given that EBPs have substantially increased effectiveness in treating several illnesses and in preventing disorders in certain populations (APA Presidential Task Force on Evidence-Based Practice, 2006). However, as Aisenberg (2008) found, EBPs are not universally applicable to the entire population at all times. As he articulates, "the universal approach of EBP fails to respect or understand the contextual realities of the histories, languages, values, traditions, and indigenous wisdom of diverse communities of color that affect the use and delivery of mental health services" (p. 300). He shows that most EBPs are normed on non-Latino White populations and do not take cultural differences into account, though the literature has shown consistently that there are disparities in mental health care for ethnic minority populations (Chow, Jaffee, & Snowden, 2003; Lagomasino et al., 2005).

Aside from EBPs, Tondora et al., (2010) found that, in general, mental health services are largely lacking in cultural appropriateness. A review of empirical literature showed that ethnic-specific mental health services showed the most promise for reducing barriers to service access (Nguyen et al., 2012). For this reason, it is important to tailor effective treatment to every minority community, and Hindu Americans are not an exception. However, it is important that this be done carefully—without appropriation. An example of this can be seen with mindfulness, a practice that has roots in Hindu and Buddhist philosophies that has become increasingly popular in modern therapeutic approaches (Ninivaggi, 2008). The Buddhist community has been particularly vocal in its criticisms of contemporary mindfulness programs, stating that these new and commercial approaches to mindfulness, when distanced from its religious roots, lose the morality, the focus on cessation of suffering, the liberation from *samsara* (the cycle of birth and rebirth), and the compassionate commitment to act for the welfare of all sentient beings (Purser, 2015). The community assert that current approaches are, instead, reinforcing a Western society rooted in individualism, consumer capitalism, and demands for tangible and worldly benefits (Purser, 2015). To the extent that members of the Buddhist or Hindu communities are aware of this appropriation, there is the potential that it would lead to distrust of the systems and institutions that commercialize their sacred practices (Antony, 2014). Thus, it is important to be aware of this possibility when working with the Hindu Americans who may often find their ancient practices being appropriated (Antony, 2014).

Overall, given the demonstrated efficacy of culture specific services and research, as well as the current deficits of the field in these areas, it stands to reason that an important step in creating efficacious treatments for the Hindu American population involves fully understanding the experiences of Hindu Americans and their conceptions of mental health. It is a hope that

gaining a sense of how Hindu Americans define mental illness and approach seeking mental health treatment will allow for treatment that bridges gaps of misconceptions and stigma.

This Study

The therapy recommendations to date have been limited to conceptual implications, drawn from personal experience, or limited to very specific Hindu concepts. Few studies have asked actual Hindus what they believe – focusing instead on scripture, and in a few cases, on personal experience. Another problem with conceptual theories is that they largely come with the assumption that the Hindu has sought out services and is engaging in psychotherapy. It has been shown that this population underutilizes services and is unlikely to engage in psychotherapy. Thus, it is important to reach members of the Hindu population where they are, instead of waiting for them to come into offices, and their beliefs must be gathered directly from them. It is also important to consider variations in experiences, beliefs, practice, and mental health awareness across different subsets of the Hindu American population. The goal of this study is to address these two needs by interviewing members of three segments of the Hindu population that are of particular interest—the average Hindu, Hindu mental health providers, and Hindu clergy and community leaders.

The Average Hindu. Cinirella and Loewenthal (1999) looked at how different religious groups in the United Kingdom thought about depression and schizophrenia particularly. While this study is dated, it gives a sense of what the average Hindu believes about these two mental illnesses. They found that while Hindu participants were confident as they defined depression and its symptoms, they were more confused and hesitant when it came to speaking about schizophrenia. The researchers reported that participants offered religious reasons (such as crises of faith) as factors that may lead to depression, but generally seemed the think that schizophrenia was more biological and began suddenly with no warning. Respondents were also asked for

their thoughts about intervention – centered on medication, psychotherapy, and prayer. Findings indicated that respondents thought that medication use was largely superficial for depression, while psychotherapy was thought of more positively, and prayer was seen as helpful. Speaking about schizophrenia, participants said that medication was necessary for schizophrenia, that psychotherapy was seldom helpful, and that prayer was a moderate but definite form of help. In comparison to other religious groups, Hindus found prayer to be the least helpful, and placed the most faith in psychotherapy as an effective treatment. While the paper itself did not speak to the connection between these findings, it is possible that this is connected to the Hindu conception of God as a formless entity, without attributes, that does not interfere in daily life and cannot be appealed to for change with prayer. Possibly, without a reason to put faith in God, Hindus put their faith in psychotherapy.

Further exploration of this theme, and the resultant questions about the disconnect between belief in psychotherapy and actual utilization of services, is necessary. When asked about other religious forms of support, Hindu respondents said that while they themselves would not, they thought that their Hindu brethren might wish to visit a holy person or believe that mental illness was spiritual in nature (Cinirella & Loewenthal, 1999). One of the reasons respondents offered for why, was that these approaches would invoke fewer stigmas in the community. Researchers found that Hindu participants also preferred seeing Hindu therapists, as they felt that people who shared their faith would better understand them. Others have corroborated that Asian Americans generally prefer to see therapists of their own ethnic background. (Fraga et al., 2004). This is difficult given that there are very few Asian American counselors available (Gloria, Castellanos, Park, and Kim, 2008). In the present study it will be important to corroborate these findings where they fit, to understand if they apply to the American community of Hindus as well, and to extend them by answering more questions about

conceptions of mental health, mental illness, and how and when average Hindu Americans seek and recommend seeking help.

Hindu Clergy and Religious Leaders. Harteneck (2006) came the closest to studying Hindu clergy/religious leaders as a group for her dissertation, where she interviewed 25 Hindu renunciates, or individuals who had given up material comfort in order to devote themselves to contemplation and detachment in order to make progress on their spiritual path. Her participants came from different countries and different religious orders. Some of the renunciates she interviewed provided counseling to their community members, and Harteneck interviewed them with the stated goal of better understanding how to apply Hindu psychology to the West, given that there were few Western psychologists who practiced Hinduism or Hindu psychology. The participants were asked their beliefs, and the researcher analyzed whether they were uniquely Hindu, or could be interpreted as either Cognitive-Behavioral or Psychoanalytic. The Cognitive-Behavioral and Psychoanalytic beliefs were equal in rate, contrary to the researcher's prediction that they would be more Cognitive-Behavioral. However, uniquely Hindu beliefs were dominant over beliefs in either school of thought. Harteneck also found that the renunciates expressed more Cognitive Behavioral thoughts when asked specific mental health questions versus general or philosophical ones. She also found that there was an impact of length of residence in the United States on how much the participants referenced psychoanalytic thought – the longer the residence in the United States the more psychoanalytic thought was referenced, suggesting that American culture was making an impact. A majority of the participants also recommended psychotherapy or psychopharmacological treatment for emotional problems. A minority of the participants articulated that childhood trauma can have a long–term effect on adult emotional life, that pathology derives from repressed memories of childhood trauma, and that behaviors are derivatives of unconscious traces. Some of the participants also expressed ideas that contradicted

the scientific materialism of the West and reflected Hindu metaphysical notions instead. For example, a majority expressed the idea that consciousness is a phenomenon that gives existence to the brain and the mind, and a minority articulated that there are spiritual truths independent of the physical world, and that the body and mind are the same but in different forms of manifestation. This aligns with the Hindu conception of the mind discussed above (Frawley, 1997). The study offers a glimpse at how Hindu American religious leaders may have integrated their Hindu beliefs with an understanding of Cognitive Behavioral Therapy and Psychoanalytic thought, though it does not look at how they interact with their communities. More research will be necessary to understand exactly how this integration plays out in their involvement in the community, and more tailored research on how these clergy and community leaders actually apply this integration to their counseling. More understanding of how the leaders interact with their communities will also be key to understanding the broader picture of Hindu conceptions of mental health, and how to ensure that Hindu Americans are encouraged to seek professional services by those to whom they reach out for help.

Vermaas, Green, Haley, & Haddock (2017) found that Christian Clergy, in their roles as informal helpers and conduits to the formal mental health care system, are understudied. They created an assessment tool for mental health literacy and found that clinical mental health training was necessary for higher mental health literacy scores. They also spoke about the necessity of using these findings to inform mental health counselors on how to build interprofessional dialogue and referral partnerships with clergy. Though this study was entirely with Christian clergy, it shows the importance of the goal in the present study of assessing mental health literacy and to understand how clergy refer, or are prevented from referring, their parishioners to mental health services. Yamada, Lee, and Kim (2011) also studied Asian American Christian Clergy and found that prior mental health education, knowledge of mental

illness, time spent providing individual counseling, and referrals to general practitioners were associated positively with making mental health referrals. Between these two findings and the corroboration that Asian Americans turn to Clergy when in distress (John & William, 2013), it is clear that psychoeducation for clergy on mental health and mental illness will be key to ensuring that service utilization rises in the Hindu American community. This study's focus on Hindu American Clergy in particular will make it possible to extend this work to this community for future research and future outreach endeavors.

Hindu Mental Health Providers. To understand how the beliefs of Hindu mental health providers impacted their practices, Padayachee and Laher (2012) conducted semi-structured interviews with six Hindu psychologists in Johannesburg, South Africa. One striking finding was that all of the study participants expressed a willingness to refer their clients to healers if necessary, as long as the client also continued with therapy. This may seem surprising, given the questionable efficacy of healers in the minds of most other scientists or practitioners, and given that all the Hindu psychologists participating in the study said they used a bio-psycho-social approach in their work. However, the finding could be explained in part by another concept upon which all interviewees agreed—that stigma could inhibit their Hindu clients from seeking or using treatment effectively. Participants also all referenced Hindu concepts throughout their interviews to explain their thoughts and ideas. In particular, they used the ideas of *karma* and astrology, and also described mental illness as an imbalance of something in their patients' lives. The paper does not elaborate on what is meant by imbalance, but it is possible that the participants are referring to the imbalance of the *gunas* or of the mental, physical, and spiritual that were discussed earlier as causes of psychopathology (Frawley, 1997). The participants also spoke of Hinduism culturally, as well as philosophically, and emphasized the importance of cultural competence in therapists' work with Hindu collectivist dynamics. They remarked that

"the mom in law/daughter in law problem is a big problem" (p. 431) and that therapists needed to understand the duty-role connection that Hindu philosophy inspires, to understand why their clients behaved and felt the way they did about their families. This could be a reference to understanding *dharma* and how it leads people to act differently in different contexts. One of the most intriguing findings was that Padayachee and Laher (2012)'s participants reported feeling conflict between their Hindu identities and their psychologist identities at times. This was not elaborated upon in the paper, but it would be important to explore this idea, and how training as psychologists, likely in a Western/integrative model as referenced above, may be disconnected and at odds with the Hindu identity. The researchers noted that several of the Hindu psychologists they contacted simply did not respond or engage in the study, indicating a possibility that many Hindu psychologists would be averse to discussing how their faith informs their practice perhaps because there is too much conflict. No other research could be found on Hindu psychologists' views on depression and schizophrenia, or even mental health in general. These reasons serve as rationale for why this study looks closely at Hindu American psychologists, and endeavors to understand if they feel conflict between their faith and their practice, and what drives that conflict if so; to see if they are also impacted by the stigma that plagues the rest of the community; and to learn how they feel other therapists can become culturally competent in working with Hindu American clients.

Methods

Research Design

In depth, semi-structured interviews with three groups of adults – Hindu Americans, Hindu American mental health providers, and Hindu American clergy and community leaders – were conducted to explore their conceptions of mental health. Participants had to be between the ages of 18 and 75, living in the United States, and self-identifying as Hindu. The Clergy group was defined as those who spent at least 2 hours a week teaching about Hinduism and providing informal advice or counseling to the members of their temple or organizational community. The Mental Health Professionals group was confined to those who practice psychotherapy with a doctorate level degree.

The interviews consisted of responding to vignettes describing different situations of mental distress. A vignette is defined as a "short, carefully constructed description of a person, object, or situation, representing a systematic combination of characteristics" (Atzmüller & Steiner, 2010). The vignettes used followed the Paper People format of asking participants to respond to a written or read situation with their explicit decisions, judgments, and choices or to express behavioral preferences (Aguinis & Bradley, 2014), which has found to be an effective method of assessing underlying attitudes (Murphy et. al, 1986). After reading each vignette, the participants spoke about how they would counsel and advise the party in the vignettes, and responded to other questions illuminating their personal experience and understanding of mental health (see Appendix B). The interviews were audio-recorded, transcribed verbatim, and analyzed using the principles of grounded theory (Corbin & Strauss, 2014) to identify common themes.

Participants

Selection and Recruitment. The 18 participants in the study met the criteria for the study overall, as well as for the particular group of which they were a part. All participants were between the ages of 19 and 71, living in the United States, and self-identified as Hindu. During the recruitment phase, those in the Clergy group affirmed that they spent at least 2 hours a week teaching about Hinduism, and providing informal advice or counseling to the members of their temple or organizational community. The Mental Health Professionals group confirmed that they all practiced psychotherapy professionally. Recruitment was conducted through the Principal Investigators network. Emails were sent to several listservs consisting of Hindu Americans, Clergy, and Mental Health professionals, to successfully encourage participants to engage in the study. Recruitment goals were fulfilled through both network and snowball sampling, no other methods of recruitment were necessary.

Demographics. The participants were given codes for the purposes of assessing and analyzing the data (see Table 1).

Table 1

Participant Demographics

Participant	Age	Gender
A2	31	M
A3	30	F
A4	19	M
A5	32	M
A6	51	F
A7	27	F
C1	45	M
C2	65	M
C3	66	M
C4	71	M
C5	26	M
C6	29	F
MHP 1	36	F
MHP 2	63	M
MHP 3	30	F
MHP 4	35	M
MHP 5	38	F
MHP 6	30	F

Table 2

Participant Demographics Analysis

Group	Average Age	Standard Deviation	Female
Average Hindu Americans	31.7	10.6	50%
Clergy	50.3	19.8	17%
Mental Health Professionals	38.7	12.3	67%
All Participants	40.2	16	44%

The groups differed in their age and gender breakdowns. A greater number of participants qualified for the Average Hindu American group than were required for the study, so it was possible to aim for diversity of age and to also balance the group equally between males and females. The Clergy group was predominantly older males. This may be reflective of the Clergy themselves, as it was difficult to recruit female clergy, despite targeted recruitment attempts. The

Mental Health Professionals group is skewed slightly to having more females than males, which may also be reflective of the field.

Procedures

Consent Procedures. Participants were asked to read and complete an informed consent form prior to the interview. The consent form explained the purpose and procedure for participation, risk and benefits of the study, confidentiality, limits to confidentiality, and provided contact information for all individuals affiliated with the study (Appendix A). The consent form explained that participation was entirely voluntary and that participants had the right to terminate participation at any time during the interview process without penalty. The addendum to the consent form asked for consent to audio record the interview (Appendix A.2). All participants signed both components of the consent form prior to the interview. All participants were given a copy of the dated and signed informed consent form for their records.

Interview Procedures. All participants were interviewed using the semi-structured interview protocol developed by the researcher. All interviews were audio-recorded, and then transcribed verbatim. No identifying information was attached to audiotapes or transcriptions as these were labeled with the participant codes.

The interview consisted of open-ended questions aimed at facilitating free-flowing responses (see Appendix B). The vignettes and interview questions guided the interview and were tailored to explore themes. Prompts and questions were used to clarify and expand answers. The participants were given the opportunity to ask questions at the end of the interview and were thanked for their participation in the interview. Participants were informed that they could call the researcher if they had any concerns or questions about the study, or if they had additional thoughts.

Semi-Structured Interview Protocol. After confirming their consent, participants provided basic demographic information, including age, ethnicity, and gender identification. The interview started with the presentation of two vignettes, describing a presentation of depression and a presentation of schizophrenia. Participants were asked open-ended questions about what they thought was ailing the character, what advice they would give to the character, and what they would do if they were in the character's shoes. The interviewer then asked broader questions about the participant's understanding of mental health, and the barriers that may be faced by those who could benefit from professional help. Follow up questions were asked as needed. The detailed list of exact questions asked can be found in Appendix B.

Treatment of Data. All participants were assigned a participant code and pseudonym in order to keep their names confidential. All interviews were audio recorded, and then transcribed.

Data Analysis

Each interview was transcribed for analysis. The Grounded Theory Method, developed by Corbin and Strauss (2014), was used to analyze the results. The primary goal of data analysis was to identify common themes among responses of participants being interviewed. In grounded theory, the researcher begins by reading the entire transcript. The researcher then codes the interviews systemically, reading through each response and pulling out themes that will address the current hypotheses and inspire hypotheses for future research. Three types of coding were used – open coding (labeling and categorizing the blocks of data by concepts), axial coding (developing connections between the concepts on various levels to develop themes), and selective coding (refining and trimming to create a core theme). The grounded theory approach was used to develop a plausible theory from the collection of ideas generated from the perspectives of the participants in order to create a clear picture of the conception of mental health in the three groups, and how they relate to each other. As grounded theory analysis is an

exploratory approach seeking to remain open to the themes that arise from the data, no prior hypotheses were tested in the study. Each group was coded separately, and then compared and contrasted.

Results

Table 3

Vignette 1 Question 1: What do you think is ailing Rakesh?

Group	Drinking	Closure of Business	Mental Health Concerns
Average Hindu Americans	83%	83%	17%
Clergy	33%	83%	33%
Mental Health Professionals	100%	50%	100%

The first question, "What do you think is ailing Rakesh" required the participants to tell the interviewer what they thought of as the root or cause of Rakesh's difficulties. The participants each offered multiple reasons in their answers, but there was overlap in the factors they mentioned. In the Average Hindu American group, five out of six of the respondents (83%) brought up drinking issues as part of the problem. A4 said, "Then also, the drinking did not help that or benefit ... help that situation out, possibly made it worse." Two other participants used the phrase "did not help" as well, possibly indicating hesitation to pinpoint alcohol as the main problem. Five out of six of the respondents also brought up the fact that the business closed, and appeared to view the financial stress of that event as Rakesh's major challenge. The sixth participant said that the problem may be stress, though she did not specify what may be triggering the stress, making it possible that she was also referring to financial stress. A7 explored the connection between the closure of the shop and Rakesh's symptoms:

> I think like ... Well the closure of his business is probably like a really big part of this ... Or might be ... I don't know. Like that would have an impact on kind of someone's wellbeing. I know a lot of people ... A job is like a really important thing to have and when you lose a job or lose a business like that, it's not easy to just kind of pick up and move on carefully. So, I imagine that's maybe a possible cause of why he's feeling this way.

One participant added that Rakesh's lack of social support or a family network may be a part of the problem. A different participant (A5) added that Rakesh's family "being on his case is really agitating." Lastly, while one participant said that there were mental health concerns, no other participants used the words mental health.

When the Clergy group was asked "What do you think is ailing Rakesh," they referenced some of the same factors as the Average Hindu American group, as well as some that did not come up for that group. In the Clergy group, five out of six (83%) spoke about the closure of his business, and the stress related to that. C6 explicated on the stress:

> Well, I think the paranoia probably stems from some anxiety around like his failing business. And then I think it spirals out of control once, I guess, when it rains, it pours, and so it's a combination of like fear and anxiety. Maybe it started with his business, but then it spiraled into maybe some embarrassment, and then pushing away people who are close to him, and I'm sure the drinking didn't help either.

Four out of six of the participants (67%) spoke about Rakesh's stress more generally. Two out of six, or 33% of the participants, spoke about the drinking as part of the explanation of Rakesh's symptoms. Two of the participants additionally referenced Rakesh not seeking help, socially or otherwise, as a part of the problem. C1 speculated, "Looks like he also is not in the mood to take help from others." Mental health issues came up with two of the Clergy. C3 said"

> Apparently, there is some mental health issues. He feels depressed, he feels neglected, he feels alienated and therefore frustrated and hostile. He feels ignored; disconnected from everybody, and he feels low self-esteem, and I think that's what's going on in his mind.

One of the clergy also asked about what Rakesh had been doing since the closure, and pinpointed the "idle mind" as the problem. Another participant said that he simply did not have an understanding of what was bothering Rakesh.

The mental health providers (MHPs) responded to the question "What do you think is ailing Rakesh" with some of the same factors as the Average Hindu American and Clergy groups, and also added factors consistent with their profession. All six (100%) of the MHPs referenced drinking or substance use in their formulations. They all spoke about mental health concerns in different ways. Five out of the six spoke about "psychosis," and the sixth also spoke about paranoia and delusions. This showed validity for the vignette itself, as the providers all appropriately recognized and were able to discuss the symptoms. Four of the MHPs wondered about depression, and three spoke about shame and self-esteem issues. MHP4 tied all of it together:

> Basically, it sounds like there's, let's see, so definitely there's a substance abuse issue happening, it's specifically alcohol abuse. I do conceptualize alcohol abuse as, say he's using alcohol as behavior of coping with maybe the situational stresses that he's having right now. With his dry cleaning shop closing down and financial difficulties it's possible that it may have spurred on a depressive episode of some sort that has psychotic features, perhaps.

Three out of the six (50%) referenced the closure of the business in their diagnostic attempts.

Table 4

Vignette 1 Question 2a: Do you know anyone like Rakesh?

Group	Yes	Partially	No
Average Hindu Americans	17%	50%	33%
Clergy	50%	0%	50%
Mental Health Professionals	100%	0%	0%

Table 5

Vignette 1 Question 2b: What did you recommend to them?

Group	Professional Help	Other Interventions
Average Hindu Americans	50%	50%
Clergy	50%	67%
Mental Health Professionals	100%	33%

The second question for the first vignette was “Do you know anyone who has gone through anything like this? What did you advise that they or their family do?” In the Average Hindu American group, three (50%) said they knew people who displayed some of the same symptoms, but not to the same extent or intensity of Rakesh, two participants (33%) denied knowing anyone who went through anything like this, and one participant (17%) said that she knew someone who displayed similar symptoms. The participants varied in what they told, or would hypothetically tell, their friend to do in similar circumstances (the participants who did not relate to Rakesh spoke hypothetically). Three of the participants (50%) said that they would recommend professional help. Notably, one of these two participants was the one who said that she had known someone who displayed similar symptoms, and she described how she helped her friend get help. A7 stated:

> It was something that we tried to like encourage her to like to talk to somebody about and talk to somebody professional about it. I think she was always really scared to like, you know, share it with more people. Or, talk about it with more people. She thought it was something that was like really private. Like only she could understand and nobody else could understand. A few friends that she felt like really comfortable with she would share her feelings with. But she didn't really share it with her family. Like her parents had no idea she was going through this. So, like it was kind of up to me and a few friends to try and help her find resources. And eventually she did get some help and things like that. And, she's doing much better and managing like some of the things that she's been through.

The other suggestions were encouraging Rakesh to voice his concerns to his parents, talking to Rakesh personally, and helping him to change his decision making.

The Clergy group was split – three of the participants (50%) said they knew someone who dealt with similar symptoms to Rakesh, and three said they did not. They were split in their recommendations as well. Three of the participants recommended seeking professional help. Two of the participants (33%) recommended faith-based strategies like prayer and meditation. C2 said:

> Well, I am from a background that I like to teach meditation, etc., so that is usually the thing I recommend to anybody. That way you take some control of your mind. Otherwise, your mind drags you in a casual manner and you don't even realize it. So as far as I'm concerned, you follow Patanjali yog sutra which is to calm down your mind to make your mind instrument worth of any function. And I personally think it has solution to all kinds of problems. Whether it is a turbulent time you are going through or even in a calm time, whatever is the phase of your life, this is a useful thing to do. So in the circumstances also, I will ... Of course it becomes difficult for this person, their mind is quite agitated for him to sit for meditation, but we have to start somewhere.

The 6th participant did not offer what they would have recommended as they did not know anyone in circumstances similar to the client.

The Mental Health Professionals group all knew someone who fit Rakesh's profile either personally or professionally. They all recommended that the client/patient/friend seek professional help in some fashion – through inpatient, a psychiatric evaluation, or through therapy. However, even as they acknowledged that it would be important to seek professional help, several of the MHPs referenced the need to be sensitive to the stigma and hesitation to engage in treatment. MHP1 said,

> I recommended support and whatever way ... in whatever way they could receive at that time. So, some people were very anti go to therapy but they were open to seeing a

primary care doctor or talking to a family friend who is a doctor or talking to their minister or priest or whatever. Whatever support they were willing to receive and take next steps around is what I recommended.

MHP5 reflected on the impact of religion and culture:

I don't think it would change based on religion because, and the spirituality could be used as tools later on as a coping mechanism and it's like connecting to a higher power and to something bigger than yourself. That's down the line, but right now the acute symptoms of the alcohol use and feeling that his family and friends were trying to harm him, like he's being spied on by radio, like those paranoid thoughts seem to be much more acute. In any religion, I would probably recommend the same thing. This person definitely needs to meet with a psychiatrist and engage in substance use treatment. Because of the escalation of behaviors related to the alcohol and mood symptoms, and because he's actually threatening to kill people, I would probably recommend inpatient first. Inpatient as a place to stabilize and take alcohol out so that he can be properly medicated, if those symptoms still persist.

Table 6

Vignette 1 Question 3: What do you recommend that Rakesh or his family do now?

Group	Professional Help	Other Interventions
Average Hindu Americans	100%	33%
Clergy	50%	83%
Mental Health Professionals	100%	0%

The next question was “What do you recommend that Rakesh or his family do now?” The goal was to understand if this answer was different from the previous response, which asked participants what they told people that they actually knew in real life. Overall, every Average Hindu American participant brought up going to a professional mental health provider in some capacity. A2 suggested going straight to a mental health provider, A3 suggested starting with a

primary care doctor and relying on them to refer to further resources, A5 suggested going straight to a therapist, and A7 suggested going to a professional as well. A4 suggested first trying to talk to the family to work things out, and then going to a therapist or counselor if Rakesh was unwilling to speak to the family. A6 similarly recommended talking to a therapist, while also trying to talk to someone in the family to build support. In contrast to A4 and A6, A7 firmly stated that it would be beneficial to see a therapist or other professional instead of a family member as family members would not be able to be honest and open about what needed to happen next.

In the Clergy group, when asked about next steps for Rakesh and his family, the group split between telling Rakesh to seek professional help (50%) and other advice. C1 said that Rakesh should open up to someone to whom he is close, adding that it would be important to work with a respected spiritual leader to find strength within himself. C2 said that the solution would be for Rakesh to get a job so he can make money and contribute to society. C4 recommended reading scripture and being clear in describing what was bothering him. Of the three who recommended that Rakesh see a professional, one also recommended scripture and reading horoscopes in addition to seeing a mental health specialist. Another said that he would usually try to talk to someone in Rakesh's situation, but, since it seemed that it would be impossible to reason with Rakesh given his state of mind, he would recommend professional help first. Three of the clergy also said that they would keep the spiritual recommendations for Rakesh's family while also urging the families to ensure that Rakesh got help. In summary, half of the clergy recommended seeing a professional and five out of the six clergy (83%) incorporated spiritual solutions in their advice.

Every one of the mental health providers recommended that Rakesh get help from a professional. The specifics ranged from starting with a substance use counselor to starting with a

primary care doctor and moving to a psychiatrist to recommending inpatient. MHP3 added that she would assess religiosity –

> I would test for the presence of spirituality or religious affiliations and if so, also introduce that as a way to help them understand what's going on with Rakesh. I think I would push a test for what is their level of religiosity. So, you know if they do identify as moderate, liberal, and then get them to understand, how they could utilize prayers or religion to increase resiliency as a family. I don't know if I would introduce a lot of that to the individual because I think for him, it would be a slightly different sort of ... Initially I feel like it would be a slightly different intervention but I would say more so for the family, to increase their resiliency to what's going on with him.

MHP6 emphasized that she would look for a culturally competent therapist or psychiatrist, as did MHP4. As shown previously, the Mental Health Professionals group consistently stated support for seeking professional resources.

Table 7

Vignette 1 Question 4: What would you do if you were in Rakesh's situation?

Group	Professional Help	Other Interventions
Average Hindu Americans	33%	67%
Clergy	17%	100%
Mental Health Professionals	100%	0%

The final question referencing Vignette 1 was "What would you do if you were in Rakesh's situation?" The Average Hindu American group largely (four out of six, or 67%) did not say they would seek professional help. They said they would look inward, be even-minded, or talk to their friends or family. A4 summed up it up as "I personally don't think I would need a therapist, because I'm pretty comfortable talking about stuff with my friends and family, but obviously that's different for a lot of people." On the other hand, A2 said he would likely deny or brush away the problem for a time before seeking professional help, and A3 said that, after

recognizing that there was a problem, she would look for support from her family and friends, then,

> … find professional help to support that too, because getting out of that situation would be a lot of strain on yourself and your family and friends, so if you could help yourself and help everyone around you by seeking professional help, I think that's always a good idea.

The Clergy group was less likely than the Average Hindu American group to seek treatment if they themselves were in Rakesh's position. The majority of the participants (83%) did not reference seeking mental health services, and preferred other interventions. C1 said he would turn to family and friends and hope they could give him help, though asking for financial support would be difficult. C5 said he hoped that the people around him would help him in that situation. C2, C3 and C4 all spoke about spiritual and meditative practice within themselves. C3 elaborated,

> Because of my personal background, I would first seek spiritual counseling, and because I think it's a broken spirit that manifests in mental health issues, so that's what I have tried to do, is spiritual counseling. Find strength within to deal with whatever it is.

One Clergy (17%) referenced seeking a professional in her response. C6 said,

> I would hopefully seek help from family and friends first because I'm already very close to my family and friends. I mean, this I think would be a little challenging considering in this situation it says he's like threatening to kill his family and friends, so hopefully I would just seek help from either a mental health professional, family or friends, or honestly like an elder at the temple or like a spiritual coach. I'm very close to people at my temple, so like somebody who I've known for a long time that I've known through the mandir. Somebody who can provide proper guidance and who I'm comfortable to talk to.

Overall, the Clergy appeared to prefer to seek help through resources they already had rather than seeing a professional.

All of the Mental Health Professionals said that they would seek professional help. Two of them (33%) said they would talk to their friends in the profession for guidance, as well as speak to other professionals. One of them (17%) said she would check herself into an inpatient or rehab setting. One of them (17%) reflected on the difficulty of actually connecting to therapists despite intention. MHP6 said,

> It's funny that you're asking me this now because I've been trying make myself find a therapist for the past couple months, which I'm laughing at. And it's at a point, where again, these are moments in my life where five years ago I'd be like, "I'll be fine and I can be fine." But I'm trying to remind myself that I can always use some extra help.

MHP 3 said she would reach out to her immediate support system, and hope that they would be able to connect her to an appropriate professional.

Table 8

Vignette 2 Question 1: What do you think is ailing Aarti?

Group	Depression	Stress	Broad Mental Health Concerns	Other Explanations
Average Hindu Americans	33%	83%	50%	17%
Clergy	17%	66%	0%	33%
Mental Health Professionals	100%	17%	0%	33%

The second vignette was about Aarti, a 35-year-old woman suffering from symptoms of depression. The prevalence of depression is higher than the prevalence of schizophrenia in the U.S., and the goal of this vignette was to understand how the participants thought about symptoms that may be more common among their friends, family, and themselves. The first question that the participants were asked about Aarti was, "What do you think is ailing her?" Three of the six participants, A4, A5, and A6 (50%) referenced mental health in a roundabout

way –citing insecurity, “lack of strong emotional health,” or “some sort of issues mentally.” Two out of the six participants, A3 and A7, (33%) in the Average Hindu American group used the words depression or depressed to describe what they saw. The sixth participant, A2, (17%) said he saw Aarti as “trapped” by her difficult circumstances.

In the clergy group, three participants, C1, C3, and C5, (50%) cited stress and being overwhelmed, with C1 adding that being a female made the situation more difficult. C3 added that from a Hindu perspective, one could see Aarti as being astrologically weakened by the influence of the planets and stars. One participant, C6, (17%) stated “I think she's battling depression.” Participant C2 said that Aarti had a mind engaged in “agitated behavior.” He began his response with “I don't think, out of the story, it looks like she has any problem, whether any kind of physical illness or mental illness. It is just her circumstances are challenging.” Participant C4 said that “It’s obviously something more than what meets the eyes” and that he would have to meet with Aarti to understand what was ailing her. Overall the majority of the group (66%) referred to stress in some fashion, one said she was depressed, and one was unclear on how to understand what was ailing Aarti. The idea that she was weakened astrologically was also presented.

In the Mental Health Professionals group, every participant (100%) said some form of depression, ranging in specificity from mood disorder to “major depressive disorder, kind of between mild to moderate symptoms.” This showed validity for the vignette, as all of the professionals were able to recognize and discuss the symptoms. They also brought up other factors such as relational stress or potential co-morbid fibromyalgia. Two participants, MHP5 and MHP6, spoke about how they saw depression through psychosomatic symptoms such as the body aches specifically. MHP4 also added an Ayurvedic perspective after presenting his

thoughts based on the DSM, and speculated about whether Aarti was feeling spiritually fulfilled. Overall, there was consensus that Aarti was facing some form of depression.

Table 9

Vignette 2 Question 2a: Do you know anyone like Aarti?

Group	Yes	Partially	No
Average Hindu Americans	17%	0%	83%
Clergy	83%	0%	0%
Mental Health Professionals	100%	0%	0%

Table 10

Vignette 2 Question 2b: What did you recommend to them?

Group	Professional Help	Other Interventions
Average Hindu Americans	0%	67%
Clergy	33%	100%
Mental Health Professionals	100%	33%

The next question asked in relation to the Aarti/Depression Vignette was, “Do you know anyone who has been through something like this? What did you recommend to them.” Five of the six participants (83%) said they did not know someone with these symptoms at this severity, and the other participant said he did (17%). Four of the participants offered suggestions, A4 from personal experience, and A2, A5, and A6 more hypothetically. A4 recommended “talk to each other and kind of think about how you're treating each other and why, and what problems you're having with each other and why.” A2 recommended talking to other friends in similar situations, A5 recommended “stepping back from everything and hitting the reset button and reevaluating life at this point and making the correct decisions,” and A6 recommended that Aarti “stay strong. Stand for yourself.” None of the participants referenced seeking help or getting therapy.

In the Clergy group, five out of six (83%) of the participants said they could identify someone whose profile was similar to the one presented in the vignette. Those five shared what they recommended, and of the five, two of the participants, C3 and C6, said that they had recommended talking to someone – family, friend, or a professional mental health counselor. C5 said he would try to talk to the couple himself, noting that change would have to come from within the couple but that he would be there to facilitate through the reluctance. C1 recommended that the husband and wife talk to each other to figure things out, while also emphasizing the importance of self-care through things like *yoga* and meditation as well as doing spiritual things together as a family. C2 recommended meditation.

In the Mental Health Professionals group, all of the participants (100%) said they could identify with someone who was similar to the character in the vignette. They all (100%) said they recommended therapy in some fashion, though some of the participants spoke about the challenges of recommending therapy and added other elements that they felt would be helpful – physical activity, diet, and support groups. MHP6 reflected on how she saw her mother in the vignette, and how difficult it had been to refer her to therapy.

> There are things I would wish to be able to tell her that I think could help mental health-wise to give her more care to her body and her mind. I've also come to a place to realize it's just not gonna ... it's almost going to be more stressful for her and painful for her to let go of some of those things, for her culturally. I can sit here and talk about with my mom how it's ... I just sort of have accepted where she's at and that feels almost easier for me and her. But then you give me Aarti's story, and I'm like, "Yes, let's get her all the resources." And I think of the Western ones and the other ones and the ones that my family uses that aren't approved here, so to speak. It seems harder with people that we know.

Table 11

Vignette 2 Question 3: What do you recommend that Aarti or her family do now?

Group	Professional Help	Other Interventions
Average Hindu Americans	33%	83%
Clergy	67%	67%
Mental Health Professionals	100%	50%

The third question for the second vignette was "What do you recommend that Aarti or her family do now?" In the Average Hindu American group, two of the participants, A2 and A4, (33%) recommended that Aarti seek some counseling or therapy with her husband. Three other participants, A3, A6, and A7, recommended working on the relationship with the husband. A5 recommended taking a break and doing some soul searching. A2 and A6 also added vacationing, *yoga*, and meditation as self-care steps on top of their primary responses to work on the relationship with her husband. None of the participants recommended individual counseling.

In the clergy group, four of the six participants (67%) recommended that Aarti and her husband get professional help. C5 said that he would want to work with the couple himself as a mediator, then recommend the *pranayama* practice, before recommending a mental health specialist. C1 also said "If they cannot figure out by themselves then they can take somebody's help, or professional help." C6 recommended seeking help directly, as did C3, who followed the recommendation to see a mental health professional with things he would do to help the couple further if they expressed interest, including checking horoscopes, doing *yoga* and meditation, and reading the Bhagavad Gita. Two participants (33%) did not reference mental health professionals, and recommended meditation (C2) and "[having] faith in God and [understanding] that this too shall pass" (C4). With the exception of C4, all of the participants began their responses speaking about the couple, using "they" or "them" to identify to whom their interventions were tailored.

In the Mental Health Professionals group, every participant (100%) recommended seeking professional help. The participants also all referenced wanting to be aware of what the client was comfortable with and wanting to support her by finding the prefect intervention, whether it was behavioral or seeking medication. MHP1stated,

> I mean depending on her views of therapy if she's open to it, I'd suggest that. If not, I think I would think about what support she is open to. Is a mindfulness based class something she'd be willing to go to or *yoga* or ... Is she willing to speak to her supervisor about getting support at work. Like what are the interventions that will boost her mood. I'd also recommend that she talk to her primary care doctor about ... I mean I know there's nothing to be found but ... and vitamin D and iron and stuff like that. But, if she is open to therapy I'd recommend therapy and if medication is needed maybe supporting that.

All of the participants in this group also talked about how to help Aarti as an individual. While couples counseling was brought up as a potential modality in one response, overall the recommendations were for Aarti individually.

Table 12

Vignette 2 Question 4: What would you do if you were in Aarti's situation?

Group	Professional Help	Other Interventions
Average Hindu Americans	0%	83%
Clergy	33%	100%
Mental Health Professionals	100%	50%

The final question for the second vignette was "What would you do if you were facing what Aarti is facing," asked with the goal of seeing if the participants would do the same things they recommended to the hypothetical character, or to the friends and family they did know in this situation. In the Average Hindu American group, three of the participants (50%) said that they would speak to their spouse to try to work things out. A4 added that if this did not work, he would consider separating from the spouse and focusing on his career and making sure that the

kids were taken care of. One participant (17%), A7, said that she would try to get feedback at work on her performance to improve in that field, then talk to friends and her family to work through the conflict. Participant A5 (17%) said he "…would probably just go by myself and try to figure things out on my own, "and participant A6 (17%) said she could not imagine being in Aarti's situation stating "I wouldn't let it go to that level." None of the participants (0%) said that they would seek professional help.

In the Clergy group, two of the participants (33%) incorporated the idea of seeking help in their responses. C3 said,

> I personally try to find the strength within to deal with, and I guess I'm blessed that I have some spiritual background which allows me to tap into my own strength, but I'm fully cognizant that everybody may not have that ... be blessed with that. And even then, I think I would have been better off had I had some counseling, in hindsight.

The rest of the participants chose other interventions. C1 said he would focus on establishing a strong routine with diet, exercise, and sleep. C2 said he would focus on his meditation practice. C4 simply said he would "march on." C5 said he would cultivate *prasadha buddhi*, or gratefulness, for what he had, as a counter to depression.

In the Mental Health Professionals group, all of the participants (100%) said they would seek professional help/treatment in some fashion. Two of the participants (33%), MHP1 and MHP3, spoke about starting with their primary care physician, making sure that they looked carefully to ensure there was not a biological factor first, and altering diet and exercise routines before seeking a therapist or psychiatrist. MHP4 said he would reach out to colleagues and work on his personal spiritual practice. MHP5 and MHP6 spoke about how difficult it would be to have insight. MHP6 said "I think that's what scares me the most, the idea of living alone. Because if people don't get to see you every day, I think it gets very slippery with mental health."

Table 13

How would you define 'Mental Health'?

Group	Functioning	Balance/ Peace	Sense of Self	Well-being	Other
Average Hindu Americans	66%	0%	17%	0%	17%
Clergy	33%	50%	0%	17%	0%
Mental Health Professionals	50%	17%	0%	33%	0%

The next question moved the participants away from thinking about the hypothetical characters in the vignettes toward thinking more conceptually about mental health. The question was "How would you define mental health?" In the Average Hindu Americans group, four of the six participants (66%) spoke about ability to deal with the challenges of the world in some fashion. A3 said, "Mental health in a way is just not giving up." A6 said, "Mental health is something I think if you're able to deal with what is happening without getting too cranky, too stressed always." A7 said, "Mental health I think is like taking care of yourself like emotionally and managing kind of how you ... I don't know. Like interact with the world and face … the challenges of the world and things like that." A5 also added to this group's perspective, saying that mental health was being "in tune or intact with the way that they're living and not struggling due to thoughts or some other type of mental ailments." A2 spoke about the ambiguousness of mental health and how it was something that could not be detected in a "laboratory examination." A4 spoke about emotional well-being being dependent on "who you are as a person, what you do, the people you meet," and stated that mental health is "how you feel about all of those things related to yourself."

In the clergy group, three of the participants (50%) spoke about mental health being when the mind was at peace or balanced. C3 and C5 spoke about functioning. C3 said mental health was "being able to deal with your day to day conflict, the day to day situations… being able to experience your own emotions and be able to experience and enjoy your own life." C5 spoke

about mental health as “reliably assessing your own needs and deficiencies and work towards meeting them and overcoming them.” Finally, C6 said mental health was a state of well-being.

In the Mental Health Professionals group, MHP5 spoke about level of functioning and how one engages in the world, MHP1 spoke about an individual client-dependent definition revolving around their ability to tolerate their emotions, and MHP2 said that it is “how effectively we cope with life.” These answers can all be grouped together as thoughts on functioning and coping skill (50%). MHP3 and MHP6 spoke about mental health as overall well-being. MHP4 said “mental health is the realm of your health that has to do with peace and contentment.”

Table 14

How would you define 'Mental Illness'?

Group	Dysfunction	Imbalance/ Lack of Peace	Impaired Sense of Self	Impaired Well-Being	Emotional Turmoil	Other
Average Hindu Americans	33%	33%	0%	17%	17%	0%
Clergy	33%	33%	0%	0%	17%	17%
Mental Health Professionals	50%	17%	0%	0%	33%	0%

The next question required the participants to define mental illness. In the Average Hindu Americans group, two of the participants (33%) said that they thought of mental illness as an imbalance. A3 said, “When you think of diagnosis to illness I think someone who has an imbalance that needs to be treated with a professional's aid” and A7 said “mental illness is something that is just kind of like an innate like imbalance of something in your body and it creates some mental instability.” The rest of the participants explained mental illness in different ways. A2 and A5’s answers were about functioning. A2 said that illness is “anything that I guess causes any of the other factors in your life to be negatively impacted,” and A5 said mental illness is anything that prevents one from functioning on a daily basis. A4 said that mental illness was

when there was something unhealthy in one of the components of mental health, which he defined as emotional, social, psychological, spiritual, and physical well-being. A6 spoke about insecurity as the root of mental illness, along with intense emotions like agitation, anger, and jealousy beyond a level with which one could cope.

The Clergy group's answers to the question "what is mental illness?" were varied as well. C1 and C2 spoke about instability and "lost balance of mind." C3 and C5 spoke about functioning. C3 said it was an "inability to cope," and C5 said mental illness was "a state of mind where we are unable to reliably assess ourselves." C6 defined mental illness as "a sickness of your emotional state or your psychological state." C4's definition was broad, and he acknowledged that it would encompass the majority of people, as he said it was "when we excessively depend on outside things to be happy."

In the Mental Health Providers group, many of the participants (50%) spoke about level of functioning and distress. MHP2 said it was any imbalance that a person experiences that interferes with one's day to day functioning. MHP5 also said that mental illness is when "level of functioning is significantly impacted." In a similar vein, MHP6 added that mental illness is when "our way of being and functioning and thinking and behaving is not working well in day-to-day life." Two responses (33%) were about emotional distress. MHP1 defined mental illness as "either marked or intense moments of or prolonged periods of emotional, physical distress." MHP3 also offered a definition of "a state of, like, emotional turmoil." MHP4's response was not about functioning or distress. He said it was "any kind of persistent perturbation of that peace of mind."

The participants were then asked about their religious identity. They all confirmed that they identified as Hindu, while they differed in their expression of how religious they were.

Table 15

Do you feel any conflict between your religious identity and your understanding of mental health?

Group	Yes	Partially	No
Average Hindu Americans	0%	33%	67%
Clergy	0%	0%	100%
Mental Health Professionals	0%	17%	83%

The next question was "Do you feel any conflict between your religious identity and your understanding of mental health?" In the Average Hindu American group, four of the six participants (66%) said that they did not feel any conflict. A5 qualified his response, saying that he did not feel a conflict between Hinduism and his conception of mental health, but he did see a conflict with "overall cultural background of what is thought of mental illness." Two participants (33%) said they felt a conflict. A2 said he felt that many religious explanations for mental health are lacking, and that these beliefs make him feel less religious at times. A7 said that she personally found faith helpful at times, but saw how there could be conflict. She said that the religious philosophy of being detached might push people to say things like:

> Oh, wait. The religion says we have to this way. But, I'm just struggling right here to like, you know, get a hold of my life right now. I don't have time to worry about like letting go of my attachments or whatever. So, that might be a way that it's perceived that there's like conflict.

Thus conflict that was expressed appeared to be detrimental to religiosity.

The participants in the Clergy group were unanimous in saying that they did not feel any conflict between their faith and their understanding of mental health. C5 did clarify,

> I don't find that there's any conflict but I do think that we have to define our terms very carefully. The problem that the religion that I follow attempts to address, is the fact that material pursuit cannot give us happiness and that is because we are ignorant of our true

> nature, so the solution to that problem is self-knowledge. But I don't think that in America we can define mental illness as not knowing your true nature because if that's what mental illness is, everybody is mentally ill. But that's not a useful definition as far as like, people needing help from mental health specialists because that's not what mental health specialists really offer. They offer something else. So I think we just have to define our terms carefully but I don't think there's any conflict.

C6 said that while she did not feel a conflict, there was "an absence of Hinduism really outlining mental health issues," indicating that she felt that there was not an overlap between faith and mental health.

In the Mental Health Professionals group, five of the participants (83%) said that they did not feel any conflict between their faith and their understanding of mental health. MHP2 and MHP3 said that they found that their faith actually aided them. MHP2 said "In fact, I have used my own religious identity to understand and also explain to my patients their conflicts are their sufferings," and MHP3 said "In fact, I would say that it has aided my understanding of mental health." MHP1 said that she found that "the Hindu traditions can be causes or can contribute to either mental health or mental illness." While she found that "our faith traditions can be really healing and really grounding and really centering when we're in the midst of dealing with mental health issues" on one hand, on the other she struggled with the fact that "because there's not an understanding of what mental health is generally speaking, it can perpetuate someone's illness or suffering just due to unawareness," In line with this, she shared an example of a priest who did not understand mental health and recommended praying more.

Table 16

Have you felt mentally ill or sought professional help?

	Have you felt ill			Have you sought help	
Group	Yes	Maybe	No	Yes	No
Average Hindu Americans	0%	33%	67%	17%	83%
Clergy	17%	33%	50%	0%	100%
Mental Health Professionals	-	-	-	67%	33%

Table 17

What, if anything stopped you from seeking help?

Group	Family/Friend Support	Cost/ Logistics	Don't need help	Cultural Competence	Stigma	Other
Average Hindu Americans	66%	17%	0%	0%	0%	17%
Clergy	0%	0%	83%	17%	17%	0%
Mental Health Professionals	0%	17%	33%	17%	33%	17%

The next set of questions required the participants to think about themselves and their own mental health. The next question had three components that the participants usually answered together – "Have you ever felt mentally ill yourself? Have you sought help? What type? What, if anything stopped you from seeking help?"

The Average Hindu American group responded to the component about feeling mentally ill themselves in different ways. Four participants (66%) said that they did not feel that they were ever mentally ill. One participant (17%) said he had sought help, but that he did not know how to answer the question. The final participant was reflective in expressing that he was not sure whether he was or not. A2 spoke about time in college when he "probably should have seen somebody for [his] drinking" but did not because "everyone was doing it".

Asked if they had ever sought help, five of the participants (83%) said that they had not. Participant A3 said she had thought about it and A4 said he had gone as far as looking online, but neither saw a therapist. A5 (17%) said he had sought treatment.

All of the participants were asked what the barriers were to seeking treatment. A5 said he did not know how to answer the question, as he had sought treatment. Four of the participants (66%) said that they felt that they could talk to their own friends and family. A7 said,

> I mean, well, I think like you know you kind of start with your family. Like, I don't know, for me like if I ever had issues with anything I'd start with my friends or my family, you know? Then I would go from there. And usually I've been able to find the support I've needed from my friends and my family. So, I haven't had to really to go much further than that. You know?

A2 said that a barrier was comparing to peers, and feeling that behaviors, particularly his own binge drinking, were social norms and did not merit concern. A3 added that on top of feeling that family and friends were enough, cost was a barrier, as well as the difficulty of knowing how to find a therapist. Sharing,

> I wouldn't know where to go, where to start. I know that I said earlier that you can go to your primary care physician and then they can recommend something, but I don't have a PCP right now, so that's another barrier. Because once you're moving out of your household that you grew up in, your parents aren't there to help guide you. They're not like, "Here's the dentist you go to, here's the doctor you go to." It's kind of like urgent care has made everything so easy that you don't need to have a primary care physician.

Overall the group was unlikely to say that they had ever felt mentally ill, largely because they felt they could rely on friends and family for help.

In the Clergy group, three of the participants (50%) said that they had not experienced mental illness. C4 said that in his upbringing, “we don't know what mental illness is, mental illness is a privileged disease of affluent society.” The other two participants expressed hesitation to use the words “mental illness” to describe what they had experienced, but noted that they had struggled at times. C3 said that he had faced what Aarti, the character with depression, had faced, but it was unclear if he considered this mental illness. Additionally, C2 said:

> When I look back I can now feel that, yes, though some years ago in those circumstances, probably I was not quite ... I had some sort of a complex so to say. I won't say illness, but a complex, that I didn't have a proper perspective of certain things. No, at that time I was not aware that I have a perspective problem due to complexes. Now when I look back, I am able to feel so. At that time, I must have thought I am quite normal.

One participant, C5, (17%) said that he had personally suffered from a mental illness. None of the clergy (0%) said they sought professional help.

Five of the participants in the clergy group (83%) said that the main barrier to seeking help was that they did not need it. C3 stated the sentiment, as “I just wanted to challenge myself to do it on my own. I had to convince myself that no, I'm not sick. My circumstances may be challenging me and I have to learn how to deal with my circumstances.” C1 said that a barrier would be that he would not want to work with a stranger or with someone from a different cultural background:

> I would go to somebody who is a professional but who is a close friend. If I were in India, I would've gone to a stranger also. But in America, I really feel as I said earlier, that I'm not sure if the professional, if he's not from my background, he'll really understand me. And where I'm coming from.”

C3 said that stigma would stop him, as well as the desire to challenge himself.

In the Mental Health Providers Group, no participant clearly answered the question "Have you ever felt mentally ill yourself," and they went straight to the question on seeking help, beginning their responses to the question by stating whether or not they had sought help. Four of the participants (67%) said that they had sought help. Of the four, three said that they had sought resources through a requirement of their graduate training. According to MHP1, "it just mostly was like you got to go to therapy because you're in grad school so I went." Two of the participants (33%) said that they had not sought help.

The participants offered several different barriers that may have impeded them from seeking professional help. MHP1 spoke about stigma.

> Yeah. I think the cultural shame like Indian people don't go to therapy. Or, at that point no one I knew that was Indian was going to therapy. I think also for me I think because there is a stigma in our culture about mental health, not wanting my parents to think they did something wrong or something's really wrong with me because I'm going to therapy. I think that would've gotten in the way if it wasn't mandated by my grad school.

MHP3 said that while she was open to seeking help, she never felt the circumstances called for getting professional resources because she had the internal and external resources to help her. MHP4 also said that he felt he received what he needed from meditation, but added, "I mean I wonder if there is some amount of stigma. It's not something that I'm consciously aware of but I find it hard to believe it's not playing some role." MHP6 cited several reasons, including not knowing the logistics of how to find a therapist, struggling to spend the money on therapy ("and I had a hard time spending money on something like that. That felt extra"), difficulty finding a culturally competent therapist, and procrastination.

Table 18

What, if anything, stops other Hindu Americans from seeking help?

Group	Family/Friend Support	Cost/ Logistics	Don't need help	Cultural Competence	Stigma	Other
Average Hindu Americans	0%	50%	0%	0%	100%	0%
Clergy	17%	0%	0%	33%	100%	50%
Mental Health Professionals	33%	0%	0%	50%	100%	50%

The participants were then asked what they felt stopped other Hindu Americans from seeking help. In the Average Hindu American group, each participant offered several responses. All six of the participants (100%) mentioned stigma or the idea that it would be a disgrace to seek treatment. A2 differentiated between physical illness and mental illness, saying "where there is a mental illness, people blame the family or the circumstances and that makes it harder to get help." A4 added, "A lot of people do think that mental illness is not a real illness." A5 reflected that peoples' "inner perception of what they think of themselves because they have to seek help" may be a challenge; and A5 said that "accepting something wrong is happening with me" might be associated with "real serious consequences" in a way that "heart disease" is not. Additionally, A7 offered, "People think that they can't be helped. They, you know, that what they are going through is so unique to them that nobody understands." Two of the participants (33%) mentioned cost as a barrier, and another (17%) added that the logistics of finding a therapist could be very daunting.

The Clergy group also responded to the question about barriers to seeking help by all (100%) speaking about stigma, and the idea that seeking help meant that something was wrong with the person, or that people would think less of them. C2 speculated that a factor that increases stigma is that Hindu Americans "lack privacy, they have less respect for others' privacy." They also brought up other factors. C1 spoke about how there seemed to be "nobody

who can give specifically for Hindus professional help," and C5 also spoke about the need for cultural similarities between therapists and patients, meaning 33% of the participants spoke about cultural competence. C3 spoke about ignorance, saying it may be a larger problem than stigma. He defined ignorance as "not knowing the difference between what is mentally healthy and what is considered to be mentally ill." C6 thought that part of the reason that the community does not speak about mental health is because the first generation of Hindu Americans was working too hard to worry about mental health. She saw promise in that the second generation was becoming more open to talking about mental health. C4 expressed his skepticism about the effectiveness of therapy, and wondered about therapists practicing who were themselves unhappy or mentally ill: "yeah people get certificates but it doesn't reflect in their life and when it's not an integral part of the life you really cannot help others. You can get paid but you can't really help others." C4 also added that the culture of strong families precluded the need for therapy.

The Mental Health Professionals group also all (100%) cited stigma in some form, speaking about people being afraid that seeking help made them weak. MHP1 spoke particularly about the "shame" that comes with the idea of "something must be really wrong with me that I need therapy" and the way that people connect character and mental illness." Three participants (50%) also spoke about cultural competence, and the difficulty of finding a therapist that people felt would understand them. MHP4 added that this is difficult because people may fear being vulnerable and risk the idea of exposing their weaknesses only to find that no one can help them. MHP6 added that in addition to the issues involved in finding a culturally competent therapist, racism and power dynamics add further complications: "I think it's hard to trust a system that wasn't created within a community, at least in the States." MHP3 also spoke to this, stating:

> This would be more of a challenge that they face, here in, as they identify as not being part of the dominant culture. So, you know, what if suggestions from me that do not fit our culture and do not fit my values. And also, because there's a really hard line that they draw with disagreeing with authority. So feeling like they need to agree and obey and they do place their therapist as having power and authority. And so, you know, I really quite disagree with them, at the same time, what they are asking me to do is so uncomfortable. So, that's the sort of break. So there's all of this that they're thinking about before they even walk into a therapist's office or walk into receiving mental health services.

MHP6 also added that the immigrant culture makes it difficult to accept needing care, stating "Mental health difficulties sometimes feel accepted in the family as just part of the struggle." She further added that:

> there's so much value in our culture, at least the way I've learned it in my family of taking care of each other, that sometime mental health and the idea of taking care of ourselves, the way that it's framed doesn't fit.

MHP2 also added that people "don't seem to value psychiatry as a branch of medicine." Three of the participants (50%) spoke about Hinduism and Hindu philosophy itself as a barrier to seeking help. MHP1 said, "I think about Hindu idea of correct behavior and our behavior leads to suffering. There can be sometimes this like I must have done something bad because I'm suffering. I think those things can prevent people from getting therapy." MHP4 stated,

> The traditional Indian medicine doesn't really emphasize mental health as like a medical thing. It's not an illness it's more of a spiritual ... It's something that's addressed more through spirituality. So I think that like if you look at ... I mean even now if you look at Ayurvedic treatments across the world, there's very little emphasis on mental health.

MHP6 said,

> I think we have so many ways of healing that sometimes it feels like we don't need this extra thing. So, I think a lot of people like to try things that they know of first. I think when we think about things like therapy especially and the way that it's done through talking ... talk therapy I should say, specifically ... feels very different.

MHP2 brought up the idea that people may think that if they had family or friends to talk to, then they would not need therapy.

The Clergy and the Mental Health Professionals were asked questions specifically tailored to their professions. The first question posed to only the Clergy was "How do you counsel those who come to you who may be mentally ill?" Three of the participants (50%), C3, C5, and C6, incorporated telling the people that sought their services to seek professional help. C1 and C3 spoke about the necessity of starting a conversation that invites the person seeking help to feel comfortable opening up, and the need to fully understand what is going on for the person first. They also both added that giving the person hope that everything would be all right would be important. C1 said he would recommend a change in the routine and, potentially, *yoga*, meditation, and prayers to help the person cope. He also added that he would make sure the person knew that they could contact him at any time for support. C5 said,

> based on my personal experience, whatever anecdotal help I may be able to give, I will offer it, but I will always give that grain of salt, "That you have to be aware that it's possible you need some professional help." I try to, as much as I can, de stigmatize it. Because culturally, Indian people are not ready to hear, "You may have a mental illness." They do not consider it like any other illness, they think of it like some taboo thing. So part of my work, when I meet people who I suspect need some professional help is, showing them that it's okay.

C4 was one of the participants that did not incorporate seeking professional help in his answer. He said,

> I always tell them that I am not a counselor so I really cannot counsel because I'm not a trained professional. But because they know me, and they believe in the scripture, obviously if they come to me they believe in the scripture, then I ask them to read scriptures and more importantly do some japa. And I also ask them to come and listen to me every Sunday because the more the understanding the better they will accept the world.

C2 said that he did not think "that anybody comes to [him] for advice for mental health or something like that." He added "but I can see sometimes somebody's face and I can feel this person is going through depression or he's a depressed person. But generally, I wouldn't say anything to him. I would just encourage him to learn meditation." C6 qualified that the questions she gets are not about mental health issues, but added:

> I mean, hypothetically if someone was to come to me with a mental illness, I think, like I said previously, I would encourage them to talk about it and not suppress it, to reach out to either a professional or I'm willing to have a conversation about it, too.

Hence, the Clergy were split in how they counseled their parishioners and what they recommended.

The Clergy were then asked "Do you feel your faith helps or hurts you in your counseling?" Four of the six participants (66%) said that faith definitely helps in their counseling. Participant C6 said,

> I don't know. I think I'm in the middle. I definitely don't think it hurts me because I think Hinduism has a lot of positive attributes that over and over again in our spiritual texts we see characters who have done the right thing for the right reasons, and so I definitely

> don't think it's harmful. As far as helpful, I mean, I do think there's definitely, like I said, some positive attributes in Hinduism that allow people to feel certain ways.

Participant C2 (17%) said the question did not make sense because faith grounded everything he did.

The Clergy were then asked "How do you feel about advising people to seek services?" Five out of the six clergy (83%) affirmatively said that they would advise people to seek services; though they varied in how quickly they would suggest it. C1 said it would come "second or third" in his suggestions, because:

> I also know that it'll take a while for them to accept it and also I feel that many times I also have a hesitation, that's why I'm saying that the second and third option would be professional, is that I also know that culturally compatible professional help for Hindus is less accessible in America.

C2 said that hypothetically, if he felt that it was difficult for someone to even learn meditation because of their situation, he would advise them to see a psychiatrist. C3 said that "I think more and more people are realizing that this is a conversation that needs to be had, even in the medical community," and noted that he was particularly able to speak to them and make them feel comfortable:

> The thing I have noticed is when I'm present in the temple, people will talk. If the same person was to meet me in a public supermarket, no, they would not talk. The temple has a tendency to open people up.

C5 said he would not have an inhibition in recommending therapy "if it was a necessity." C6 emphatically stated "Yeah. I'm all for it. I think that's why professional services are there." The sixth participant, C4 said:

> Personally, ok, I'm a little skeptical of the professional help because many times you know it's very easy to get you to feel good but it doesn't solve the problem, it's a temporary feeling. It doesn't really help. Unless one faces himself and changes himself from within. It's a temporary relief.

Thus, the Clergy expressed some skepticism in response to this question.

After the question "Do you feel any conflict between your religious identity and your understanding of mental health?" the Mental Health Professionals were asked "Do you feel any conflict between your identification and your practice?" Four of the six participants (66%) said they did not feel any conflict. MHP1 added, "one of the premises that kind of drives my clinical practice is just believing in the inherent worth, inherent dignity of the person sitting in front of me. That value is something that I've learned from the Hindu faith." MHP4 and MHP6 described their conflict. MHP4 said,

> Conflict ... I don't know if I would use that word but I'm mindful of the very scientific community that I'm a part of and that while there is some sort of openness to spirituality I think religion is something that can sometimes be frowned upon. So I'm mindful of the elements of my approach to mental health that are viewed as unscientific that are probably founded in my religious studies. So there are a lot of things that I think would benefit patients that I do not engage in or recommend because they don't fall under the umbrella of "Standard of Care" or "Evidence Biased Medicine." I feel restricted.

MHP6 said, "Sometimes I have an inner conflict with the way we were trained and feeling sometimes at a loss of how to practice healing for mental health in ways that fit indigenous practices a little better." She also spoke about mindfulness, stating "I have sort of an inner conflict with the way that mindfulness is used in the psychology field." She described the

conflict between wanting to disseminate a practice that people found useful, and frustration with the way that mindfulness is separated and distanced from its roots in Hindu spirituality:

> I feel like it's been appropriated when it's sort of cut off from the history. And you can't ... I get frustrated just knowing that these are the practices as a kid that I used to get made fun of. So, when I think about the way that meditation and *yoga*'s brought in, it feels like just another way that ... you can't take something from a people and then not take the people with it. I think the idea of giving it away to people is great. But if feels like it's only in pieces. Like people are picking and choosing the pieces they like. Like I'm gonna disconnect from the idea that this is a lifestyle and it's not just something that you go from a one hour class and come back. It's actually not meant to make you relaxed. That's not the goal or purpose.

Thus some elements of cultural competence as it relates to cultural appropriation were brought up.

The next question that was posed specifically to the Mental Health Professionals Group was "What do you think providers can or should do in order to engage Hindu Americans in mental health treatment?" The providers came up with several responses. Four of the participants (66%) spoke about the necessity of outreach, psychoeducation, and building relationships with the community. MHP3 said, "It's to do more outreach activities and to go to where the individual is rather than expecting the individual to come to where you are." She added that part of her outreach is altering the language used:

> So kind of, reducing, taking away the words that are heavy like psycho-therapy words or psychology terms and turning them into more layman terms. And so I've also noticed, choosing the language has helped a lot of time to bring themselves in.

She also added that she uses religion and prayer in her outreach efforts. Two of the participants (33%) spoke about providers needing to learn more about the culture. MHP1 said,

> Part of it for me feels like just being curious and in some ways being open to the things we learned in graduate school not working and that not being pathology of the client. There's different ways of being which deserve benefit of the doubt.

MHP6 said, “Learning more about the religion, the culture, is step one.” Two of the participants (33%) said therapists could work to start a conversation that invited people to be comfortable with seeking help. MHP2 shared a story of planting the idea in the mind of a friend who expressed skepticism about the benefits of psychiatry. He told his friend that psychiatry could be useful to anyone at any time. The friend returned after 3-4 days asking if that was really true. He responded,

> See, I had just planted a little seed in your mind and you came back to me 3 days later because you've been thinking about it constantly. You started to ruminate and worry about “what if?” A simple sentence caused a sense of anxious nervousness within you. So this was a very, mild internal feeling, which is going to be gone by the end of our conversation today. But it can happen. So if you notice somebody going through it, then you should tell that person, “Hey go see somebody.”

MHP4 said,

> So I think providers need to assess what a patient's understanding of what's happening to them is. And then sort of invite the possibility of mental health treatment actually being helpful. Maybe the biggest thing is to explore with patients what it means if they engage in mental health treatment. Like what does that mean if you're someone who sees a psychiatrist? How do you think that affects who you are? Yeah. I think it's important for patients to have ... I think if you actually want people to engage in mental health

> treatment, they have to be at a place where they can do that internally. They have to be able to accept that this is something that could help them and that who they are as a personal doesn't necessarily change.

At the same time, he added, “I think for some patients, it may actually be better to just be very directive and rather than explore things, to just make a medication recommendation.” MHP6 added the necessity of mental health professionals reflecting on their own biases. MHP5 added a systemic suggestion:

> A one stop shop might be helpful. Basically, if a person is going in for something medical, medical as in like a physical illness, using that as an avenue to say like okay, is this person suffering, also from maybe depression, or anxiety, or PTSD, or something else and having somebody in house that the person can consult with maybe right away. That might be one way of engaging certain populations where there is a bit of stigma for seeking mental health treatment.

Discussion

In this section, the responses to each question are analyzed in order to make meaning of them. The responses of each group are examined, trends across the groups are then assessed, and finally larger themes that emerged from this analysis are discussed, and the section ends with implications for treatment and for psychoeducation.

Themes from the "Rakesh" vignette

Conceptualization of Rakesh and schizophrenia. Overall, in response to the set of challenges meant to mimic schizophrenia, the Average Hindu American group responded to the question "what do you think is ailing Rakesh" by focusing on financial stress and substance use as the primary problems. The vignette ended with Rakesh's delusions and possible hallucinations, but these symptoms were largely ignored as the respondents focused on the finances and substance use. It is possible that the participants were internally thinking that the stress may have caused a psychotic break, or that the substance use was leading to psychosis, leading them to focus on those "causes." However, this is entirely speculation, as none of them articulated any biological roots to the character's symptoms or spoke about the psychosis, or its causes, in any way. To a large extent both financial stress and substance use are external explanations for Rakesh's symptoms, rather than explanations that rely on Rakesh's internal state, descriptions of his mind, or biological factors. This is striking given the American public's growing understanding of schizophrenia's biological roots (Pescosolido et al., 2010). This may be reflective of an overall trend in the community to find external roots for certain problems, particularly ones that involve psychosis or severity. This finding may speak to norms within this group related to perceptions of locus of control. There has been no research in the last 20 years on locus of control in Hindu, or even Indian populations, specifically; however, the findings in Asian American societies have been mixed. Some studies have shown that Asians and Asian

Americans have a more internal locus of control than their Caucasian counterparts (Brown et al. 2007). Other studies have shown the opposite, indicating that Asian-Americans tend to hold a more external locus of control (O'Hea et al. 2009) than European Americans. Norenzayan and Lee (2010) and Yeh et al. (2006) found that the "fatalistic" beliefs of Asian cultures (for example, the belief in *karma*) are associated with external loci of control. Other research has found that loci of control may be different in different contexts, as Asian Americans tend to have a high internal locus of control with regards to academics (e.g., Si et al. 1995; Stevenson and Stigler 1992). Based on this, it is possible that while Hindu Americans have an internal locus of control for academics, where they are very successful, they may have a more external locus of control with regards to certain aspects of mental health and well-being, like psychosis, where they have little knowledge or experience. This difference could be a product of comfort with external roots, and avoidance of looking inwards or at the mind for causes of difficulties when it comes to something as severe as psychosis, because external factors seem easier to treat. Frawley (1997) did say that according to Ayurveda, the environment conditions the mind, and the Average Hindu American's responses may be focusing on that aspect when thinking about Rakesh and the severity of his symptoms. This way of thinking about Rakesh and the externality of his symptoms is also reflective of how Average Hindu Americans conceptualize mental health, because the treatments for "financial stress" and "substance use" are also thought about differently than the treatments for biologically based or internally rooted disorders, as the next question further shows. The inability of the group to engage fully with the psychotic part of Rakesh's presentation and make meaning of it is an indication that psychoeducation about schizophrenia will be important for the broader Hindu American community. Thinking of schizophrenia in this disjointed, avoidant way may perpetuate the stigma that has been found to be so detrimental to those who suffer from the disease (Corker et al., 2015).

The Clergy group appeared to assess stress more generally, rather than specifically through the lens of finances, by looking at the closing of the business. This is important because general stress and financial stress may be thought about differently, as general stress can be through of as leading to chronic stress while financial stress may be more acute and related to immediate problem solving. Chronic stress has many more negative health implications than acute stress, which is considered more adaptive (Lovallo, 2015). The Clergy may be focusing on the chronic element of Rakesh's stress due to recognition that it is more problematic and internally driven, rather than circumstance driven, and in need of specific psychological treatment. Only a minority of the group brought up alcohol, and they referenced it as a symptom rather than identifying it as a main root of Rakesh's problems. The responses about Rakesh failing to seek help and the problem with an "idle mind" are also more internal, mind-based explanations for his symptoms. The response about an idle mind certainly follows the Hindu Ayurvedic perspective of mental disease being a mind that is not in full control (Frawley, 1997), and all of the responses looking at Rakesh's response to stress as being an internal struggle to cope with the given situation can be thought of as following the Hindu conceptualization of mental disease as an agitated mind. This is possibly due to their profession and the deeper understanding of the Hindu conception of mental health, which sees all mental illness also as a severe imbalance in the mind (Frawley, 1997). This imbalance can be caused by environment and external factors, as the previous group seems to have grasped, but the Clergy appear to be looking directly at the impact on the mind, potentially due to their greater familiarity with Hindu scripture. They did not speak of psychosis, however, so there is still an apparent avoidance of the most severe feature of Rakesh's profile, which may be best explained by unfamiliarity with said symptoms (Ogurchukwu, 2016). Another potential theory behind the ignoring of the psychosis is that, beyond it being alarming, it was confusing and they simply did not know how to speak

about or reference that with which they were not familiar. Indeed, Gronholm, Thornicroft, Laurens and Evans-Lacko (2017) found that the six themes that stopped people from seeking help for their psychosis were "'sense of difference,' 'characterizing differences negatively,' 'negative reactions (anticipated and experienced),' 'strategies,' 'lack of knowledge and understanding,' and 'service-related factors,'" (p.1867) showing that lack of knowledge and understanding of the disorder is indeed an impediment. Penn et al. (1994) found that participants expressed more stigma after hearing the description of symptoms rather than hearing the label schizophrenia alone, further adding evidence that the symptoms may be what people find most alarming. It is also notable that there are indications of very little literacy on schizophrenia in the Hindu population (Ogurchukwu, 2016).

The professional identity of the Mental Health Professionals group is reaffirmed in their unanimous consent that Rakesh is suffering from a mental illness. They all acknowledged the external factors with which Rakesh is dealing in terms of the impact of alcohol on his relationships and the impact of his financial difficulties, but grounded their belief of what is really "ailing" him in internal factors – his mental health, his psychosis, his experience of shame. This group looked at Rakesh's presentation holistically, likely due to the fact that their professional training has involved a great deal of psychoeducation about schizophrenia already. That this group was able to see Rakesh in a human way and understand how all the factors were related is further evidence that psychoeducation could help the other groups see Rakesh in the same way.

Overall, the three groups responded to the same vignette and the same question in different ways. The Average Hindu American group was the most likely to place the root of Rakesh's problems in his finances and substance use. This may be reflective of an overall trend in the community to find external roots for certain problems, particularly ones that involve

psychosis or severity. The Clergy group was more likely to give an internal explanation for Rakesh's symptoms, potentially thanks to their professional identities and deeper knowledge of Hinduism. Though it may be unclear what led both the Clergy group and the Average Hindu American group to ignore the psychosis in their conceptualizations of what was ailing Rakesh, it is clear is that psychoeducation about schizophrenia will be important as a step to reducing stigma. The Mental Health Professionals group spoke clearly about Rakesh's mental health and potential mental illnesses that may be driving his symptoms. They were the only group that spoke about Rakesh's psychosis, showing that they considered all parts of his symptom profile, unlike the other groups, which appeared to avoid speaking about the most severe symptoms entirely. This is expected given the professional identity that binds the group, but it is worth noting that the Hindu part of the group's identity may be manifest in the fact that the members of this group also worked to understand the context surrounding Rakesh, and the cultural factors driving his experience.

Help-seeking for friends and family like Rakesh. The next question was "Do you know anyone like Rakesh? What would you recommend to them?" The results indicate that more than half of the Average Hindu American group was able to relate to knowing someone who had symptoms similar to the symptoms of the schizophrenic individual described in the vignette. This is surprising given that schizophrenia only affects 15 out of 100,000 people (McGrath, Saha, Chant, & Welham, 2008), and likely results from the fact that this group is focusing on the non-psychotic features of Rakesh's symptoms. Half of the participants recommended professional help, and the other half, even given the severity of the symptoms described, did not consider mental health resources in their answer, and focused on talking to Rakesh themselves. Research has found that social support, or an explicit form of support entailing disclosure to others and reliance on others for assistance or emotional solace (Taylor, 2011), is an important factor in

help-seeking (Maulik, Eaton, & Bradshaw, 2011). Chang, Chen, & Alegria (2014) found that Asian Americas were less likely to rely on, or disclose to family and friends, in comparison to White Americans, which meant that they were also less likely to use informal mental health services. The researchers predicted that their results meant that friendship ties could help Asian Americans overcome barriers to mental health treatment. Indeed, Vogel et al. (2007) found that 75% of people who decided to seek professional help had known an individual who recommended treatment. Thus, it is possible that if this half of the participants did not think of or recommend mental health resources in this situation, with severe psychosis, that they would be unlikely to recommend professional services for their friends and family with lower levels of distress, to the detriment of the community.

The Clergy group's response to this question was very similar to the Average Hindu American group's responses, despite the fact that they conceptualized Rakesh's symptoms differently in the first question. Half the group could relate to knowing someone with these symptoms, and half the group suggested professional resources. A third of the group focused on what they themselves could offer—religious coping strategies—even as one participant recognized that religious coping strategies would be difficult in the moment given that the character was struggling so acutely. This is also similar to the Average Hindu American group, where those who did not recommend mental health resources focused on what they themselves could offer their family or friends, rather than considering seeking professional help. There are many potential ways to interpret this. It could simply be that these two groups offer only what they can personally offer because they feel unknowledgeable about anything else that could be offered, and are most comfortable with working within their own skillset. This theory is partially supported by literature that shows that Asian Americans adopted coping strategies that relied on familial and social ties when they had strong networks, instead professional help (Yeh & Wang,

2000), as well as research that shows that individuals are less likely to seek professional help when they have social support (Maulik, Eaton, & Bradshaw, 2011). It is also possible that there is skepticism that other avenues, like professional help, could actually work. The Clergy communicated this skepticism throughout their interviews, supporting this theory. It is also possible that they are following the Hindu idea of preferring a "spiritual friend" for healing rather than seeking a distant stranger. Ultimately, however, the inconsistency in the groups' usage of Hindu psychology concepts in their conceptualizations and responses necessitates more research to identify which theory drives the findings that these groups were unlikely to recommend professional help to friends and family. However, understanding that their unlikeliness to recommend professional mental health services is indeed a pattern or trend among the participants, and that this trend has been shown to decrease help-seeking behavior, should guide future implementation of psychoeducation in addition to future research. There is a possibility that simply understanding what therapy consists of, and the impact of being able to talk openly with friends and family while also recommending professional services, would be a meaningful intervention in changing the behavior of how Hindu Americans talk about seeking help within their communities.

The Mental Health Professionals group's responses did differ from the responses of the other two groups. They all found the character profile familiar, and they all recommended professional help. The first component is likely due to their professional work, and the frequency with which they are able to see different symptom profiles. The second component also likely stems from their work and their conviction in the power of professional resources. If it is accepted that the Average Hindu Americans and the Clergy offer what they know best and draw from their own personal skillsets when figuring out how to help, it follows that the Mental Health Professionals do the same, and recommend seeking professional help because they know

how and because it is a strength in their own skillsets. Their cultural competence, whether stemming from their identities as well trained Mental Health Professionals or as Hindu American minorities, also appears to increase their awareness of the barriers that may exist. They also display a greater ability to think through how to ease individuals into seeking treatment, however slow that process may be.

Overall, the Average Hindu American and Clergy groups had responses that were very different from the Mental Health Professionals group. About half of the first two groups could identify with knowing people who met the profile in the vignette, versus the totality of the third group. This is important because contact with people suffering from an illness has been shown to reduce stigma against that illness (Rüsch et al., 2005; Kolodziej and Johnson, 1996; Desforges et al., 1991), and increasing contact is an important step in reducing stigma. The first two groups only had half of their members recommend professional services, while the Mental Health Professionals group was unanimous in their prescription. This question was framed to make the vignette less abstract and more tangible in order to see how the participants would respond when thinking about their friends and family in the given situation, particularly if they could recall a specific friend or situation in which they were called to offer guidance, support, or advice. Half of the Average Hindu American and Clergy groups could recall a specific situation, and they recommended treatment. The other half of these groups did not consider treatment, even given a vignette with severe symptoms and psychosis. In addition to the research showing the power of individuals being able to recommend that friends and family seek professional help, Thériault and Colman (2017) found that when participants were aware of the treatment histories of family and friends, they were more likely to seek help themselves. This shows that if participants were not speaking to their friends and family about treatment, they were less likely to seek help themselves, as the next question demonstrated. That they put less emphasis on seeking help and

more on offering their own skills, is likely indicative of the way they perceive symptoms of mental distress, as well as their limited knowledge of, comfort with, and faith in professional resources. This finding points again to the importance of using psychoeducation to make sure that Hindu Americans fully understand what schizophrenia and other mental illnesses look like, and are then able to use that knowledge to understand the necessity of having open conversations with friends and family. Ultimately, this has been demonstrated as a strong way to address increasing help-seeking and decreasing stigma.

Help-seeking for Rakesh. The groups were then asked to again focus on Rakesh, with the question "What do you recommend that Rakesh or his family do now?" The participants in the Average Hindu American group differed in how exactly they would recommend professional resources to someone in Rakesh's position, but they all recommended that he seek help outside of his family and friends in some fashion. It was of note that the recommendations varied from emphasizing that family or friends should not be relied upon to indicating that family and friends should be a first resort with professional help as a backup. While only half of the group considered mental health resources when initially asked to speak about anyone they knew personally who was "like Rakesh," they were more open to suggesting mental health resources when the vignette was made abstract again and they were asked what they would tell the fictional character. This ability to recommend resources to the fictional character, while avoiding mentioning these resources for someone they actually know, is likely driven by stigma and the complicated feelings the group may carry about the implications of having a conversation with close family and friends that involves telling them to seek professional resources. The implications would likely feel very different for offering the fictional character the same recommendations. Indeed, Lee et al. (2009) found that Asian American adolescents said that they did not often hear about mental health problems from peers, and that their peers were likely to

hide what was going on for them if they were suffering from mental health distress. This stigma is likely partially driven by the Hindu idea that being surrounded by positive influences and good environments should be enough to sustain good mental health (Frawley, 1997). Participants may have been going back and forth between the ideas of mental health to which they have been acculturated in the United States and their internalized Hindu ideas of mental health in order to give the interviewer an answer for Rakesh that felt "correct" based on the fact that she was a psychologist. However, when presented with greater personal connection or investment, their desire to hold on to their beliefs when thinking about family and friends may have been stronger than their desire to appear correct to the interviewer.

The Clergy group differed from the Average Hindu American group, while staying consistent with their answers to the previous question. When asked if they knew people like Rakesh and what they recommended, half of the group said they did and a majority of the group recommended professional help. Here, asked more abstractly about what they would tell Rakesh, they were slightly less likely to recommend professional help. This may be a mark of their conviction in their spiritual practice (which they were more likely to recommend in the hypothetical situation) as a solution to the problems faced by Rakesh or by friends and family. This would imply that the ways to talk to the Clergy about mental health are different than the ways to talk to Average Hindu Americans, seemingly dependent on familiarity with, and conviction in, spiritual practice and spiritual conceptualizations of illness and health. The Clergy are likely the most familiar with Hindu concepts of mental health given their familiarity with scripture, which may lead them to be consistently wedded to that way of thinking rather than changing their suggestions dependent on the context of the person about whom they are being asked. While the Average Hindu American group seemed to be more influenced by the impact of stigma, given that they were willing to tell Rakesh to seek professional help but not their friends

and family, the Clergy group seemed rooted in their beliefs about spiritual practice, regardless of whether they were talking to an abstract character or their friends, family, or parishioners. This further adds to the argument that the Clergy are skeptical that professional mental health services are effective, and that this is why they consistently avoid recommending them. Research has found that perceived benefits of mental healthcare are an important part of psychological help-seeking, as those with lower perceptions of benefit are less likely to seek help (Henshaw & Freedman-Doan, 2009; Kung, 2004). It has also been found that Asian Americans perceive lower benefits to therapy, and that this accounts for some of the lower utilization of services (Kim & Zane, 2016). Potentially, generating a change in the attitudes of Hindu American Clergy will require building their faith in the efficacy of professional mental health treatment, as well as increasing their understanding of how professional services can complement, without competing with, religious practice and fill gaps where religious practice does not extend as a treatment.

As shown previously, the Mental Health Professionals group consistently stated support for seeking professional resources, while half of them also cited working to be culturally competent. They emphasized understanding where the client/character is in their understanding of what would be helpful, to tailor treatment, while standing firm on the need for therapy and intervention.

Overall the three groups differed from one another. The Average Hindu American group stated that Rakesh should seek professional help across the board, half of the Clergy group recommended treatment and emphasized spiritual practice as the solution, and the Mental Health Professionals group unanimously touted treatment. This shows that psychoeducation is necessary to increase help referring behaviors.

Help-seeking for self in Rakesh's position. The final question of the first vignette asked the participants to look within themselves, and respond to the question "What would you do if

you were in Rakesh's situation?" Overall, the Average Hindu American group was unlikely to seek professional resources themselves. Most of the group did not reference professional help, and the two that did spoke about it as a last resort. This follows the pattern established across the last two questions. When asked about the fictional character, they all advocated for seeking help. When asked what they had recommended to friends and family in the same situation as the character, they were less likely to recommend seeking help. When it came to thinking about what they would do themselves, they were even less likely to seek professional help. This follows all of the literature that shows that the broader Asian American population is unlikely to seek help (Abe-Kim et. al., 2007; Bui & Takeuchi, 1992; Cheung & Snowden, 1990; Kinzie & Tseng, 1978; Loo, Tong, & True, 1989; Snowden & Cheung, 1990; Sue & McKinney, 1975; Sue & Morishima, 1982; Uba, 1994), as well as the study that showed that Hindus are less likely to seek help themselves than for their friends (Ogurchukwu, 2016). That finding that Average Hindu Americans are the least likely to seek help for themselves is likely a function of stigma, and the impact stigma has on how people see themselves. There are no consequences for telling a character like Rakesh that he should seek professional help, only the potential benefits of treatment. These participants did not know Rakesh, so he could not be hurt or offended by the recommendation. On the other hand, it was more difficult to recommend help to friends and family. As discussed before, this is likely due to the observed practice of the broader Asian American community being unlikely to talk to their friends or family about their own mental health or that of their friends (Chang, Chen, & Alegria, 2014). There is likely a consequence to the suggestion of seeking professional services that impedes the participants from recommending them, and there appears to be an even greater consequence to thinking about a situation in which they themselves may need to seek help. This is self-stigma, and it has been shown that this phenomenon leads to decreased self-worth and self-efficacy which make recovery more difficult

(Corrigan and Rao, 2012). It is possible that the consequence that drives this stigma is from their Hinduism-framed conceptualization that asking for help would mean that they could not still their own minds (Frawley, 1997), or rely on their own resources, thus making them weak. Indeed, it was shown that seeing mental illness as a lack of willpower was a prevalent opinion in the Asian American community that precluded help seeking (Lee et al., 2009). Though participants putting themselves in Rakesh's situation was just as hypothetical as giving Rakesh advice and it can also be argued that the consequences of telling the interviewer they would seek help would be low, participants were still unlikely to see themselves as needing professional help. This is consistent with research that has found that self-esteem was decreased by internalized stigma against mental illness, as well as stigma against seeking help. However, only stigma related to seeking help led to decreased help-seeking, which shows that these Hindu Americans are likely holding onto at least the latter form of self-stigma as they could not speak about seeking psychological help even in a hypothetical situation (Lannin, Vogel, Brenner, & Tucker, 2014). This must be a factor in the barriers that stop this community from seeking help when they need it, and it will be important to create psychoeducation to address this. It is possible that being able to show Hindu Americans that they are thinking about others in more empathic ways that allow permission for others to seek help in ways that they do not allow themselves might encourage the group to start decreasing self-stigma.

The Clergy group was also less likely to seek professional help if put in Rakesh's position themselves. While at least half the group recommended seeking professional help to both the abstract character and to people they knew personally, they were very unlikely to say that they would themselves seek help. As Clergy, they appeared to be strong in their conviction about the power of spiritual practice. While they might have seen the people coming to them as needing more support than spiritual practice could provide, they themselves may have felt they

were strong enough to get through the issue without seeking professional help. While their responses to the character and to their family and friends implies a strong conviction in the power of practice, the fact that only one member of the clergy group could see himself seeking help showed that there is an element of stigma in this group. Previous answers showed that they could see a situation in which a help-seeker would be suffering too much to make the most of spiritual practice; however, they, like the Average Hindu American group, were unable to see themselves in any situation, even hypothetical, where they would not be able to treat themselves. This shows that the Clergy also carry self-stigma against seeking help (Lannin, Vogel, Brenner, & Tucker, 2015). This could potentially come from their conceptualization that mental illness comes from an uncontrolled mind (Frawley, 1997), and their sense that as clergy they should have full control of their minds. The exact mechanism of the stigma aside, the presence of it shows that psychoeducation for Clergy to increase their personal help-seeking behaviors would be most beneficial if it is posed as a compliment to their spiritual practice rather than as a challenge.

The Mental Health Professionals group continued to demonstrate consistency in their recommendations – recommending mental health services with unanimity for the abstract character, for anyone they knew personally, and for themselves. They showed some awareness that seeking help themselves would be more difficult, whether explicitly or by saying that they would hope that friends would help them connect to a professional instead of saying they would directly seek therapy. This is subtle, but a difference from what they would have said to the fictional character Rakesh, or to their family and friends, to whom they recommended direct routes to intervention. This is possibly a product of stigma that they have internalized despite their conviction in the usefulness of mental health services when helping others. It is also possible that given their practice in the field, MHPs do not think they would need additional help

because they feel they take care of their own mental health. Given that Orlinsky et. al (2011) found that 87% of therapists in the United States seek therapy at least once and carry very favorable attitudes, it is likely that is stigma that these practitioners carry as part of the Hindu and Indian American communities that makes it uniquely difficult for them to seek treatment. It will be important to bring this to the awareness of Hindu Mental Health Professionals if they are to increase their own help-seeking behavior.

Ultimately, when asked what they would do if they were in Rakesh's position, members of all three groups responded differently. The Average Hindu Americans were somewhat likely to seek help, the Clergy were the least likely to seek help, and the Mental Health Professionals all said that they would be able to seek help. There may be a common thread among the groups in being less able to consider seeking resources themselves, in comparison to considering seeking help for the character or for someone they knew personally. This may be reflective of the larger Hindu American community's discomfort with saying that they themselves could use help, as it could mean that they are "weak" or lacking in self-control. As Lannin, Vogel, Brenner, & Tucker (2014) found, low help-seeking can be associated with self-stigma specifically against seeking help. Part of this is likely driven by the particularly Hindu idea of the strength that individuals must have in stilling their own mind to combat illness (Frawley, 1997). Indeed, in their responses, all three groups had participants say in some fashion that they could see themselves getting through the difficulties Rakesh faced by "being strong" and turning within themselves for resources. It is possible that this is particularly driven by the Asian American culture (not the wider Asian culture) that inspires the participants to abide by the stereotypes of Asian American achievement that distance anyone who fails, underachieves, or shows any weakness (Reyes, 2017). Indeed, the misguided perception that Asian Americans are less likely to experience mental distress has been found to lead to fewer mental health services being

available for Asian Americans, showing that the necessity of showing strength reinforces itself through systems (Okazaki, Kasseem, & Tu, 2014). There are several theories on the weakness in pan-Asian literature, but the broadness of that definition precludes meaningful application to the specific Hindu American community, especially given that broader pan-Asian literature is generally grounded in East Asian values (Le Espiritu, 1993). The fact that even these Hindu American Mental Health Professionals were more hesitant and indirect in how they would seek help offers evidence of the deep nature of the stigma that the community holds at large, as even training in Mental Health did not appear to be sufficient to allow an open embrace of seeking help directly when in need. While a strong link between the Hindu conception of strength to still one's mind and the stigma this population holds cannot yet be determined, that the pattern of self-stigma exists across the groups shows that psychoeducation will have to be geared towards reducing the self-stigma all of these groups hold against seeking help. Further research can show if specifically addressing conceptualizations of the mind needing strength to be stilled is helpful in reducing self-stigma.

Themes drawn from the "Aarti" vignette

Conceptualization of Aarti and depression. The participants were then read the vignette about Aarti, and were asked "What do you think is ailing Aarti?" Some of the participants of the Average Hindu American group used the term depression, and overall showed that they understood the difficulties that Aarti faced as an internal struggle of some sort, unlike the external explanations they used for the schizophrenic symptoms from which Rakesh was suffering. Aarti was also struggling at work, which has similarities to Rakesh's difficulties with the closure of the dry-cleaning shop. She was also working through interpersonal problems with her husband, which can be related to Rakesh's struggles with his family. However, there were large differences in that the presence of substance use and psychotic symptoms in the Rakesh

vignette was not paralleled in the Aarti vignette. The substance use and the overall intensity of Rakesh's symptoms may have led to the more external explanations participants provided for his situation. This also likely stems from society's lower rate of mental health literacy around schizophrenia, as compared to a higher literacy related to depression (Ogurchukwu, 2016). The participants' descriptions of what Rakesh is suffering from created a picture of maladies that did not come from his own self, mind, or character with solutions rooted in solving the external problems since his psychosis was ignored. For example, the Average Hindu American participants seemed to view financial problems as "causing" Rakesh's stress, but seemed to think that Aarti "was" stressed and increasing her difficulties with her own inability to cope. Since there are some similarities between Rakesh and Aarti, the factors that differ are likely the ones that lead to the differences in conceptualization. In other words, the substance use and the financial stress lead to an external understanding of Rakesh's suffering, while the symptoms of depression Aarti is facing lead to an internal explanation. There may also be a gender bias, and a sense that it is easier to associate distress or emotionality with women than men. It has been shown that men have more negative attitudes towards seeking help than women, and that may be at play here (Arora, Metz, & Carlson, 2015). The suggestions for treatment in the following questions will likely follow this conceptualization, showing that Average Hindu Americans may be more likely to seek help for external rather than internal problems. Also, as the group demonstrated more knowledge of depression than schizophrenia, psychoeducation on depression may require less emphasis on building knowledge of symptoms, and more on understanding that help is still necessary.

The Clergy's responses also indicated a more "internal" way of looking at Aarti's current challenges; however, they seemed to take a different perspective than the Average Hindu American group by clearly saying "this is NOT mental illness." This may be part of their

conceptualization of mental health and that belief that symptoms faced by all people, such as stress and feeling overwhelmed, cannot be a part of mental illness because they are so ubiquitous. They may be saying that this is NOT mental illness in the Western psychopathology sense, given that the Hindu definition of mental illness is any time the mind is out of balance or disturbed (Frawley, 1997). There are no labels for disorders in the Hindu system, so the idea is less pathologizing in some ways because it means that most people are "sick," rather than just those with symptoms severe enough to warrant a diagnosis. Indeed, this way of thinking is similar to transdiagnostic approaches to mental health. Transdiagnostic approaches are also built on the idea that there are similar etiological elements that grow from similar genetic, familial, and environmental risk factors through similar cognitive-affective, interpersonal, and behavioral maintaining factors to result in very different presentations (Newby, 2015). Looking at anxiety and depression particularly, as defining them collectively as emotional disorders leads to understanding of one of the largest causes of disability worldwide (Kesslet et al., 2005), has shown that there are many similar genetic, familial, and environmental risk factors (Kendler, 1996; Kessler et al., 2005). Emotional disorders have also been demonstrated to share similar cognitive-affective, interpersonal, and behavioral maintaining factors, with the similarities superseding any minor differences between disorders (Harvey, Watkins, Mansell, & Shafran, 2004). All of this shows that the Hindu conception of mental health may be rooted in mechanisms consistent with what has been found though psychological research. Furthermore, transdiagnostic approaches to treatment have been found to be very effective in reducing symptoms (Newby et al., 2015). Notably, transdiagnostic approaches to schizophrenia are more difficult than approaches to depression and anxiety, though they are also growing in research (McGorry & Nelson, 2016). This difference, however, may be why the Clergy made no such statement about Rakesh's profile NOT being "mentally ill" as they did with Aarti's. The

differences in the vignettes imply that the distinctions stem in part from the Rakesh vignette being more severe and containing substance abuse and psychosis, and thus perhaps easier to label as mental illness or at least atypical. It appeared that it was specifically the idea that Aarti would be labeled mentally ill and given a specific diagnosis that was difficult, because the Clergy saw this presentation as something that does not fit with such labels. This can come from a transdiagnostic way of thinking, and from feeling that this is a situation in which Aarti can and should be able to rebalance internally rather than being dependent on external help. This transdiagnostic way of thinking should be reinforced in all psychoeducation efforts, and Clergy should be shown that psychology too is moving in a direction that will make sense in accordance with their seeming belief about labels and how mental health and mental illness work. Their understanding will also need to be corrected in ways, and they will need to be shown that seeking help is important when one is suffering from depression as well, this will be easier when buy-in is created around what they can agree to.

The Mental Health Professionals group, as part of their group identity, was trained to recognize symptoms such as those faced by Aarti as some form of depression in the Diagnostic and Statistical Manual, so they did with unanimity. Part of the group also showed awareness of the impact of Hindu culture, recognizing that depression can manifest through somatic symptoms. This is proof of their competence in their roles as Mental Health Professionals. Their approach can be used to help non-Hindu American Mental Health Professionals who work with Hindu American clients.

Overall, the three groups seemed to interpret Aarti's symptoms in different fashions. The Average Hindu American group used words closely associated with mental health, in part, and appeared to offer internal explanations of Aarti's suffering. This was in contrast to the more external and limited explanations they offered for Rakesh's symptoms. The Clergy group offered

more internal but limited explanations for Rakesh's challenges, and offered internal explanations for Aarti's challenges. There appeared to be a difference, however, in considering Aarti's symptoms as distinctly "not mental illness" in comparison to Rakesh. The Mental Health Professionals group all clearly defined the Aarti's symptom profile as depression. Ultimately, the three groups appeared more aware of depression and how it manifests, making psychoeducation on depression less crucial than psychoeducation on schizophrenia.

Help-seeking for friends and family like Aarti. The participants were then asked the second question on the vignette – "Do you know anyone like Aarti?" The vignette on Aarti was meant to model depression, which is far more ubiquitous than the schizophrenia of Rakesh's example (World Health Organization, 2008). However, the participants in the Average Hindu American group were far less likely to recognize Aarti's symptom profile in their own friends and family than they were Rakesh's. This could be due to the way they conceptualized Rakesh's case through his financial stress and substance use, which could potentially be more visible to the outside community. On the other hand, Hindu Americans may be unlikely to share their internal feelings of being hopeless, helpless, or overwhelmed. It has been shown already that Asian American's do not share these feelings with friends and family (Chang, Chen, & Alegria, 2014), and indeed this has been found to be true of even the broader American community as stigma can prevent all who feel mental distress from sharing (Corrigan, 2004). The participants were also less likely to recommend professional help in this scenario. This likely follows from the way that they conceptualize each case, and their idea that Aarti's struggle is more internal, given that it was designed to be more relatable. They seem to feel that, given the internal nature of her struggle, she should be able to draw on her own internal resources, or at most ask family or friends to help her at this time. They were more likely to accept that Rakesh could use help. This finding points to an important element of psychoeducation for this group, as they need to be

shown that internal resources can be compromised when depression strikes and that psychological treatment has been found to be effective and with few consequences (Carr & McNulty, 2016).

The Clergy group did identify with knowing a greater number individuals with Aarti's profile than they did with Rakesh's profile. This may be because individuals who are suffering from depressive symptoms are more likely to share them with the Clergy they seek out for help. Indeed, John and Williams (2013) did find high rates of Asian Americans seeking help from religions leaders. Though it is unclear how this relates to rates of talking to family or friends, Chang, Chen, and Alegría (2014) found that Asian Americans felt inhibited from talking to immediate social support which provides evidence that Clergy are preferred. Alternatively, this could be partly due to the Clergy being quicker to recognize these symptoms because of the introspective nature of their profession. The group appeared to advocate for solutions that involved relying on or developing inner strength through meditation or *yoga*, in addition to reaching out to someone with whom they could talk. They were far less likely to recommend professional help to those like Aarti than they had been to those like Rakesh. This is likely related to their difficulty with Rakesh's schizophrenia/presentation, and their sense that external help is more necessary when presented with that profile than with the more familiar profile of Aarti. To better equip Clergy to be able to work with potentially depressed parishioners, they should be provided with psychoeducation that shows that professional help is effective for depression as well as for schizophrenia.

The Mental Health Professionals group remained consistent in their approach – all of them said they knew someone with the same profile as Aarti, and they all recommended therapy, just as they had with Rakesh. They continued to display cultural competence as well, adding other factors they had considered in order to assure that their clients/friends/family members

engaged in treatment. They were more likely to speak about cultural competence when discussing Aarti than Rakesh, potentially because of the nature of schizophrenia versus depression and the necessity of more intensive treatment (inpatient, medication) for the former. Given the severity of the psychosis, they may have felt that cultural competence of a clinician may not have been as important because involuntary commitment would be necessary as compared to Aarti where it would be more important to generate her buy-in and investment to treatment with cultural sensitivity.

The three groups continued to show that they thought about Aarti differently than Rakesh, and differently from one another. The Average Hindu American group was less likely to identify someone who met Aarti's symptoms than Rakesh's symptoms, and were less likely to recommend professional help in the Aarti scenario compared to the Rakesh scenario. The Clergy were more likely to identify someone similar to Aarti's example than Rakesh's, and were also less likely to recommend professional help in the Aarti scenario than the Rakesh scenario. The Mental Health Professionals group uniformly recognized both profiles and recommended professional help in both situations. These results could be indications that while the symptoms that were picked were intended to make the Aarti vignette more relatable than the Rakesh vignette based on prevalence rates, that it was actually less likely for the Average Hindu American to see internal symptoms of distress, while Clergy and Mental Health Professionals were more primed to recognize these symptoms. This could potentially be due to their occupations, given that the Clergy worked in ways that require introspection and looking within themselves and that Mental Health Professions are trained in recognizing symptoms of depression. Alternately, it could be due to the fact that depressed individuals were more likely to seek members of these two groups for support than to talk to their family or friends. Overall, it became clear that the groups all recognized depression and its symptoms with more clarity than

symptoms of schizophrenia, but were less likely to feel that depressed profiles indicated that someone needed help. When framing future psychoeducation, it will be important to acknowledge this and to show that treatment for depression is just as necessary and useful as it is for schizophrenia.

Help-seeking for Aarti. The participants were then asked what they would recommend to Aarti and her family to do next. The Average Hindu Americans group said that they would tell Aarti to work on her relationship and to engage in self-care. They had not recommended couples counseling to their family and friends who they identified as being like Aarti. This is a shift in their conceptualization, when thinking about friends and family like Aarti, only one participant spoke about the husband as part of the problem. Asking what the group would recommend to the fictional character themselves is more abstract than asking what they would recommend or had recommended to their real family and friends. The responses seem to indicate that while they see therapy, in a couples context frame, as necessary for someone dealing with everything that Aarti is dealing with. However, they also indicated that they would be less comfortable telling family and friends to use that medium, instead trying to encourage them to draw on their own strengths. In fact, Ahmed, Driver, McNally, and Stewart (2009) found that South Asian women reported stigma, gender roles, children's well-being, loss of social support, knowledge gaps, and myths as reasons that they delayed seeking professional help. The perceived loss of social support as a reason not to seek help from that study particularly demonstrates the point, as does the previously discussed literature on Asian Americans feeling inhibited from speaking to family and friends about mental health concerns (Chan, Cheng, & Alegria, 2014). The participants going from not referencing mental health professionals at all to part of the group recommending professional marital counselors, mirrored their responses in the Rakesh vignette. There too, as they went from being asked about friends and family they had a personal connection to, to the

abstract character in the vignette, they became less likely to suggest seeking professional help. These findings all show why psychoeducation revolving around addressing fears of loss, and encouraging the community to shift the way they conceive help-seeking will be crucial.

The Clergy group showed the same pattern as the Average Hindu American group, they spoke about the couple when asked about next steps even though they had spoken largely about Aarti as an individual in the first question of the vignette. They also spoke about the individuals they personally knew in Aarti's situation as individuals in the previous question and recommended individual solutions. When asked to consider Aarti in the abstract, however, the majority of the group spoke about dyadic solutions aimed at working on Aarti's relationship with her husband. As it has been shown that recommendations to family and friends are inhibited in this population (Chan, Cheng, & Alegria, 2014), it follows that the recommendations to Aarti the vignette character are the ones that are the least tainted by stigma. This is indication of a shift in their conceptualization – friends like are Aarti are individuals, but when it comes to solutions, Aarti the character is seen largely as part of a dyad. It is possible that the prospect of intervening in someone's intimate relationship is difficult (Ahmed, Driver, McNally, & Stewart, 2009). Research will need to be done on how to build acceptance of couples therapy, largely through talking to participants of any psychoeducation efforts on how to feel comfortable speaking about seeking help, after learning to identify cases in which seeking help is deemed important.

The Mental Health Professionals group was once again consistent in their conceptualization, and they did not shift in how they saw Aarti or her challenges depending on the abstractness of the scenario. They recommended professional help at the same rate across all the questions, and besides one response, always recommended individual modalities of treatment. This could be from their own experience working with individuals, because the vignette focuses on Aarti inspiring them to do the same, or even because they conceptualize

Aarti as struggling from depression that is impacting her personal relationships rather than the converse. While the exact motivations are unclear, what is meaningful is that they were consistent. If this group, the one most trained in psychology and in intervention, saw the necessity for individual treatment, then it seems important to make sure that the community is also taught about how individual treatment could be useful in this situation in addition to the couples therapy that the groups have already highlighted as a potential solution.

Ultimately, the three groups responded to the question of what they would recommend to Aarti in different ways. The Average Hindu American group went from saying that their friends like Aarti needed to work on themselves to saying Aarti needed to work on her relationship in tandem with her husband. The Clergy group showed the exact same pattern in their responses. The Mental Health Professionals group, on the other hand, was consistent both across vignettes and across questions within the vignette. This could be because Hindu Americans, who are not grounded in mental health training are less likely to recommend professional services for interpersonal problems to people they actually know. This could be driven by their greater comfort with working through things internally rather than systemically, and avoiding things that are uncomfortable with family and friends. Hindu ideas of mental health reaffirm this focus of looking at the individual, and the need for the individual to still his own mind to fight illness, which may preclude encouraging friends and family to seek treatment (Frawley, 1997). The positive aspect of this individual approach for themselves is that the Mental Health Professionals all largely advocated for individual treatment, meaning it likely is important for treatment to start there. These findings highlight the need for psychoeducation to help all Hindu Americans recognize that those suffering from depression, like Aarti, can benefit greatly from psychological treatment regardless of the modality.

Help-seeking for self in Aarti's position. The Average Hindu American group, when asked finally to put themselves in Aarti's shoes, did not see themselves seeking professional help. While a majority of the group had recommended couples counseling to Aarti, only half the group saw themselves seeking that solution. This is parallel to how the group was less likely to seek help when they put themselves in Rakesh's shoes than they were when they thought about what they would tell Rakesh. They also seemed to see themselves more individually when considering themselves in Aarti's shoes, versus in the dyadic way that they saw Aarti, the character. This may all stem from it being challenging for the participants to picture themselves being in such a difficult position that they would need to ask a professional for help or would have to rely on their spouse to work through things with them. As participant A6's response "I wouldn't let it go to that level" indicates, it is difficult for individuals to imagine being vulnerable, being in less than full control of their lives, or essentially being weak. This is reflected in their avoidance of seeing themselves in the same way that they saw Aarti. This is all likely due to stigma, and the findings that seeing oneself as sick leads to increased feelings of being different, dangerous, unpredictable, or incompetent—feelings against which this group is likely to protect itself (Sue, Sue, Sue, & Sue, 2015).

The Clergy group showed the same shift that the Average Hindu Americans group did, and largely did not say that they would seek resources. This is the same shift they engaged in when asked about the Rakesh vignette. The Clergy group offered the most spiritual responses focused on aiding themselves as individuals, when considering themselves in the shoes of Aarti compared to when they considered anyone they knew personally or Aarti abstractly. This may have stemmed from their desire to see themselves as strong and capable of working through any difficulty on their own, with minimal help from external sources of support. This is similar to the

effect found in the Average Hindu American group, and is likely driven by self-stigma and protecting themselves from a negative self-image (Sue, Sue, Sue, & Sue, 2015).

The Mental Health Professionals group responded to the question about what they themselves would do in the same way that they responded after the Rakesh vignette. They all said they would seek professional help, but they were notably less direct (i.e., going to a primary care doctor or talking to colleagues rather than going straight to a therapist). Part of this indirectness may be driven by the difficulty of having insight when suffering themselves. This could also potentially be driven by the same stigma that the rest of the Hindu American participants demonstrated, particularly in terms of the difficulty with seeing themselves as individuals who would need help. As discussed before, this is a contrast with the rest of the mental health field in general, where there are high rates of service utilization and positive attitudes about help-seeking (Orlinsky et al., 2011), and may be specifically related to the Hindu American identity of these therapists.

Overall, all the participants, across all the groups, showed more hesitation with seeking help if they themselves were in Aarti's shoes than they did in the previous questions. The Average Hindu American had zero participants saying they would seek professional services, and the Clergy group had a very small part of the group saying that they would consider seeking help if all their other solutions did not work. The Mental Health Professionals group all said they would seek help, but there was a difference in how they spoke about seeking help themselves versus what they would have recommended to Aarti, or to people they knew like Aarti. The question was hypothetical, but it still drew out responses that indicated that the Hindu American participants overall were less comfortable seeking help, and that they hoped that they would be strong enough to be able to depend on themselves and their own internal resources in moments of crisis. This is unsurprising, given what has already been established about Hindu Americans

through examining low rates of service utilization among the broader Asian American community (Abe-Kim et. al., 2007).

Defining mental health

The interview then shifted to asking the participants to define mental health. The World Health Organization (2008) defined mental health as "a state of well-being in which the individual realizes his or her own 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." The Average Hindu American group largely defined mental health in a similar way, as most spoke about functioning; though their answers also reflected well-being, sense of self, and the difficulty of defining something so ambiguous. The idea of mental health as being able to cope with the world (i.e. functioning) is practical and, according to the World Health Organization, a universal way to understand the construct. It also aligns, to some extent, with how the Mental Health Professionals defined the term. However, this way of defining mental health implies that not having mental health/not being mentally healthy means that an individual is incapable, unable, or in some way too weak to function or do what is necessary. Galderisi et. al (2015) argued that this way of defining mental health is problematic, because it "champion[s] positive emotions and excellence in functioning," at the risk of excluding those who experience discrimination and rejection or are unable to achieve excellence in functioning because of contextual reasons. The authors do not discuss stigma, but it is possible that this championing of excellence and positivity further add to the idea that to be "unhealthy" is to be inherently compromised, weak, or unable—ideas that have been shown to increase stigma and decrease ability to seek help (Arora, Metz, & Carlson, 2015).

The Clergy's most popular answer to the question "What is mental health?" was balance. This aligns with the ideas espoused in Hindu scriptures of mental health as balance (Frawley,

1997). As the Clergy are the most likely to read and internalize Hindu scripture, it makes sense that their conceptualization most closely follows the scriptures. The idea of imbalance may be less stigmatizing than other definitions that speak about people's inherent sense of self. Imbalance implies that balance is possible, and does not have the permanent or character driven connotations that "ability to function" has. Furthermore, the idea of mental health as balance moves away from labels for patterns of symptoms, and instead falls into a transdiagnostic lens. That the Clergy spoke about mental health as balance implies that the Clergy would be more willing to speak about mental health given a less stigmatized way of thinking about the concept. However, there is a component to this definition of mental health that requires further exploration – what do the Clergy believe is the appropriate way to achieve balance? If there is a skepticism of therapy, as expressed by at least one participant, it is likely that the questions about next steps will result in answers that involve a spiritual intervention or "rebalancing" in the face of distress. This then may not show less stigma to professional psychological interventions. The Clergy were indeed more likely to seek spiritual interventions, but they were also more likely than the Average Hindu American group to seek or recommend professional help, while still less likely than the Mental Health Professionals group. This shows that thinking about mental health as an imbalance may offer opportunities for addressing ways to combat stigma. Thus, this finding supports validating and re-enforcing the idea of imbalance for Clergy, and possibly using psychoeducation to spread it more widely throughout the community.

The Mental Health Professionals answers were spread across the domains of functioning, well-being, peace, and contentment. The biggest part of the group referenced functioning, just like the Average Hindu Americans group, and similar to the definition of mental health provided by the World Health Organization. All of the therapists in the group paused and said that the question was "good" or "difficult," and a few of them commented that the struggle to define

mental health was ironic given the amount of time they spent striving to help their clients achieve it.

Overall, the Average Hindu Americans and the Mental Health Providers seems to have a definition of mental health that seems to align with standard definitions of mental health, while the Clergy group had a different perspective. The standard definition (World Health Organization, 2004) has been criticized by some as overly positive and dependent on excellence in functioning, and it is possible that even this widely accepted definition is both indicative, and a root, of stigma (Galderisi et al., 2015). On the other hand, the Clergy seemed to articulate a definition that was based on balance rather than any inherent quality. Since they were more likely to seek and refer professional services, there is a chance that this view is the least stigmatizing. However, this assertion must be examined more closely given that the Clergy were also the group most likely to express skepticism about the field of psychology as a whole. It may be important to draw a distinction between the idea of imbalance and the idea of the need to still the mind, as the two concepts seem to have different levels of stigma attached to them. Given the similarity between the idea of imbalance and the theory underlying transdiagnostic techniques, it is possible that imbalance may be less stigmatizing because transdiagnostic approaches to mental health have been shown to reduce stigma (Stanly, Horn, & Joiner, 2016). In contrast, the emphasis on stilling the mind has the potential to increase stigma because solutions are person-focused and strength driven which can lead to greater feelings of shame, stigma, or a self-perception of weakness if stillness is not achieved. Ultimately, these findings demonstrate the potential need for community psychoeducation that validates the idea of mental health as balance, and also frames the stilling of the mind as something that therapy and psychological interventions can help to achieve with few consequences.

Defining mental illness

The participants were asked to define mental illness after they defined mental health, with the hope that they would articulate the differences between the two concepts in a way that allowed the researcher to better understand what may make it difficult to seek services. While the World Health Organization (2004) defined mental health, it did not offer a definition of mental illness. It discusses the impact of mental disorders and speaks about the necessity of both prevention and treatment, but there is no definition of the overall term aside from mental illness being "common and universal." National Alliance on Mental Illness says "mental illness is a condition that affects a person's thinking, feeling, or mood" and the American Psychiatric Association defines mental illnesses as "health conditions involving changes in thinking, emotion, or behavior". These definitions are broad and likely worded carefully to avoid stigmatization by avoiding saying much at all, relying instead on definitions of particular diseases for people to understand what mental illnesses really are in practice and in diagnosis. This may be why the participants appeared to struggle more with defining illness in cohesive ways that led to consensus. No more than two participants in the Average Hindu American group had similar definitions, with response varying from dysfunction to imbalance to impaired well-being to emotional turmoil. The answers also did not closely mirror the focus on functioning seen in the answers to the question about defining mental health. Additionally, the answers did not align with the Hindu conception of mental illness, which revolves around imbalance (Frawley, 1997). All of the definitions could be conceptualized as different forms of weakness, given that they all look inward at something that is not functioning correctly rather than externally at context, circumstances, or biological roots. However the responses are understood, they all appear to have basis in concepts or ideas that lead to stigma and preclude individuals from seeking help (Sue, Sue, Sue, & Sue, 2015). For psychoeducation to be effective,

it will be key to reframe these ideas of mental illness within the Hindu American community; and using Hindu ideas may be particularly palatable and meaningful to this population in helping shift definitions away from deficit towards imbalance.

The Clergy's answers were also different from their answers to the question about mental health, and varied widely with no consensus in responses. Unlike their focus on balance as the key to mental health, responses ranged from dysfunction to imbalance to emotional turmoil. Nevertheless, these ideas do follow the Hindu conception of mental health as imbalance, though it is surprising that the Clergy did not state that definition more broadly or clearly. These responses are also likely to generate stigma and make it more difficult for clergy to seek help than the ideas of imbalance (Sue, Sue, Sue, & Sue, 2015), so it will be important to address this in any future psychoeducation.

The Mental Health Professionals group was consistent, half the group said functioning was the key to mental health, and half of the group said dysfunction and the inability to cope was the root of mental illness. This may stem from professional training, and that they were offered a more consistent definition that they internalized and stated here, especially given that their definitions aligned with the standard, professionals definitions discussed earlier.

Overall, the groups defined mental illness in very different ways. Aside from the Mental Health Professionals group, where consensus was found between two responses, the responses varied widely and did not present a simple opposite to their definition of mental health. While Hindu ideas of balance were prevalent in the definitions of mental health, they were not as present in these definitions of mental illness. It may be that these "non-Hindu" ways of viewing mental illness are driven by stigma, since the preponderance of definitions that they offered instead are shown to be linked to making one unlikely to seek treatment. Given the literature that ideas like this make it unlikely that individuals seek treatment, it will be important to use

psychoeducation efforts to teach Hindu Americans about definitions of mental illness that enable them to both seek and recommend help (Sue, Sue, Sue, & Sue, 2015).

Conflict between Hindu identity and definitions of mental health

The next question posed to the participants was about conflict between their identities as Hindu and their definitions of mental health. In the Average Hindu American group, two participants reported experiencing conflict including some difficulty with the Hindu faith; while one expressed the challenges posed by Hindu/Indian culture. The difficulties they shared were with feeling that the religious explanations for mental illness were lacking, and that the goal of *moksha* conflicted with taking care of oneself. These answers showed that, on average, the Ayurvedic ideas of what mental health and mental illness are in Hinduism are not broadly known. The fact that they are not taught or understood widely appears to decrease religiosity, as stated by participant A2. In efforts to create psychoeducation for this group, it may be vital to help individuals address and resolve the conflict so that they can feel free to access professional mental health services. Teaching Hindu concepts and ways of thinking about mental health in a way that is not at odds with seeking help could be very meaningful in decreasing internalized stigma.

The Clergy were the most comfortable with their religious identities and their definitions of mental health, as they all answered that they did not feel any conflict. This is likely because their religious views inform their definition of mental health, which leaves little room for any dissonance. Indeed, one participant was careful to state that the lack of conflict comes from his comfort with using the Hindu way of thinking about mental health and mental illness. In some contrast, another Clergy said that she felt Hindu definitions for mental health were lacking, indicating that there were knowledge gaps even among the Clergy who would be expected to know what the scripture says about mental health. Given that the Clergy were overall slightly

more likely than the Average Hindu Americans to seek help or recommend seeking help, it is possible that psychoeducation efforts that stem around understanding Hindu concepts of mental health will indeed be useful in decreasing stigma.

The Mental Health Professionals largely said they did not feel any conflict between their faith and their understanding of mental health. One participant qualified her response and said that the low level of awareness and psychoeducation in the community could perpetuate illness, but none of the participants spoke about the religion or the conceptualizations that the religion inspires as conflictual. This reinforces the idea that widely teaching about Hindu concepts of mental health will not be detrimental, and may indeed be helpful to the community. This is in contrast to the study by Padayachee and Laher (2012) which found that South African Hindu Psychologists reported feeling a conflict between their professional and faith identities. More research would be necessary to understand if this is simply an effect of low sampling in both studies, or if American and South African cultures contribute differently to the ideas of being psychologists and Hindus.

Overall, when asked about conflict between identity as Hindu and definitions of mental health, participants did not express conflict. The Average Hindu Americans expressed some conflict between culture and the goal of *moksha* detracting from taking care of oneself, and one participant in the Mental Health professionals group found conflict in the lack of information. However, all of these conflicts can be resolved through careful framing and wider dissemination of Hindu concepts of mental health.

Personal mental health and help-seeking

The participants were then asked the most personal question of the interview, “Have you ever felt mentally ill?” In the Average Hindu American group, there was not a single participant who said yes. There were two “maybe” responses, with one participant saying he simply was not

sure and another wondering about whether following the college culture norms of drinking excessively should be defined as mental illness. Given that the prevalence rate for mental illness is in the South Asian population is 20%, it would be expected that at least one person of out of six would have been ill if this was a truly random sample (Masood, Okazaki, & Takeuchi, 2014). This may stem from the nonrandom group simply being very healthy; however, it may also stem from factors such as the way the group defined mental health and the desire to say "no" and imply that they had never been weak, unable, or compromised in any way. Indeed, research has shown that underreporting is widespread while high rates of distress are masked (Nguyen, Shibusawa, & Chen, 2012; Sue, Cheng, Saad, & Chu, 2012). These responses show that there is much work to be done with the community to enable acceptance of personal mental illness.

The Clergy group appeared to be more comfortable admitting that they had felt mentally ill at some point. One participant said yes to the question, and two said maybe. The rest (half) said no, but their responses did not revolve around portraying themselves as strong and healthy, and instead expressed skepticism of the words "mental illness" to describe their own experiences, and a sense that the field of psychology as a whole was not meant for them because it was "a privileged disease of affluent society." That the Clergy were able to partially acknowledge that they may have been mentally ill at some point, and to partially express that their hesitations may have been about the labels rather than the concept itself, may be an indication that this group thinks about mental health in a different way than both the Average Hindu American and the Mental Health Provider groups. They may be seeing mental illness broadly in a way that doesn't invoke stigma or a compromised sense of self if they see themselves as ill. Certainly this ability shows that psychoeducation that teaches the concepts of Hindu mental health that these Clergy have internalized can indeed be powerful tools in reducing the stigma of saying that one is sick. The responses to this question also show that the Clergy

may be able to move past any stigma that they may still be holding about the field through both psychoeducation and through the use of terms that are less loaded with stigma and misconceptions.

Interestingly, despite identical framing of the question, the Mental Health Professionals did not answer whether or not they had been mentally ill, skipping straight to the second component of the question. It is possible that this comes from the stigma that this group has demonstrated when asked what they would do if they were in the shoes of the characters of the vignettes.

Overall, Average Hindu Americans did not say that they had ever felt mentally ill, and the Clergy were somewhat more likely to say that they could recognize mental illness in their lives. This is likely a demonstration of stigma in the community. It can also be seen that when Clergy align with Hindu concepts of psychology, they are more likely to be accepting of mental illness within themselves, lending credibility to the idea that imbalance is a less stigmatizing way to see mental illness. If this idea is indeed credible, it will be important to form future psychoeducation around this idea.

The second component of the question “Have you felt mentally ill” was “Have you sought help?” The Average Hindu American group said no with a large majority, with only one participant saying yes. They were then asked “What, if anything, stopped [them] from seeking help?” The most common answer was that they did not need the help because they had the support of their family and friends. This reaffirms that their conception of mental health revolves around feeling that they have all the resources they need to be functional, given that they are saying that the relationships they create and maintain should protect them from needing any outside intervention. Several studies (Akutsu, Snowden, & Organista, 1996; Lee, 1988; Lee et. al., 2009; Narikiyo & Kameoka, 1992) have found that Asian Americans are most likely to seek

support from their family members and friends when they are incapable of managing mental issues on their own, though other literature has found that Asian Americans are still less likely than White and Latino American to speak to family or friends (Chang, Chen, & Alegria, 2014). None of the Average Hindu Americans said that they would seek help from clergy or religious leaders either, despite research that this is a popular form of support in the Asian American community (John & William, 2013).

The Clergy all also said that they did not seek professional help, even though they were the group most likely to say that they had experienced mental illness themselves. This contrast likely highlights that the Clergy are defining mental illness in a broad, less deficit-driven way that calls for treatment and interventions that are different from seeking professional help. A dominant majority of the group stated that their biggest barrier to seeking help was that they did not need it. Given that participants had already expressed that they felt mentally ill at times in their lives, this assertion could be understood as another way of expressing skepticism about the utility and effectiveness of the field of psychology. This would be consistent with literature that has shown that Asian Americans see less benefits to therapy than other Americans, and that this accounts in part for lower service utilization (Kim & Zane, 2016). Thus, if their ability to say that they were mentally ill at some point is proof that they are not attempting to maintain the appearance of strength, then the skepticism fits. It may also fit with Hindu ideas of mental health. In other words, the Clergy can readily say that they faced illness because the imbalance that is at the heart of illness may not invoke stigma or a sense of weakness. However, the treatment for such an imbalance is a stilled and controlled mind (Frawley, 1997), and the Clergy may struggle more with needing to seek help to do that as it would certainly be viewed as a weakness. Simply expressing a history of having been mentally ill appears to be more acceptable. This implies that possibly it is a source of pride to be able to say that they were indeed ill, but that they did not

need help outside of their religious practice and strength to overcome their challenges, and that they would recommend being able to draw on that same strength to those who consulted them.

The Mental Health Professionals group was the most likely to say that they had sought professional help, though many of the participants did say that it was through a mandate from their training program. Only one participant reported that she chose to go to therapy through a personal decision. This could be connected to internalized stigma present in this group, as discussed above, despite their professional training. At the same time, this group did not have a consensus about what, if anything, stopped them from seeking help. The most popular answers only had two participants each state them, and they were that the participants did not feel that they needed help and experiences of stigma. These answers are related of course, as stigma is likely to cause an individual to deny needing help to avoid the feelings of shame or inadequacy associated with admitting a need for help.

Barriers to help-seeking

Looking across the groups, what was most surprising was not what the participants said, but what they did not say. Only two out of the 18 total participants cited the logistics and cost of getting help as a barrier, though research has consistently shown that this is a barrier for Asian Americans (Abe-Kim et. al, 2007; Abe-Kim & Takeuchi, 1996). Furthermore, the same low number of participants cited cultural competence as a barrier. It has been shown that Hindus prefer seeing Hindu therapists (Cinirella & Loewenthal, 1999) and that this trend is also common for Asian Americans (Fraga et al., 2004); however, studies have also shown that that these groups struggle a great deal to find Asian American therapists with whom they feel comfortable (Gim, Atkinson, & Kim, 1991; Gloria, Castellanos, Park, & Kim, 2008;). Instead the most common answer across the groups was that the participants felt they did not need the help because they could rely on internal resources, which is an answer that points to stigma,

especially if we think of stigma as any negative belief about mental health that precludes seeking help. Psychoeducation could be valuable across all of the groups to help Hindu Americans in different roles learn that that seeking therapy is effective at enhancing internal resources rather than something that implies weakness.

The final question posed to all the participants asked them to reflect on what stopped other Hindu Americans from seeking help, with the goal of identifying whether they saw the barriers for others differently from the barriers for themselves. This was indeed the case, as the Average Hindu Americans all cited stigma, and two participants additionally cited cost and logistics, rather than a lack of need. This contrast confirms the way that stigma works—denying the need for personal help despite recognizing the need as present for others. The participants did not express any dissonance about the idea that, while they did not need help, others did and did not seek it because of the embarrassing implications of needing help. However, the fact that they were able to see stigma as a barrier is important in that it allows for psychoeducation efforts that will both push participants to use knowledge of stigma to better help their friends and family who do need help, and also slowly demonstrate that they are seeing themselves in a harsher light than they are viewing others. The hope would be that individuals would begin to recognize that that it is acceptable if they need help themselves.

The Clergy all cited stigma as well, while also offering other answers, ranging from concerns about cultural competence to a belief that therapists who were themselves sick could not help others. These responses questioned the field of psychology as a whole, which is consistent with the skepticism that the Clergy expressed about professional services as treatment. It will be important that this skepticism is addressed in any psychoeducation efforts for the clergy, ideally with facts about how therapy and other psychological interventions work and can be helpful despite the held misconceptions.

The Mental Health Professionals group also all cited stigma. Half of the group further added that cultural competence was a barrier. This follows their broad awareness of what stops other Hindu Americans from seeking treatment. These factors will definitely need to be addressed in any psychoeducation efforts for the community.

The fact that that one of the participants showed an awareness of stigma as a barrier, though they were far less likely to say that stigma was a barrier for them personally, could be seen as reinforcement of the idea that stigma is indeed the largest barrier to treatment in this community. Understanding that Hindu Americans define the challenges they face personally as different from the challenges they see for the broader community will also be key in framing psychoeducation. Hindu Americans will need to be validated in recognizing the stigma seen in friends and family and charged with the responsibility of slowly changing that. They will also need to be slowly shown the discrepancy in how they see others and how they see themselves, so that they can begin to reduce self-stigma as well.

Themes from the Clergy

The Clergy were asked three questions specifically about the connections between their work as Clergy and their experiences with mental health. The first question was "How do you counsel those who come to you who may be mentally ill." This question was stated with the assumption that this counseling takes place, instead of giving the Clergy the option to say that they did not engage with mental illness, so at times the answers were hypothetical. This question could have been framed with a "do you" to begin rather than "how do you," and the Clergy should have been specifically asked how often they engaged in counseling parishioners who may be mentally ill. Those limitations given, half the participants did say that they incorporated seeking professional help in their responses. The clergy were more likely to offer themselves and their services (both practice based, such as meditation, as well as talking) than to recommend

seeking professional help. This follows the observations that have been made about the Clergy's convictions in the power of their spiritual practice. Going forward, psychoeducation will need to reinforce the idea that psychological services can be offered in tandem with their own services to enhance overall wellbeing.

The Clergy were then asked if their faith helped or hurt them in their counseling (again the assumption was made that they engaged in work with potentially mentally ill parishioners), and only one participant indicated that she felt some conflict/hurt, though she was unable to articulate what exactly about the faith or the practice led to this. This reaffirms that the Clergy overall feel confident in their definitions of mental health, and their Hinduism-driven ways of treating parishioners, without conflict. This shows that psychoeducation aimed at identifying psychotherapy as an effective supplement or alternative to their own practices should be feasible, if the Clergy can be validated in their conception of mental health and shown that the conflict does not lie there.

Next, the Clergy were asked specifically how they felt about advising people to seek services. A majority of the group said they would incorporate recommendations to seek services, though only one was emphatic. The other four participants said they would recommend professional services as a last resort or if they did not feel that their spiritual practices would be helpful. These answers all align in showing that the Clergy are overall unlikely to push suffering parishioners toward professional resources, despite stating that they do not think that their faith-based practice conflicts with suggesting mental health services. The responses also align with the skepticism that Clergy had already expressed about the field of mental health, and whether it is actually effective. It will be important that psychoeducation for Clergy directly address the roots of this skepticism, partially by proving that psychotherapy is effective, especially when culturally competent practitioners are found, and partially by showing that it can complement rather than

conflict or detract from their own services. This fear was not articulated by any of the clergy, but it may be useful to state it in psychoeducation efforts all the same.

Themes from the Mental Health Professionals

The Mental Health Professionals were then asked about the connections between their practice as therapists and their identity as Hindus. The first question was if there was conflict between their understanding of mental health and their religious identity. The majority of the group said that there was no conflict, and that indeed they felt that their faith helped them practice psychology in the best way. However, the participants that dissented spoke about their frustrations with the field of psychology and evidence-based standards that stopped one participant from using practices based in Hinduism that he thought could be helpful and frustrated another participant because they were appropriative and distanced from their Hindu roots. This gave an overall message that these Professionals felt that they could use their faith to increase their effectiveness as psychologists, but felt restricted by the field rather than feeling any implicit conflict between faith and psychology. This follows findings that the mental health profession is largely silent about the influence or importance of spirituality and religion in mental health (Saunders, Miller, & Bright, 2010). Gonsiorek, Richards, Pargament, & McMinn (2009) found that one of the reasons that therapists did not feel comfortable discussing spiritual or religious issues with their clients was because they believed they may be seen as usurping the role of the clergy. Other reasons were feeling uncomfortable, concern of being seen as proselytizing or judgmental, or feeling inauthentic. It would be important in the future to explore how therapist hesitation to speak about religion and spirituality in session interact with Average Hindu Americans' and the Clergy's' assessments of the mental health field. For example, would Clergy be less skeptical of psychology as a field if they felt that their practices were not being appropriated and passed on as "mindfulness" that misses an important spiritual core? Would they

be more likely to refer parishioners to services if they thought that Mental Health Professionals were enabled to use all parts of their Hindu faith in practice? These concerns have to do with the field as a whole, so to address them will require psychoeducation for therapists, conversations about what being a culturally competent therapist to Hindu Americans entails, and showing Clergy that these efforts are being made.

The Mental Health Professionals were finally asked what they would recommend that other providers do to engage Hindu Americans in treatment. A majority spoke about outreach and the necessity of building relationships with the community in order to provide psychoeducation. Other themes that surfaced were changing the language to match the terms that the community used, and making sure that providers were learning about the culture. They offered several suggestions, from the personal to the systemic, and all of these should be considered by anyone who hopes to work with this population. The suggestions follow what the Average Hindu Americans and the Clergy said about their hesitations and barriers well, thus indicating that psychoeducation should be driven by all of these suggestions.

Main Themes

As the interviews were analyzed, several themes emerged through the important findings. The first was that literacy on schizophrenia was limited in the Average Hindu American and Clergy groups, as they avoided the psychosis in the vignette entirely in understanding what was ailing Rakesh. None of the participants used the word schizophrenia. Both groups recognized depression more readily, though not universally. Both groups were also less likely to recommend treatment for the schizophrenia profile than for the depression profile. The Mental Health Professionals showed that they were literate on both depression and schizophrenia, and recommended help-seeking in both scenarios.

The Average Hindu Americans and the Clergy both showed a general pattern in both scenarios of being most likely to recommend help to the vignette character, less likely to recommend help to friends and family in similar situations, and being the least likely to seek help themselves. The Mental Health Professionals did not show this pattern, however, they did show hesitancy to seek help themselves indicating that this group was also plagued with stigma despite their educations and choice of career paths.

Looking at definitions of mental health and mental illness, all of the groups spoke about balance for mental health to some extent, but had wide, non-cohesive definitions for mental illness. This finding was consistent in part with Hindu ideas of achieving mental health through the balance of the *gunas* and *doshas*. The prevalence of Hindu psychology ideas was highest in the Clergy group, showing that Average Hindu Americans and even the Mental Health Professionals were not guided entirely by these ideas and that Western ideas of psychology also had some part in how they understood mental health.

As barriers were explored, the participants universally spoke about stigma as a barrier to the rest of the community. However, when asked about the barriers that they themselves felt, they were most likely to respond that they "didn't need it." They spoke about cultural competence and cultural matches, cost, and logistics as other barriers to treatment. The Mental Health Professionals emphasized that it would be necessary for psychoeducation for this community to be done through outreach rather than waiting for the community to come to them.

Overall, conflict between Hinduism and ideas of mental health or practice as Clergy/Mental Health Professionals was limited. When conflict was expressed, it appeared to be related to limited understanding of Hindu concepts of psychology and implied that psychoeducation could be used to address the deficits. The Clergy expressed more skepticism of psychology as a field than conflict. Mental Health professionals were more likely to feel

restricted in their practice, but indicated they felt they could not use their Hindu faith holistically, rather than any experience of feeling that their training made feel conflict about what Hinduism espoused.

Limitations of Study

There are a number of limitations on the study that must be considered before applying the findings broadly. For one, the sample was small, and cannot be applied widely to understandings of any of the three groups. Relatedly, the sample was collected through the interviewer's networking, and it is likely that those who responded were those who were already interested in the topic of mental health as it relates to Hinduism. Selection bias could then have a play in responses, limiting the generalizability of the findings to the broader Hindu American community. In particular, the Clergy group was older and predominantly male, while the Mental Health Professionals group was largely middle aged and predominantly female. Furthermore, all of the participants in this study were Hindu Americans of Indian heritage. This was done because the sample was so small, that introducing different ethnic backgrounds may have made the results more difficult to interpret. This is a limitation however, given that Hindu Americans come from many different ethnic backgrounds other than Indian. In addition to selection bias, the principal investigator conducted all of the interviews, which may mean that there is researcher bias at play in the responses. Furthermore, as noted in the introduction, the Hindu American community is broad and diverse, and it is crucial to consider this diversity with nuance when attempting to understand the implications of this research.

This qualitative research design was chosen despite these limitations due to the advantages it offers in being able to collect rich and detailed interviews about how the participants understand Hinduism, mental health, and mental illness. The open-ended approach

allowed for building of rapport throughout the interview, and space for participants to offer more than what was asked, which opens up possibilities for future research studies.

Implications

Treatment. The mental health professionals offered many insights that would be valuable to have influence and inform therapy by Hindu and non-Hindu professionals who hope to work with Hindu American clients. For example, they indicated that the nature of the field of psychology caused them to feel dissuaded from using religious understandings in therapy. They also highlighted that the field appropriates Hindu practices like mindfulness and commercializes them, which leads to frustration in the therapists and distrust among potential Hindu clients.

Participants also highlighted that therapists will need to actually reach out to the Hindu American community to engage members, as simply waiting for them to come into their offices would not be sufficient. One specific systemic suggestion was to use "warm handoffs" from general practitioners to mental health professionals to maximize that Hindu Americans are more likely to go to their general doctor than a professional. They also recommended that therapists start using the terms that match those that the community itself uses when discussing mental health.

Psychoeducation with the Hindu American Community. There is a support in the literature for the idea that psychoeducation is key to combatting stigma across many communities (Krafft, Ferrell, Levin, & Twohig, 2017), and that culture specific psychoeducation will be the most effective (Fox et. al., 2017). Findings from this study showed that this is likely true for the Hindu American community as well. Psychoeducation will need to account for Hindu ideas of mental health, reconcile these ideas with Western/mainstream conceptualizations, and teach Hindu Americans how to navigate the logistics of when, how, and why to seek professional help. There may also be significant benefit to differentiating between

psychoeducation for Clergy and for Average Hindu Americans, with the focus for the Clergy being on how to enable them to better serve the Hindu American population that may come to them when they are in distress, and showing them that therapy can be a compliment to their spiritual practice rather than ineffective competition. Emphasizing collaboration, and strengths-based approaches that acknowledge and appreciate the work that the clergy is already doing for the community will be key in creating a facilitative environment. These dialogues could be effective in a structured workshop format, potentially through an agenda that allows Clergy the opportunity to share their insights, in addition to working with Mental Health Providers to learn the components of reconciling Hindu and Western/mainstream conceptualizations to teach Hindu Americans how to navigate the logistics of professional help seeking. Theoretically, having Mental Health Providers and Clergy then work together to create the programming for Average Hindu Americans will be particularly meaningful. Cultural hubs that the community gathers in for other workshops will be excellent locations for engaging the community; temples seem particularly promising in the potential they offer to engage the Hindu American community in its entirety.

The interviews showed that there is not broad awareness of what Hindu scriptures say about mental health. Though the Clergy demonstrated more awareness than the Average Hindu Americans, as expected, there was evidence that further information was still needed. Thus, any psychoeducation should likely begin with showing participants that mental health is acknowledged and valued in the Hindu scriptures. It should also enable them to align their broader worldviews and spiritual goals, and empower them to speak about the topic in a way that may be precluded when they feel that the idea of mental health is not given value and should not be discussed. Another significant theme for future psychoeducation would be the importance of talking about the balance of all things (*gunas, doshas*, and vital energies) and stilling/controlling

the mind. The idea of mental illness being rooted in imbalance can encourage strength, resilience, and possibly even help-seeking, if presented in a way that encourages these ideals. Conceptualizing mental illness as an imbalance holds inherent the idea that rebalancing is possible, which is in opposition to ideas of inherent weaknesses that appear to form the basis of current definitions for many members of the Hindu American community. One important piece of psychoeducation will be reaffirming the positive framing of this conception of mental illness. It will be necessary for individuals to explore and come to terms with the idea of the mind needing to be stilled and controlled to achieve peace as well. Since this idea can be isolating and invoke a sense of weakness and inability in a way that the concept of imbalance does not, it would be important to show that this is a difficult task with which one can seek help, and that only a mind that has achieved some level of balance through help can hope to achieve this goal. Both Clergy and Average Hindu Americans can be taught that psychotherapy can help achieve a still mind as a next level of spiritual progress.

Once everyone shares understanding of what Hinduism says about mental health, the next step would be to resolve any conflict felt about definitions of mental health and mental illness that individuals have derived from broader American culture. This will be particularly important when the audience is Clergy. While part of the conflict can be resolved by simply showing that there is a Hindu perspective on mental health, the other part of the solution will be showing that psychology, as a field, can be a useful complement to the development of Hindu spirituality. It will require explaining all the potential modalities of treatment as well as the different orientations to show Hindu Americans the mechanisms of change, and how they can follow Ayurvedic principles of knowing oneself deeply (along psychodynamic lines) or changing behavior or the environment (along cognitive behavioral lines) in order to find health. It will also be important to discuss the benefits of having a stranger who can maintain boundaries as a

therapist, given the preference and desire in the community to have friends and family as advisors.

Most importantly, the community must be taught when to seek help, both for themselves, and for others with whom they interact. This will involve learning to recognize symptoms, particularly underlying or internal symptoms that may be masked by overt or external symptoms, showing participants that help for depression is as necessary as help for schizophrenia. Participants will need to have a conversation about identifying when suffering reaches a point where professional services are recommended or deemed necessary. Psychoeducation must also involve teaching individuals how to speak to someone who they recognize as needing help. Given that it has been demonstrated that individuals are more likely to tell friends to seek help than to seek it themselves, part of psychoeducation should also focus on asking participants to understand this about themselves and to begin treating themselves as they would a friend in distress, rather than demanding higher abilities to cope and function from themselves. Ultimately, these elements of psychoeducation should work together to transform what participants think it means to seek help and to assist others in seeking help. The goal must be to reduce as many of the negative connotations of help-seeking as possible, by validating that seeking help aligns with religious values and cultural values in a way that empowers the seeker rather than highlighting his or her weakness.

The final step will be helping Hindu Americans learn to navigate the mental healthcare system, and to understand the costs and logistics. A large part of this will be showing participants how to find culturally competent mental health providers who will help the community feel understood. Database consolidation of providers will be useful, as will tips on how to work with insurance companies to navigate cost. Understanding the different types of providers, and when to go to whom for which modality of treatment will be key to psychoeducation efforts as well.

Ending psychoeducation (potentially a workshop) by telling participants that they are now empowered to go out in the community and decrease stigma will be key to extending the impact of all psychoeducation efforts.

Future Research. Given the significant lack of research on the Hindu American community, any and all research focused on them will be welcome in the future. Interviewing enough participants to have a representative sample of the community would be particularly meaningful. This study focused on depression and schizophrenia, but it would also be important in the future to understand how other DSM diagnoses categories are interpreted – particularly with anxiety disorders. Gender factors were also not explored in this study and may be important to building understanding and even more tailored psychoeducation efforts. Age and immigration status (i.e. first versus second generation Hindu Americans), as they relate to mental health conceptions, are promising avenues of future research as well. While help-seeking behaviors have been studied extensively, research on help-referring was difficult to find. Continuing to research how and when Hindu Americans (or even the broader population) refer their friends and family to seek help will be an important part of understanding how to decrease stigma, as it has been shown that rates of help-seeking increase when a familiar individual recommends the help (Vogel et al., 2007). Lastly, the psychoeducation recommended here must be implemented and evaluated to find the most effective way to serve this community.

Conclusion

In conclusion, there is much that remains to be understood about Hindu Americans, and how to best serve them. Literacy in the community on both depression and schizophrenia needs to be built, and needs to be informed by clear understandings of how illness manifests in this community. Clergy should be recognized as important sources of comfort in the community, and partnerships should be built to enable them to better serve. More than anything, it should be

recognized that Hinduism offers a conception of mental health that can be used to better help its believers.

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Appendices

Appendix A

INFORMED CONSENT AGREEMENT

Study Title: Hindu Conceptions of Mental Health

Invitation to Participate: This research study is being conducted by Kavita Pallod Sekhsaria, Psy.M., an advanced doctoral candidate in the Clinical Psychology Psy.D. Program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

Purpose: The purpose of the study is to understand how Hindu Americans understand mental health. In doing this, the hope is to understand how to make resources for wellness more accessible to Hindu Americans.

Participants: This study will use a network sample of approximately 12-30 adults, aged 18 and older, who identify as Hindu American.

Procedure: Participants who consent, will be interviewed individually during a designated time at an agreed upon location. The interview will be audio recorded. It is expected that the interview will take approximately 90 minutes to complete. However, the length may vary greatly depending on the depth of the answers provided. All interviews will take place in-person at a location in New York or New Jersey or via phone or video chat, as mutually agreed upon by the participant and Kavita Pallod Sekhsaria. All in-person interviews will be conducted in a location that allows for privacy, comfort and convenience for the interviewees. For those interviews taking place via video chat, care will be taken to choose a spot that is comfortable and private. In the case of interviews taking place via video chat, the interviewer will be alone, either at her residence or in a secure room in the Psychology Building at Rutgers University.

Risk: The interview focuses on experiences with mental illness, and there is a chance that this may cause one to feel upset. If, in reflecting on experiences, any discomfort recalling memories or discussing personal matters is felt, participants are encouraged to notify the principle investigator immediately, to work through and process feelings. Participants may refuse to answer any questions, and are encouraged to take breaks as necessary. Participation is voluntary and the interview may be terminated at any time with no consequences. The Psychological Services Clinic at Rutgers University at 1-848-445-6111 should be contacted to make appointments or for referrals to further counseling services. The study will not pay for any counseling services recommended following participation in this study.

Benefits: Participation in this study may or may not directly benefit participants. Many people find it rewarding to share their stories with a mental health professional who responds with empathy, non-judgment, and compassion. Additionally, when people are given the opportunity to reflect on their past experiences it often leads to better understanding of themselves. Furthermore, the present research will contribute to the literature on Hindu American's conception of mental health, and will help reduce barriers to treatment.

Compensation: There will be no compensation for participation in this research study.

Cost: There will be no cost for participating in this research study.

Confidentiality: This research is confidential. Personal information will be kept private. All identifying information will be removed, and study records will use a participant code and pseudonym. Participants are asked to refrain from providing identifying information during the interview.

Data: Hard copies of interview data and audio recordings will be stored in a locked filing cabinet in the principal investigator's home and no one else will have access to the information. Once the data is transcribed the information will transferred to a password-protected and firewall-protected computer at the principal investigator's home. All data will be given an identification code and a pseudonym and only the researcher will have access to the code key. The code key will be stored apart from the data in order to ensure privacy. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law.

If a report of this study is published, or the results are presented at a professional conference, all identifying information will be disguised. The findings will be summarized and reported in group form and no participant will be identified personally. After the completion of the research, all study documents including participant identification codes, audio files and other computer files will be kept for five years, after which time all study data will be destroyed by the researcher.

Voluntary Participation and Withdrawal: Participation in this study is voluntary. Participants may choose not to participate, and may withdraw at any time during the study procedures without any penalty. Participants may additionally refuse to answer any specific questions with which they are not comfortable.

The principal investigator and the dissertation faculty chairperson Dr. Shalonda Kelly may be contacted with any questions, comments, or concerns at:

Kavita Pallod Sekhsaria, Psy.M.
Principal Investigator
GSAPP, Rutgers University
152 Frelinghuysen Road
Piscataway, NJ 08854
Kp614@gsapp.rutgers.edu

Shalonda Kelly, Ph.D.
Professor, Department of Clinical Psychology
GSAPP, Rutgers University
152 Frelinghuysen Road
Piscataway, NJ 08854
skelly@gsapp.rutgers.edu

If there are questions about the participant's rights as a research subject, they may contact the IRB Administrator at Rutgers University at:

Institutional Review Board
Rutgers, The State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Email: humansubjects@orsp.rutgers.edu

(732)235-9806

Copy of Consent Form to Subject: A copy of this consent form will be given to each participant.

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.

Participant (Print) _____
Participant Signature _____ Date _____
Investigator Signature _____ Date _____

Appendix A.2

AUDIO ADDENDUM TO CONSENT FORM

This consent form is for participants who have already agreed to participate in a research study entitled: Hindu Conceptions of Mental Health, conducted by Kavita Pallod Sekhsaria, Psy.M. This form requests the permission of participants to allow audiotaping of interviews as part of the research study. This procedure is mandatory; participants must agree to be audio recorded in order to participate in the study.

The recordings will be transcribed to ensure the authenticity responses, which is important for data analysis to ensure that information from the research study has been recorded accurately. This analysis includes reviewing the transcripts to discover common themes, similarities, and differences across all subjects.

The recordings will include the responses that were provided throughout the interview. Any names of people or places which were disclosed will be replaced with pseudonyms. Names will not be attached to any of the recordings, identification codes and pseudonyms will be used instead. Only the researcher will have access to the code in a password secured database.

This information will be kept confidential by limiting access to the research data. The recordings will be stored on a password protected computer and any hard copies of transcriptions will be stored in locked filing cabinet in a secure location. This information will be permanently erased and destroyed five years after the study ends.

A signature on this form grants the investigator named above permission to audio record the participant as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without written permission.

Participant (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix B:

Semi-Structured Interview Protocol

Opening

Thank you for your time and willingness to talk.

For in-person interviews:

Please take a look at the consent form I sent you, which I am going to ask you to fill in and sign. It contains details of how the information will be used and who will be able to access it. I will walk you through the form and make sure that you agree with what is on there. If there is anything you do not understand, then please ask me. (Review consent form with participant). Please take your time to read through the form again and when you're ready, initial each page and sign.

For Video chat or phone interviews (researcher has received signed consent form):

Thank you again for sending me your signed consent form prior to this interview. Before we get started, do you have any questions regarding how your information will be used and who will be able to access it?

Remember, you can take a break at any time during the interview, or you can stop the interview at any point without having to explain why. You may also refuse to answer any individual question. You can also withdraw your information and remarks from the study after the interview if you wish, again, without having to explain why. Do you agree with all this?

Do you have any questions before we get started with the interview?

For the first piece of the interview, I'm going to give you a couple of short vignettes, or stories, that I'd like you to read. Then I'm going to ask you some questions about your reactions

Schizophrenia Vignette (will not be labeled as such):

Rakesh's family describes a change in his personality that began approximately two years ago. The onset of these problems coincided with the closure of his dry cleaning shop because of

financial difficulties. At this time he became quite moody, to the extent of sometimes showing marked mood swings. During the past two years there were occasional episodes of verbal abuse and threats of physical violence towards his family and friends. When he became agitated, his speech was also sometimes difficult to understand.

His condition markedly worsened approximately four to six weeks ago. At this time, Rakesh's family noted an escalation of his problems with mood swings. He became increasingly agitated, and he also became verbally abusive to his brother and his friends, even threatening to kill them. He also became suspicious, believing his family and friends were trying to harm him, and that he was being spied on by the television and radio.

Questions:

1) What do you think is ailing Rakesh?
2) What would you recommend Rakesh, or his family, do now?
3) Have you known anyone go through anything like this? What did you recommend to them then?
4) What would you do if you were facing what Rakesh is facing?

Depression Vignette (will not be labeled as such):

Aarti is a 35-year-old female. She is married, and has two children who are in high school. Lately Aarti has been complaining about being unable to sleep, and has seemed more irritable to her friends and family. Her body is constantly aching, but her primary physician can't trace a cause for this. She and her husband have been fighting a great deal, and he's started to make threats about divorce. She's also been struggling at her job as a computer programmer. She's very worried she's going to get fired, but is still struggling to concentrate and work the way she did when she first got the job. From time to time she gets overwhelmed with feelings of hopelessness, and wonders what the point is to living. She tries her best to take care of her children and to do the things she used to enjoy like cooking and watching soap operas, but she feels like she's just going through the motions.

Questions:

1) What do you think is ailing Aarti?
2) What would you recommend she, or her family, do now?
3) Have you known anyone go through anything like this? What did you recommend to them then?

4) What would you do if you were facing what Aarti is facing?

Post Vignettes:

Hindu American Group

1) How old are you?
2) What is your gender identity?
3) What is your profession?
4) How would you define mental health?
5) What about mental illness?
6) How would you describe your religious identity?
7) Do you feel any conflict between your religious identity and your understanding of mental health?
8) Have you ever sought mental health resources yourself?
9) What, if anything stopped you from seeking help?
10) What do you think has stopped other people from seeking help?

Hindu American Provider Group

1) How old are you?
2) What is your gender identity?
3) What is your profession?
4) How would you define mental health?
5) What about mental illness?
6) How would you describe your religious identity?
7) Do you feel any conflict between your religious identity and your understanding of mental health?
8) **Do you feel any conflict between your identification and your practice?**
9) Have you ever sought mental health resources yourself?
10) What, if anything stopped you from seeking help?
11) What do you think has stopped other people from seeking help?
12) **What do you think providers can or should do in order to engage Hindu Americans in mental health treatment?**

Hindu American Clergy/Religious Leaders Group

1) How old are you?
2) What is your gender identity?
3) What is your profession?
4) How would you define mental health?
5) What about mental illness?
6) How would you describe your religious identity?
7) Do you feel any conflict between your religious identity and your understanding of mental health?
8) **How do you counsel those who come to you who may be mentally ill?**
9) **How do you feel about advising people to seek services?**
10) **Do you feel your faith helps or hurts you in your counseling?**
11) Have you ever sought mental health resources yourself?
12) What, if anything stopped you from seeking help?
13) What do you think has stopped other people from seeking help?

Wrap-up Question:

1. Is there anything that we haven't discussed about your experience with mental health that we haven't talked about that you would like to add?

Summary and closing:

Thank you for sharing your story with me.

How did you find the interview?

Do you agree for your data to be included in my study?

Appendix C:

Recruitment Email

The following email was posted on the following listservs: Division on South Asian Americans (Asian American Psychological Association), NAMI SAMHAJ, Hindu Heritage Youth camp. This email was also sent to personal friends and family with a message at the beginning requesting that the contact forward the message to anyone they know who may fit the following criteria: Hindu American over the age of 18, Hindu American Clergy/Community Leader who engaged in informal counseling, or Hindu American Mental Health Provider.

Hi,

My name is Kavita Pallod Sekhsaria and I am a fourth-year doctoral candidate in the Clinical Psychology program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

I am conducting a study on Hindu American well-being. Are you a Hindu American? Are you interested in helping me find ways to better serve our community? Please contact me!

Participants will be interviewed about their thoughts on what enables mental and emotional well-being. Results obtained will be used to increase understanding of how Hindu Americans think about mental health.

If you are interested in participating or learning more about the study, please contact me, Kavita, by phone at 713-562-4524, or by e-mail at Kavita.pallod@gsapp.rutgers.edu for more information. In addition, please pass this email along if you know any other Hindu Americans that may be interested.

Interviews will last approximately 90 minutes and will be conducted in person or via phone or video chat. All interviews will be audiotaped to ensure accuracy in transcription. Confidentiality of all data obtained is ensured. Participants will not be compensated for this study.

Thank you so much for your time and consideration!

Sincerely,

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