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Lived Experiences of Pakistani American Women Who Sought Mental Health Treatment

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Walden University
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Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

Despite the research on how mental illness manifests in the United States, there is more to be known about mental health in the Pakistani American population. The goal of this qualitative phenomenological study was to understand the lived experiences of Pakistani American women who sought mental health treatment. Ecological theory provided the framework for the study. Data were collected from semi structured interviews with 10 participants via telephone and face-to-face conversations. Data were analyzed using managing, reading, memoing, describing, classifying, interpreting, representing, and visualizing techniques. Findings indicated that seeking help for mental health played a positive role in participants being able to deal with their issues. Participants preferred having someone within the family to speak with regarding their perceived problems. Participants also reported struggles they encountered when trying to seek help, including cultural stigmas around women bringing shame upon their family with this perceived weakness. Participants viewed mental illness as being lost spiritually and as something that cannot be explained all the time, and they described the frustration of an unseen burden they believed they were destined to carry alone. Findings may be used by mental health professionals when working with Pakistani American female patients leading to positive social change for the patients.

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Dedication

I would like to dedicate this to my mother who has been my backbone throughout my life and especially during my dissertation and PhD process. She is the main reason why I pursued my education this far. I have always wanted to study further, but she was the one who made it all possible with her love and support. I would also dedicate this to my whole family, especially my younger brother who has been a great help.

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There are many people who have come and gone from my life, and there are others who have always been with me through everything. They have been there through all my bad and good decisions. My family is my backbone, my rock to everything I do. I also believe that if it were not for my belief in God, I might have lost hope to do this with everything that has been going on in my life. I am grateful to everyone for their contributions through this whole process. I would also like to thank the faculty and advisor who helped and guided me in the right direction to finish what I started.

Table of Contents

Chapter 1: Introduction to the Study....1

Background....2

Problem Statement....4

Purpose of the Study....5

Research Questions....6

Theoretical Framework....6

Nature of the Study....7

Assumptions....8

Scope and Delimitations....9

Limitations....10

Significance....11

Summary....11

Chapter 2: Literature Review....12

Literature Search Strategy....12

Mental Health Illness....12

Depressive Disorder....15

Mental Health and Pakistani American Communities....22

Chapter 3: Research Method....33

Research Questions and Subquestions....33

Research Design and Rationale....34

Role of the Researcher....34

Methodology 34
Participant Selection 35
Procedure for Recruitment 36
Data Collection 36
Data Analysis 37
Validation of Results 39
Trustworthiness 39
Ethical Procedures 40
Summary 41
Chapter 4: Results 42
Setting 42
Data Collection 43
Data Analysis 43
Evidence of Trustworthiness 44
Results 45
Research Question 1 45
Research Question 2 48
Research Question 3 48
Conclusion 49
Summary 49
Chapter 5: Discussion, Conclusions, and Recommendations 51
Limitations of the Study 53

Recommendations....53
Implications....54
Summary....55
References....57
Appendix A: Request Seeking Participants for Study....67
Appendix B: Participant Responses to Question 1....68

Chapter 1: Introduction to the Study

In examining the lived experiences of Pakistani American women, there is a common theme in the emotions surrounding their personal interactions with mental illness and mental health services. The theme identified in Pakistani communities is concern for the stigma of mental illness that can be brought upon the family as a direct result of acts perceived as unbecoming of a woman. Studies have shown that many Pakistani American women residing in North America tend to avoid mental health services (Bui & Takeuchi, 1992).

The concept of self-respect, or izzat, plays a huge role in the lived experiences of these women and their role in the family hierarchy (Gilbert et al., 2004). The families have a belief that if someone is mentally ill, it should be kept a secret within the family as it is understood that it is something that could probably detract from their status within the community. Gilbert et al. (2004) conducted a study examining different South Asian communities, including the Pakistani community. The findings indicated that there is substantial distrust among the members of the community toward their doctors. Pakistani American women believe that the doctors do not abide by the laws of patient–doctor confidentiality and will disclose details of their illness to the community (Gilbert et al., 2004). Anyone labeled with any kind of mental illness is ostracized within the community because it is more important to keep the family reputation in line. The current study addressed Pakistani American women's experiences with mental health and mental health care.

The concept of izzat provided a cultural context to ground the research in the case of Pakistani American women. Izzat served as a frame of reference for understanding some of the barriers these women may face in seeking mental health care. The following section outlines other research in the field as well as foundational information on the types of mental illness, such as major depressive disorder, that the participants addressed in the interviews.

Background

Studies on Pakistani and Pakistani American coping have shown associations between cultural variables, attributes, and coping strategies. From a research perspective, this is a problem that needs to be further examined because Asian populations, including the Pakistani population, have reported higher levels of somatic problems relative to Western populations (Sue, 1991). A systematic literature search showed that there are limited studies on Pakistani American women coping with mental illness. Within the preferred supports of family and community, participants are more likely to rely on community organizations than their family. Studies of Asian American communities, including Pakistani Americans, have shown that mental illness attributions correlate with preferred coping (Sue, 1991). Furthermore, Asian American university students preferred self-help methods for dealing with psychological difficulties if they conceptualized mental illness as controllable. This was an important consideration in the current study because understanding the personal interactions with mental health issues may assist health care providers in becoming better equipped to help this community. Given these preferences for self-help or seeking support in community organizations or family over

professional services, I sought to interview women who contradicted these general trends in seeking out professional mental health care.

In analyzing the literature, I noted the lack of research on the lived experiences of Pakistani American women and their ability to seek professional help in dealing with mental illnesses. The limited research may have resulted from minority groups varying in their lived experiences given cultural norms that are not included in the dominant societal narrative. Issues such as social networks and coping strategies can play a role in mental health. For example, among Pakistani American women, there are multiple factors that influence how women are perceived by members of their family. Pakistani American women predominantly live in households where women are never left alone, and if they do not wish to disclose their mental health issues to members of their family, they find it nearly impossible to seek out assistance. Kapadia et al. (2015) stated that women felt they needed to cope with their mental illness alone. There is a strong belief among Pakistani families that such issues should be kept in house and the constant fear of having one's name in the gossip and rumor mill plays a strong role in keeping these women from going out of their social network to seek help for their illness (Kapadia et al., 2015). This reinforces the concept of izzat and the feeling that one needs to protect one's reputation above all.

Studies have shown that these same social networks have influenced and perpetuated the negative attitude toward having a mental illness, as well as seeking help for the mental illness. The primary issue within these social networks is that they consist primarily of family members and not friends. This is important because studies have also

shown that increased contact with family members and close relatives can decrease the use of mental health services (Maulik et al., 2009). This is crucial in attempting to understand what influences the thinking of Pakistani American women seeking help for their mental illness. The purpose of the current study was to obtain a deeper understanding of the Pakistani culture (see Kapadia et al., 2015).

Problem Statement

The low frequency of treated depression in South Asian women has been examined in the past but has not been sufficiently explained. The common justification for low frequency of treated depression is that women from these communities often have difficulty in articulating their grief. The purpose of the current study was to present a better understanding of Pakistani American women and their personal dealings with depression (see Burr & Chapman, 2004). Research has suggested that due to the lack of fundamental knowledge of Pakistani American women and the ways in which they deal with mental health issues, there is a disconnect between them and the medical professionals who can help them. The research purpose was to examine the lived experiences of Pakistani American women in deciding whether to seek help for mental health issues. It was important to study the lived experiences of Pakistani American women in seeking help with their mental illness because themes formulated from their experiences may be used to help them. Findings may be used to convince them to seek help, and findings have the potential to assist the next generation of Pakistani American women.

There is a general theme of preserving one's izzat in Pakistani American women and their experiences in seeking assistance when dealing with mental health. Therefore, it can be argued that culture plays a part in a women's mental health. Evidence of this can be found in the work of Steptoe et al. (2007), who examined the role that various factors (including culture) played in the mental health of their subjects. Steptoe et al. found cultural beliefs play the largest role in mental health stability. Although izzat is one of the many factors that were addressed in the current study, it was not the focus of this research. This finding merely illustrated the point that Pakistani American women are so bound to follow what they have learned throughout their culture that they tend to stick to the cultural values even when this can be harmful to their mental health.

Purpose of the Study

Akutsu and Chu (2006) reported that among Asian Americans (including Pakistani women), less than 6% received assistance from health care providers for mental health problems. When comparing Asian immigrants to other cultures and groups regarding utilization of mental health care services, Akutsu and Chu found that Asians reported the lowest rates of use. The purpose of the current study was to examine the lived experiences of Pakistani American women who had experienced mental health illness. Many Pakistani Americans refuse to seek mental health services because they are in constant fear of losing their status in the community. Although this fear was not the primary reason behind exploring Pakistani American women's experiences, it was an important factor to examine.

Research Questions

The purpose of this phenomenological study was to examine the lived experiences of Pakistani American women in Northern New Jersey who had sought mental health services. To achieve this goal, I posed the following research questions and sub questions:

Research Question 1: Has seeking help for mental health benefited Pakistani American women in dealing with their issues?

Sub question A: What are the barriers Pakistani American women face when seeking help for mental illness?

Sub question B: What are the struggles Pakistani American women face when seeking help?

Research Question 2: What meaning does mental illness hold in Pakistani American women's lives?

Research Question 3. What is the role of Pakistani American women's family members and personal shame in their experience with seeking mental health services?

These questions were used to guide examination of the lived experiences of Pakistani American women regarding their mental health.

Theoretical Framework

The theory best suited for my research was Bronfenbrenner's (1977) ecological theory, which states that the development of an individual is explained best by five separate yet intertwined environmental systems. The microsystem is the subject's immediate environment, meaning friends, family, and work environment. The next system surrounding the subject is the exosystem, which is the larger institution that

surrounds the individual's everyday life that indirectly affects their microsystem, but the exosystem of the individual does not have a direct connection with the individual themselves. Examples of possible exosystems include mass media and local community.

The next system that interconnects the micro and exosystem is the mesosystem, which is how all of the connections the subject has in his microsystem and the exosystem are related to one another, and can be viewed as a measure of the relationship between the two. The system encapsulating the exosystem is the macrosystem, which generally pertains to the culture of the area where the subject lives. This is any combination of behavioral patterns of the larger community surrounding the individual or attitudes among the larger community toward a specific object. The macrosystem is perhaps best explained as the ideas and thought processes that define the larger community where the individual lives. The final system, which permeates all of the other systems, is the chronosystem, which refers to changes over time. This can be composed of many things, including environmental disasters, social or historical events that played out on a global scale, events specific to the individual such as the death of a loved one or any major familial struggle, or normal development throughout the individual's lifespan.

Nature of the Study

The purpose of this study was to understand the lived experiences of Pakistani women as they deal with mental illness. A qualitative phenomenological approach was used to comprehend the different factors that influence these women when it comes to seeking professional assistance for their mental illness. For the purpose of this study, a qualitative approach was more appropriate than a quantitative approach. The quantitative

approach was not suited for this study was quantitative research requires numerical data to conduct statistical analyses, which was not the purpose of the current study. Qualitative methodology was more appropriate than quantitative methodology because the former involves gathering data through in-depth communication with each participant.

Assumptions

The assumptions in this study were that Pakistani women do not seek help when needed and are bound by cultural barriers. Assumptions were also made in regard to the family structure of most Pakistani American families, and their views regarding respect in the community and mental health. In addition, assumptions were also made about how these women have difficulty in discussing their mental health issues with the appropriate professionals.

Aspects of the study that were believed but could not be demonstrated to be true included the idea of the difference between Asian cultures and Western culture. Another aspect of the study that was believed to be true but could not be demonstrated was the idea that depression in Pakistani American women stems from certain preconceived notions regarding the culture including but not limited to arranged marriages and relationships that are built on things other than an understanding and love for one another. Another assumption was that Asian women feel better, similar to their Western counterparts, by talking about their mental health and their emotions. These assumptions were necessary in the context of the study because communication is considered a vital step in fixing mental health issues, and in Western culture communication is emphasized

so heavily that if a channel of communication were to be established among the Pakistan American community, they too may benefit from speaking about their personal issues regarding mental health.

Mental illness has been widely studied as a health disorder related to a personality trait (Spielberger et al., 1995). A major analysis in mental illness research is the difference between conceptualization and appearance of mental illness within different cultures. According to Akiskal (1995), the diversity of the presentation of symptoms within multiracial communities can vary as a function of cultural considerations. In terms of the Pakistani American community, it is understood that Pakistanis are known for their interdependence (Ho, 1995), which may limit seeking treatment among Pakistani women for mental health issues.

Scope and Delimitations

The specific focus was Pakistani American women who have problems with mental illness. The reason they were chosen as the focus group was because I came into contact with Pakistani American women who did not have a way to explain how they were feeling and the lack of trust they had in sharing some of their issues with someone who was not a family member. Trying to bridge that gap was one of the reasons for conducting this study. Some of the boundaries of this study were that it was conducted in Northern New Jersey, so the results can not be generalized to all Pakistani American women. Concepts that were related to the study but not investigated included whether these women were employed or had responsibilities outside of their domestic responsibilities, and whether language barriers may have influenced their willingness to

open up to someone regarding their mental health issues. Findings may provide a framework for further research.

Limitations

Limitations may have prevented me from obtaining answers to the research questions. Investigating the lived experiences of Pakistani American women regarding seeking professional mental help was intended to offset any limitations associated with this project. The way individuals deal with mental health issues is strongly connected to their culture, and Pakistanis are known for their interdependence (Ho, 1995), which may limit seeking treatment among Pakistani women for mental health issues. Umemoto (2004) found that Asian Americans, including Pakistani American university students, had a tendency to conceptualize mental health problems as inconvenient and had a greater likelihood of favoring self-help methods to address psychological problems. Therefore, one limitation may have been that the participants were not willing to address their personal issues regarding opening up to a mental health professional about their mental health. There was an issue of honesty as well, with a possibility that not all participants were forthcoming regarding their dealings with mental illness and the response of their families. This may have limited responses during the interviews. Another limitation of the study was the geographic limitation of sampling from Northern New Jersey. The geographic range prevented the findings from being generalizable to all Pakistani American women.

Significance

The results obtained from this study on the lived experiences of mental illness in Pakistani American women and their thought processes may assist mental health professionals in the future. Findings may help Pakistani American women in seeking care for mental health issues and may promote further research on this population. Understanding the pros and cons that Pakistani American women weigh in deciding whether to seek professional help may help providers better address their concerns and reduce barriers to access. The findings could also be used to inform the female Pakistani American community that it is acceptable to seek professional help for mental health by identifying the stigmas attached to the idea of mental health assistance.

Summary

Pakistani American communities are known for cultural values against seeking mental health assistance. Pakistani Americans seek every other solution to their mental health problem before seeking any professional help. Pakistani people are taught that family values are the most important thing to them, and they should always keep that in mind and not let any harm come to the family name. Understanding the lived experiences of Pakistani American women and their dealings with mental health may bridge the divide that currently exists between the target group and mental health professionals.

Chapter 2: Literature Review

This chapter presents information on mental illnesses and the prevalence of these illnesses within the Pakistani community. Mental illness is examined as a function of both background information, which includes anything from relevant statistics to major symptoms, and diagnoses.

Literature Search Strategy

The literature review was conducted using Walden University's library and research center. I used the ERIC database, along with the PSYCinfo and PSYC articles, to find articles that would help validate the central question being asked. Pakistani, mental health, experiences, reluctance, women, Asian women, and depression were some of the key words and phrases that were used to narrow the search results.

Mental Health Illness

Major depressive disorder (MDD) is present in a larger portion of the population than schizophrenia and obsessive-compulsive disorder, which present at the rate of 1–2% of the population (Angst, 1999). One would not expect such high rates of malfunction given that the pressures of evolution should have created resistance in an organ that is integral in encouraging survival and reproduction, but mental disorders persist in populations (Angst, 1999). Feeling dejected and a desire to give up occur naturally in everyone's lives at one point or another, but typically this sort of emotion passes after a short while. However, in the case of individuals suffering from a mental illness, such as depressive disorder, these negative emotions interfere with daily life and normal functioning, and they affect not only the individuals but also those who care about them.

Mental illness is an extremely common and serious illness, and most who experience it need treatment to improve in mental status. Individuals who experience depressive illness often do not believe that they need treatment (Angst, 1999). Treatment is beneficial and yields improvements in most individuals who suffer from mental illness. In the past 50 years, there has been profound and intensive research on depressive disorders resulting in the numerous medications, psychotherapies, and other techniques to help treat people with MDD (Ferrier, 1999).

MDD is the most serious of the disorders and is classified as a major mental health disorder. The condition is defined as the presence of a depressed mood or lack of interest or pleasure in usual activities for the entire day and nearly every day. There should be interference with the individual's social or occupational functioning for the conditions to be considered symptoms of MDD. Additionally, the severity of the duration and remission status, if any, is taken into consideration in classifying the condition as MDD. A diagnosis of MDD is given if there have been at least two episodes of depressive disorder (Katon, 2003).

Depressive disorders exist in several forms. The most common forms are MDD and dysthymic disorder (McBride & Abeles, d). An inability to work, sleep, study, eat, and complete normal daily activities is indicative of MDD. An inability to function normally on a constructive daily basis is characteristic of a major mental health disorder. An individual may experience an episode of a major mental health disorder only once, but there is a likelihood of it recurring throughout a person's life. In contrast with MDD, dysthymic disorder is not as a severe although it is chronic and can last 2 or more years.

People who experience dysthymia can also have one or more concurrent episodes of MDD (McBride & Abeles, 2000).

One or more episodes of major depression, without a history of mania, can be characterized as MDD. These depressive episodes are unprompted; they are not caused by a medical condition, medication, substance abuse, or psychosis. If mania, hypomania, or a composite of the two behaviors is involved, the diagnosis changes to bipolar disorder. Although MDD is known to have an onset in the early to mid 20s, there is no limit to when the disorder may begin. Some individuals experience episodes that occur years apart without symptoms of mental illness between episodes. Episodes may also cluster together as the individual ages (McBride & Abeles, 2000). An evaluation of the existence of psychotic features also takes place when examining symptom-level mental health severity (Fennig et al., 1994).

According to the Diagnostic and Statistical Manual of Mental Disorders, psychosis is not a subtype of mental health disorder but rather an indicator of mental health severity. Psychosis can qualify as mood congruent (e.g., its contents are consistent with depressive theme) or mood incongruent (American Psychiatric Association, 2000b). Research suggested that individuals with psychotic depression are typically older with poorer premorbid functioning, longer depressive episode duration, and increased likelihood of future psychotic depressive episodes (Bromet et al., 1992). Cognitive performance may be affected by aspects of an individual's course of illness, including the onset age and number and duration of depressive episodes. Another element to consider is treatment resistance, which contributes to longer episodes and increases the likelihood

of exposure to more psychotropic medications and combinations of medications for a longer period of time, which is negatively associated with cognitive function (Gibel & Ritsners, 2008).

Recurrent depression is considered more severe and disabling than single episode depression (Paradis et al., 2006). Individuals with chronic, recurrent depression express more Axis I (i.e., anxiety, substance abuse), Axis II (i.e., personality disorder), and Axis III (i.e., somatic complaints, somatic diseases) comorbidities (Katon, 2003). Increased negative perceptions of social stimuli (i.e., vocal expressions, facial expressions) and self as well as poor marital and interpersonal relationships and employment functioning are associated with recurrent depression.

In a comparison of 22 patients with nonpsychotic MDD and 30 healthy patients, Landro et al. (2001) found that those with MDD performed worse in the areas of attention, working memory, verbal fluency, and verbal long-term memory. The scores of the depressed group were more than 1.5 standard deviations lower in attention and working memory, 1.0 standard deviations lower in verbal long-term memory, and 0.5 standard deviations lower in verbal fluency. This aligned with other findings that suggested impairments in verbal fluency and cognitive flexibility (Landro et al., 2001).

Depressive Disorder

There are three phases of MDD treatment: the acute phase, the continuation phase, and the maintenance phase. Lasting 6 to 12 weeks, the acute phase aims to achieve response and remission of the symptoms of depressive disorder. The second phase, continuation, lasts 4 to 12 months throughout which there is the consolidation of

remission to prevent relapses. The final phase of treatment, maintenance, lasts 1 or more years and aims to prevent recurrences of depression. Nearly all studies in children and adolescents have been evaluations during the acute phase of treatment (Emslie et al., 2004).

Antidepressants are used to treat the full spectrum of depressive disorders, from dysthymic disorder and acute major depression to classical melancholia. Primary care physicians prescribe approximately twice as many antidepressant medications as psychiatrists in the United States. Psychotherapy, such as cognitive behavioral therapy or interpersonal psychotherapy, can also be used to treat depressive episodes (Ferrier, 1999).

Multiple symptom domains, including emotional symptoms (e.g., depressed mood and anhedonia), physical symptoms (e.g., fatigue, sleep disturbances, and appetite changes), characterize major depressive disorder. Although pain has not been emphasized as one of depression's physical symptoms, 65% of individuals with depression report at least one symptom of pain. Depression outcomes are substantially affected by the presence of pain in depressed patients (Ferrier, 1999).

Treatments of MDD that have demonstrated efficacy over the past three decades are cognitive-behavioral therapy (CBT), interpersonal psychotherapy, and antidepressant medication (De Maat et al., 2006). However, a substantial portion of depressed individuals did not benefit from these treatments despite randomized controlled trials assessing the treatments. Clinical researchers have attempted to identify factors that predict MDD treatment response in general and differential treatment response in particular. Clinicians who identify pretreatment characteristics that predict poor response

may allow them to preemptively gear treatments that target these characteristics. Furthermore, clinicians may be able to steer patients toward modalities that are most likely to be effective if certain characteristics are associated with differential risk in some treatments but not others (Rush et al., 2006).

Cognitive therapy group participants had fewer depressive thoughts than individuals with depression who did not participate (Oei & Sullivan, 1999). Psychotherapy's specific mechanism proposes change, which accounts for the effectiveness of treatment packages. Few empirical studies have demonstrated that the effects of the psychotherapeutic treatments widely practiced today can be accounted for by the proposed mechanisms.

With the leading indication of medication resistance, electroconvulsive therapy (ECT) is considered one of the most effective antidepressant treatments (American Psychiatric Association, 2001). Critics of ECT cite the resulting substantial and permanent memory loss patients experience, sometimes leading to dense retrograde amnesia that extends back several years, as a mark against the therapy. ECT courses are followed by anterograde amnesia (difficulty retaining newly learned information) and retrograde amnesia (difficulty recalling events that occurred in the preceding weeks or months; Sackeim et al., 1992). MDD is most commonly treated by antidepressant medications (Olfson & Klerman, 1993). Studies have shown that mildly to moderately and severely depressed patients benefit from antidepressant medication.

The suggested first line of therapy for patients with moderate to severe MDD is antidepressant medication according to the American Psychiatric Association's Practice

Guidelines for Major Depressive Disorder in Adults (American Psychiatric Association, 2000a). However, there is significant room for improvement in treatment outcomes given that 30–40% of patients are nonresponsive to this therapy (Antonuccio et al., 1995). CBT is the most empirically investigated psychological treatment. For depression, other investigated therapies include interpersonal therapy and short-term dynamic therapy (David, 2006). The foundation of CBT is the premise that dysfunctional cognitions are the stem for psychological problems.

Therapists work with clients in CBT to identify and focus on dysfunctional cognitions to modify them and remedy associated behavioral and emotional consequences. Cognitive therapy and rational emotive behavior therapy are two of the most widespread and influential forms of CBT (David, 2007). Beck's hypothesized cognitive model of depression states that individuals have stable cognitive patterns represented in their cognitive systems that develop because of early learning. Due to these cognitive patterns, people are predisposed to negative, often distorted, interpretations and descriptions of life events (David, 2007).

It is hypothesized that rational emotive behavior therapy (REBT) exceeds the efficacy of CBT by promoting a deeper change as it advocates unconditional self-acceptance, focuses on reducing secondary problems (e.g., depression about depression), and targets demands that appear to be the core belief in MDD (Solomon et al., 2003). REBT treatment focuses on this crucial component of depression and its main derivative that contributes to the understanding of cognitive factors in depression.

The current standard of treatment for depression remains antidepressant medication. In treating dysthymic disorder, REBT in combination with amitriptyline has been more effective than REBT or amitriptyline alone (Wang et al., 1999). Similarly, REBT in combination with lofepramine yields more improvement in unipolar depressed outpatients compared to pharmacotherapy along (Macaskill & Macaskill, 1996).

The fourth leading cause of disability worldwide is depression (Moussavi et al., 2007), and depressed individuals have a higher mortality rate than individuals who are not depressed (Cuijpers & Smit, 2002). The level of symptom severity and its potential effects on cognitive function should be considered at the time of neuropsychological testing. For example, in the case of depressive symptomatology, the number and duration of depressive episodes, duration of illness, and treatment resistance should be considered with respect to course of illness. Both neuropsychological performance and the potential resolution of cognitive impairments with treatment may be influenced by the different aspects of severity (Macaskill & Macaskill, 1996).

Between 50% and 75% of individuals diagnosed with MDD experience more than one depressive episode. The recurrent depressive episode usually presents within 6 months after the recovery from the first episode, and recurrence increases proportionally to the number of episodes (Angst, 1999). A single episode of depression is not as severe and disabling as recurrent depression (Paradis et al., 2006).

Increasing levels of disability, rather than the number of depressive episodes, correlated more with the severity of the depressive episode. There is conflicting evidence regarding whether the level of functional impairment is influenced more by the severity

or number of the depressive episodes. Generally, MDD has been associated with neurophysiological changes (Liotti & Mayber, 2001). Positron emission tomography studies have depicted decreased regional cerebral blood flow in the medial prefrontal cortex, anterior cingulate, and the orbital frontal cortex, which are areas that have been implicated in affective disorders.

Pseudodementia, the reversible impairment of memory secondary to depression, is a significant cognitive impairment caused by severe depression. In rare cases it is difficult to differentiate between dementia and pseudodementia, but in true dementia cognitive decline progresses over time, while the cognitive loss follows MDD in the case of pseudodementia (McBride & Abeles, 2000). Depression severity can modulate the relationships between global cognitive function clinically. The potential adverse effects of pharmacotherapy should be considered in addition to the positive influence that antidepressant medication may have on cognitive function in depression (American Psychiatric Association, 2000).

Varying degrees of impairment in the areas of social, functional, and interpersonal abilities are associated with depression. However, there is a limited understanding of the relationship between neurocognitive sequelae and depression severity, and depression has been inconsistently associated with neurocognitive functioning (Gualtieri et al., 2006). Increased symptom severity at the time of neuropsychological testing has been associated with more pronounced cognitive impairment. Neuropsychological domains such as visual memory and psychomotor skills largely relative to depression without psychotic features

may be negatively influenced by the presence of depression with psychosis (Reichenberg et al., 2008).

Other strategies can be employed if remission is not achieved early in the course of treatment with the first-choice antidepressant. One strategy that is generally effective if the drug has a positive dose-response effect is increasing the antidepressant dosage until the desired outcome is achieved or no further progress is seen. Other strategies include augmenting the partially successful antidepressant with a second medication, combining two antidepressants with complementary actions, or switching to an antidepressant with a different biochemical profile (Antonuccio et al., 1995). Although the treatments for anxious depression are similar to those for patients with depressive disorders, patients with concomitant anxiety and depression need higher doses of the prescribed antidepressant than patients with only depression (Chang, 2001).

David (2006) found that, without any previous warnings or symptoms of depression, major depressive disorders may occur at any point in a person's life. Major depressive disorder consists of a loss of interest in everyday life activities or a long-lasting depressed mood. It has the ability to affect memory and mental efficiency and can develop without a specific stressor. An individual may have hallucinations and delusional beliefs indicative of psychotic episodes. Environmental theories suggest a person may be suffering from major depressive disorder because of unfortunate circumstances that are difficult to change. An individual may also deny the fact that they are depressed (Reichenberg et al., 2008).

Concurrent mental illness makes major depressive disorder difficult to diagnose (David, 2006). The chronicity and presence of psychotic behavior are important aspects of major depressive disorder. Symptoms vary from age, sex, and the stage that the depression is in at the time of the diagnosis making diagnosis difficult (David, 2006).

The treatment of major depressive disorder aims to achieve complete remission or return to eurythmic, not simply symptomatic, improvement. While clinical trials have typically used response as the end, using remission as the goal of treatment sets a new, higher standard for antidepressants. Using a single antidepressant, especially one with dual activity, is one treatment option (Ferrier, 1999). Although, not the primary focus of this research depressive disorder is one of the more prevalent mental health issues among Pakistani American community.

Mental Health and Pakistani American Communities

Of all the mental health disorders, the most prevalent is depression, especially in the female Pakistani American community (Gee, 2004). The tendency of North American Pakistanis to use mainstream mental health services less than would be expected given their population size is well documented (Bui & Takeuchi, 1992). For example, a report indicates that less than six percent of Pakistani Americans sought a mental health professional's assistance when faced with a psychological problem (Akutsu & Chu, 2006). Some researchers interpret this decreased utilization as a reflection of low rates of psychological problems in Pakistani immigrants compared to other ethnic groups. The perceived severity of disturbance associated with their conditions may also contribute to the delay in seeking treatment that Pakistanis in North America have. A significant

positive determinant of treatment-seeking in Korean immigrants with mental health issues was the severity of distress (Shin, 2002). Similarly, Pakistani Americans' willingness to seek counseling can be predicted based on distress levels. In collectivist cultures, socially reticent behaviors, that do not disturb group harmony, are now regarded as maladaptive and rather are encouraged and positively valued (Heinrichs et al., 2006).

In a study of South Asian people with dementia, that included the Pakistani community, Bowes and Wilkinson (2003), found that residential care for an ill family member was met with a negative response from families and resulted in the limited access to appropriate services for the ill family member. The authors stated that the experience of dementia in South Asian communities is little understood and requires further exploration. The lack of access to mental health services by Asian individuals was also supported by a retrospective analysis of the cultural backgrounds of clients accessing inpatient mental health services at Fremantle Hospital in Western Australia (Orb, McGowan, Wynaden, & Quilty, 2001).

All participants expressed a need to maintain their family's reputation independent of the participants' level of education or country of origin. Individuals are often reluctant in discussing mental illness even if questioned by a general practitioner. Mental illness is considered a weakness and has a stigma attached to it, making it something to be ashamed of. In the case of problems that have a hereditary component, maintaining family reputation was even more important. Given that many Asian migrants hold high expectations for the success of their children they hope it gives a good impression of the family (Sheikh & Furnham, 2000).

The variation in the conceptualization and manifestation of depression in different cultures is a major area of inquiry. Some of the depressive experience may be universal but culture-specific elements of the experience may also exist. Related to the study of the unique cultural experiences of depression is the line of inquiry into assessing whether it is valid to apply Western instruments to cultures outside of the West.

Self-concept, socialization, stressors, and language are cultural factors that have been shown to affect and mediate phenomenological emotional experiences and the communication of those emotions. The lack of "standard" depression complaints is well documented. The diverse presentations of symptoms evident in clinical settings led to the multiracial taxonomy of mental health illness, including varied symptomatology (Akiskal, 1995). Interpersonal factors are being viewed as more important in the role they play in depression's origination and as the context for depressive expressions. Interdependence and collectivism are emphasized greatly by Pakistani American women (Ho, 1995). Thus, it would be understandable in the experiences and communications of Pakistani-Americans for interpersonal concerns of self-other relationships to be salient.

Coping mechanisms for mental health stressors are deeply tied to culture. Despite coping being a universal act, it is shaped by an individual's evaluation of both the stressors and available resources for coping. Particularly in the case of Pakistani Americans, scholars speculate that their coping strategies are shaped by Asian cultural values and worldviews. Some collectivistic notions that would contribute include the ideas that individuals should preserve social harmony by matching feelings to the current

environment, accept problems instead of confronting them, and not disclose personal problems to other in order to save face (Inman & Yeh, 2007).

Engagement coping and disengagement coping are the two broad categorizations of coping strategies. Engagement coping consists of actively negotiating to cope with stressful situations. Disengagement coping includes focusing on thought, feelings, and behaviors that avoid stressful situations. Compared to European Americans, Asian Americans, in alignment with Asian values and worldviews, are likelier to disengagement coping strategies over engagement coping strategies (Chang, 2001).

South Asian Americans, including Pakistani Americans, have been shown to cope with stress by relying more on social withdrawal and problem avoidance than European Americans (Chang, 2001) and less on social support (Kim, Sherman, & Taylor, 2008). There has been less research on within-group differences of South Asian Americans than comparisons with other cultural groups, such as European Americans. Acculturation to the dominant European Canadian culture was negatively associated with avoidant coping in a within-group study of Chinese Canadian adolescents (Kuo, Roysircar, & Newby-Clark, 2006).

The degree to which people from a minority culture adopt the norms of the majority culture is measured as acculturation. In contrast, enculturation reflects the extent to which individuals from a minority culture retain the indigenous cultural norms they are socialized to (Kim, 2007). It seems critical to examine whether there is an association between Pakistani American women maintaining their cultural values and their chosen

strategies of coping. The relationship between coping strategies and culture has not been studied deeply despite the potential of this association.

An effective and culturally sensitive approach to help Pakistani American women develop coping strategies that are more adaptive would consist of variable mediation rather than trying to change cultural values (Chang, 2001). Chun, Moos, & Cronkite (2006) theorized that individuals' evaluations of stressful situations and the subsequent coping strategies they employ are shaped by attributions. Chun et al. (2006) used the cultural variables of collectivism and individuals to situate differences in individuals' attributions. Similarly, Inman and Yeh (2007) suggested that cultural values come into play in that they influence the meanings individuals ascribe to events and subsequently the stress response individuals have.

Individuals' mental health coping mechanisms are closely related to their cultures. While coping is universal, it is shaped by culture in individuals' evaluation of their stressors and coping resources. According to research, Asians' and Asian Americans' preferred coping methods are related to the attributions towards mental illness that these groups hold (Xia & Jiang, 2007). For instance, Umemoto (2004) found that Asian Americans, including Pakistani American university students, had a tendency to conceptualize mental health problems as inconvenient and had a greater likelihood of favoring self-help methods to address psychological problems. Research on Pakistani and Pakistani-American coping have shown associations between cultural variables, attributes, and coping strategies.

With the numbers of South Asians (specifically Pakistani and Indian Americans) in the U.S on the rise, there is an accompanied increase in them seeking out mental health services (Durvasula & Mylvaganam, 1994). Chinese and Japanese Americans have been the main focus of studies of Asian American mental health status. The generalization of findings from theses subgroups to Asian Americans as a whole does not account for the unique elements of various Asian cultures. Conceptualizations of mental illness, treatment-seeking behaviors and patterns of acculturation and enculturation vary between cultures and are not accounted for by way of generalized findings (Durvasula & Mylvaganam, 1994).

Individuals' beliefs, attitudes, and preferences are influenced by cultural and personal experiences. But researchers' and clinicians' failure to understand differences between Asian cultural population groups can lead to potential diagnostic errors and difficulties engaging patients from those groups in treatment (Farver, Narang, and Bhadha, 2002). In the U.S., Asian Indian immigrants reported more positive mental health outcomes in association with mainstream culture acculturation and in negative association with traditional cultural orientation adoption (Mehta, 1998). Similarly, a study of older Asian Indian immigrants' psychological wellbeing found a bicultural or American cultural identity adoption correlated with less depression that a traditional cultural identity adoption (Diwan, Jonnalagadda, & Balaswamy, 2004).

A qualitative study used a vignette methodology to compare two conceptual depression models in New York City among European American and South Asian immigrant women (Karasz, 2005). The models placed varying emphasis on situational or

bio psychiatric origins of depression. The tendency to interpret depressive symptoms as an illness, compared to a feeling state, was higher in European American women than South Asian. This disease orientation of depression correlated with increased perceptions of a chronic or deteriorating timeline, need for seeking professional treatment and severity. Greater acculturation in the South Asian immigrant women was also associated with the disease orientation of depression.

Social desirability and cultural sanctions lead to delays in seeking treatment among Asian groups (Mukherji, 1995). Public displays of emotional instability are viewed not only as poorly reflecting the individual but also their family and community at large in many Asian cultures. However, somatic or physical illnesses that are culturally accepted may legitimize otherwise socially inappropriate emotional displays. Therefore, somatizing psychological complaints can relieve the psychological burden of stigma and shame associated with mental illness from a person without harming their family. The cultural stigmas associated with mental illness create a barrier to early symptom recognitions and intervention among US psychiatric hospital Asian Indian patients because families aimed to deny the illness and keep a family member's mental condition unknown to outsiders (Conrad and Pacquiao, 2005).

A major stressor in the lives of ethnic/racial minority group members is discrimination, which they are both more likely to experience and serves as a major life stressor (Williams & Mohammed, 2009). Gender-based differences in coping styles in Pakistani American populations show a tendency to employ less effective depression coping mechanisms by women than men. A ruminative depression coping style focuses

on possible causes, consequences, and symptoms of depression while an active depression coping style consists of individuals attempting problem solving and distracting themselves from their symptoms (Nolen-Hoeksema, 1994). Nolen-Hoeksema (1994) found that men were less likely to use ruminative coping styles than women and women were likelier to focus on their mood, if they reported feeling sad, than men. She concluded that an active coping style is more effective than a ruminative because rumination lacks problem solving or addressing attempts, thereby increasing the duration of the depressive symptoms.

According to Skinner (1995), though there exists a reciprocal relationship between coping and control, maladaptive reactions occur in objectively uncontrollable circumstances, potentially leading to feelings of powerlessness, frustration, and exhaustion. When considering the roles of religion and kismet, a concept of fate/destiny that is commonly used to explain life events in some Asian communities, theories involving locus of control can be considered relevant. There is an overlapping of external locus of control and internal locus of control (i.e., passive and active loci of control) caused by the belief and application of the concept of kismet (Skinner, 1995). This stems from the belief that God has predestined the individual's problems and ability to handle them as the external locus of control and the acceptance of this belief helps cope with the depression plays the role of the internal locus of control (Gee, 2004).

A systematic literature search has shown that there are limited studies on Pakistani-American women coping with mental illness. A community survey of alternative models of mental health assessing support types and coping strategies of

Asians dealing with difficulties in their lives found that more participants sought support from family and within their communities over assistance from professionals (Beliappa, 1991). Moreover, within the preferred supports of family and community, participants were more likely to rely on community organizations than their family. This creates an issue for the health service that operates on the belief that problems are managed in the umbrella of the 'extended family.' The problem type, service accessibility, and advocacy strength affected the type of support networks used. Prayer, crying, family support, self-confidence, counseling and hard work are the most commonly employed coping strategies. The listing of crying as a coping strategy is interesting. Zeidner and Endler (1996) state that some individuals may view depression symptoms, e.g., sleeping, crying, etc. as coping strategies.

A study on in-patient views on local mental health services found that the most commonly employed strategies to help Asian patients and carers cope with mental illness included religion, prayer, and seeking help from religious healers (Greenwood, Hussain, & Burns, 2000). Greenwood et al. also found that fulfilling the patient's familial obligations helped them cope by reducing their burden.

Coping mechanisms for mental health stressors are deeply tied to culture. Despite coping being a universal act, it is shaped by an individual's evaluation of both the stressors and available resources for coping. Particularly in the case of Pakistani Americans, scholars speculate that their coping strategies are shaped by Asian cultural values and worldviews. Some collectivistic notions that would contribute include the ideas that individuals should preserve social harmony by matching feelings to the current

environment, accept problems instead of confronting them, and not disclose personal problems to other in order to save face (Inman & Yeh, 2007).

There is a greater likelihood for Asian Americans to use disengagement coping strategies over engagement coping strategies than European Americans. Asian Americans cope with stress by relying more on social withdrawal and problem avoidance than European Americans (Chang, 2001) and less on social support (Kim, et al., 2008).

Population health is faced with the challenge of understanding the mechanisms that lead to population disparities in mental health. Many mechanisms have been proposed to explain population differences in mental health. Disparities in common mental disorders have been associated with poverty and livelihood insecurity which show great variation across groups and even more so between low- and high-income countries (Das, Do, Friedman, McKenzie, & Scott, 2007). Community- or individual-level poverty may be related to relative poverty which consists of lacking idealized material goods and has been associated with mental health (Dressler, Balieiro, & dos Santos, 1998). Mental health outcomes are also associated with the form or lack of social support.

Population differences in mental health may also be affected by cultural differences (Karasz, 2005). Culture consists of a shared system of beliefs, norms, behaviors, and values that differ across populations defined by ethnicity, nationality, religion, or region. Given the diversity of social markers within cultural groups, it is unsurprising that cultural differences in mental health produce varied study results (Karasz, 2005). There is no consistent difference between the mental health prevalence rates of African Americans and Americans of European descent in the US (Williams &

Williams-Morris, 2000). The severity, prevalence, presentation and recidivism of mental illness is influenced by religion.

Cultural categories themselves (e.g., Hindu religion, first-generation immigrant status, Hispanic ethnicity, South African nationality, or African American race) in some contexts may correlate with mental health differences but mediation is important. Greater exposure to violence, economic opportunities, lack of social support or poor physical health puts groups at higher mental illness risk than others (Karasz, 2005).

The aforementioned causes such as poor physical health and exposure to violence could be prevented had they been noticed earlier. The leading problem in this research is the cultural aspect because individuals are often bound to cultural values and do not consider the possible detrimental effects of following cultural norms that can negatively influence our health.

Chapter 3: Research Method

The purpose of this study was to examine the lived experiences of Pakistani American women in Northern New Jersey who had sought mental health treatment. In this chapter, I describe the research topic and design and explain the reasoning behind the chosen method of research. My role as the researcher is explained as well as the procedure and methodology behind the study.

Research Questions and Sub questions

The purpose of this phenomenological study was to examine the lived experiences of Pakistani American women in Northern New Jersey who had sought mental health services. To achieve this goal, I posed the following research questions and sub questions:

Research Question 1: Has seeking help for mental health benefited Pakistani American women in dealing with their issues?

Sub question A: What are the barriers Pakistani American women face when seeking help for mental illness?

Sub question B: What are the struggles Pakistani American women face when seeking help?

Research Question 2: What meaning does mental illness hold in Pakistani American women's lives?

Research Question 3: What is the role of Pakistani American women's family members and personal shame in their experience with seeking mental health services?

These questions guided the study of the lived experiences of Pakistani American women and their decision to seek mental health treatment.

Research Design and Rationale

The purpose of this phenomenological study was to examine the lived experiences of Pakistani American women who had sought mental health treatment in Northern New Jersey. I aimed to discover the lived experiences of Pakistani American women via their personal accounts of mental health and their dealings with it in their lives.

Role of the Researcher

My role as the researcher was to identify and interview participants and interpret the results. I attempted to have as little influence on the participants or their answers as possible by focusing on what the participants had to say, keeping an open mind, and setting aside any preconceived notions I may have had about the central issue. Although I was aware that I could have influenced the interviewee by my verbal and nonverbal responses, all measures were taken to prevent this from happening. I did not have any affiliation with other communities of Pakistani American women living in Northern New Jersey. I also had no personal or professional relationships with the participants.

Methodology

Phenomenological inquiry was the method chosen for this study. This approach was the most appropriate because this study was an attempt to examine the experience of the participant from their perspective. A phenomenological approach was best suited for this study because the aim was to study the lived experiences and analyze the data from the subjects' responses. This, coupled with the fact that this problem had not been

previously studied, made using a qualitative approach the best option in the study. The current research was designed to examine the lived experiences of Pakistani American women who had sought mental health treatment. Therefore, a phenomenological approach was of greater utility than a grounded theory, case study, or ethnographic approach because in grounded theory the aim is to build a theoretical framework, which was not the purpose of this investigation. Ethnography focuses on meanings largely through direct field experiences, which was not the purpose of this study. A case study is an investigation into a bounded system, which was not the purpose of this research.

Participant Selection

To be selected as a potential interviewee in this study, participants needed to meet certain inclusion criteria. Potential respondents had to live in Northern New Jersey. This area was defined as all of Hudson County, New Jersey. The rationale for this choice was because I reside in the area, the participants would be more easily recruited. There is an exceptionally large and accessible Pakistani American community in the Northern New Jersey area, so there was a large sample size available. Participants also had to have sought out mental health services. Mental health services were defined as those provided by any licensed therapist who is trained in treating mental illnesses. Finally, participants had to be Pakistani American women. Pakistani American women were defined as any woman of Pakistani background who had lived in Northern New Jersey for over 7 years.

For the purposes of this project, the age of the participants ranged from 18 to 45. The rationale for this age group was that the focus of this study was adults and not adolescents. Convenience sampling was used to gather the data. Creswell (2009) noted

that convenience sampling is used to recruit people who have similar experiences and backgrounds that are convenient to the researcher. There were 10 Pakistani American women participants, and I started with five and continued until data saturation occurred.

Procedure for Recruitment

I contacted the creators of various Pakistani American female mental health groups on Facebook and other social media (see Appendix A) asking the creators to reach out to their members to see if they would be interested in participating in the study. Recruitment also took place through local colleges and flyers that described the study with contact information for those interested in participating. In addition, requests at local community centers were used. This form of data collection stemmed from the hesitance members of the community had in discussing these matters in the presence of family. Once recruitment was completed, a phone call was conducted with respondents to confirm that they were open to being interviewed. An interview was then scheduled.

Data Collection

Interviews were used to collect data. The benefits of this approach were that it allowed for direct interactions with participants, which assisted in forming a more comprehensive understanding of the lived experiences of Pakistani American women who had experienced mental illness. I was the only data collector in this study and conducted all interviews either over the phone or face-to-face in a location that was private and convenient for the participant, for a total of five phone and five face-to-face interviews. All interviews were tape recorded and transcribed word for word. The interviews lasted as long as needed to explore the research questions, with an average

duration of 35 minutes. All face-to-face interviews were conducted in a conference room of a public library. The interview began after the participant signed an informed consent form. Once the interview was completed, the participant received a debriefing form, which included a summary of what the subject participated in, as well as the option of redacting certain information they supplied to the study. The purpose of the debriefing form was to maintain ethical procedures because it ensured that not only were the participants not hurt in any way by participating in this study, but also that they remained fully updated and informed on exactly what they were participating in and what their data would be used for (see Creswell, 2009). This was an example of member checking, and they were also sent a copy of the interview transcripts.

Data Analysis

In analyzing this data, three main steps were taken to authenticate the data. Verification of all information obtained as a result of this study was done through the steps of the phenomenological approach, and the bracketing method was used to mitigate biases and opinions toward the specific experience when analyzing the data. According to Creswell (2009), this process of setting aside one's preconceived notion and biases toward a particular experience allows one to be more receptive to the phenomenon. All of the interviews were transcribed and examined for key responses that had to do with participants and their exposure to mental health issues in their personal lives.

The data collection steps included setting the boundaries for the study, and it was made clear to the interviewee that the data from their interview would be securely stored within an encrypted, cloud-based storage space. I collected information through semi

structured comprehensive phenomenological interviews, and each interview was recorded and stored in the cloud securely. The questions were directed to the experiences of the participants, along with their beliefs toward the central theme of this study. Bracketing was used by me when asking the participants to speak on the subject with the most basic and direct feelings they had. This was done to have the participants speak about their lived experiences without any thought or regard for any type of normal social constraints.

The steps in the data analysis included data managing, reading, memoing, describing, classifying, interpreting, representing, and visualizing. In data managing, I needed to create organized files in the data by creating secure folders in the storage space. Each interview was assigned a specific title, such as "Participant 4 June 2018." In reading and memoing, I read through the text, made notes, and formed initial codes. Memoing was an important part of the data verification because it was my own thoughts and what I had heard or seen during the interview. It was important for me to always have notes that were based on the interview and not on my assumptions during the time with the participants.

Classifying involved finding and listing statements of meaning for individuals. This was done by creating files with dividers for the different interviews, which were divided among themselves into separate subfiles sorted by the signed informed consent. A second subfile consisted of any notes I jotted down during the interview, along with a summary of each interview typed up by me immediately after each interview, as well as a document noting any commonalities or themes from different interviews, marked with time stamps for easy follow-up listening sessions. Interpreting the data focused primarily

on an overall description of how the phenomenon was experienced. The final step in data analysis is to represent the narration of the experience (Creswell, 2009).

Validation of Results

To further validate the results, I used member checking, which is the process of data being returned to the participants to check for accuracy in their responses and experiences. Certain guidelines can help ensure transcription of interviews was accurate and that the researcher identified all possible conclusions that could be drawn from the transcripts besides the conclusion offered by the researcher (Creswell, 2009). Another step in the validation process was the recruitment of peer reviewers. It was the responsibility of the peer reviewers to review and analyze the data. For the purposes of this study, only two peer reviewers were required, recruited from Walden University instructors teaching qualitative inquiry courses. The purpose of a peer reviewer was to act as a contrarian purely for argument's sake by approaching the data, the methods used to obtain that data, and the interpretations of that data from a different perspective from the researcher. Both the peer reviewer and I kept detailed minutes of the meetings in which the peer reviewer attempted to constructively criticize my process.

Trustworthiness

The trustworthiness in this qualitative study was ensured with four primary constructs. The first was ensuring credibility. Second, trustworthiness was ensured through transferability. In this study, thorough details were provided that allowed the reader to conclude that the findings could be transferred to another situation. Third, trustworthiness involves dependability, which allows readers and other researchers to

conduct future research and replicate the current research. This was done through the use of an inquiry audit from an outside source. The point of an inquiry audit was to have an external examiner study the way in which the data were analyzed and to see whether the results could be consistently replicated. The last step was to construct confirmability. This fourth step in establishing trustworthiness was done using an audit trail. This ensured that I did not allow for bias to frame the responses of the participants in a way that conformed to a specific theme that I may have been trying to establish. This audit trail emphasized and clearly stated every step of the data analysis to show readers that the findings of this research were an accurate depiction of the participants' responses (Shenton, 2004).

Ethical Procedures

It was my responsibility to ensure that all participants in the study were made aware of the ethical parameters of the study. Each participant was informed that they were free to leave the study at any time they wished. Each participant was also given my email and phone number to contact me in case they changed their mind about participating in the study. They were also informed that all of their personal information would be kept secure at all times.

Each participant was made aware that the transcripts from their interview would not contain any information that could lead to their identification. The participant was assured that all of their information and results would be shared only in aggregate. All results were locked and password protected, and all documents pertaining to the study

will be destroyed 3 years after completion of the study. If at any point a participant had wished to leave the study, then their results would have been immediately destroyed.

Summary

This was a phenomenological study of the lived experiences of Pakistani American women who had experienced mental illness in Northern New Jersey. A phenomenological approach was best suited for the research questions being asked in this study. The study involved contacting members of the targeted community through social media, churches, and religious community centers. I screened for criteria and answered all questions the participants had about joining the study. If they were satisfied, then they were asked to set up an appointment for an interview. Upon completion of the interview, the participant was made aware that the answers they provided would in no way lead to any type of identification of the respondent. The goal of this study was to examine the lived experiences of these women in hopes of providing a foundation upon which the next generation can build to erase the stigma attached to mental illness in the female Pakistani American community in Northern New Jersey.

Chapter 4: Results

The purpose of this phenomenological study was to examine the lived experiences of Pakistani American women in Northern New Jersey who had sought mental health services. To achieve this goal, I posed the following research questions and sub questions:

Research Question 1: Has seeking help for mental health benefited Pakistani American women in dealing with their issues?

Sub question A: What are the barriers Pakistani American women face when seeking help for mental illness?

Sub question B: What are the struggles Pakistani American women face when seeking help?

Research Question 2: What meaning does mental illness hold in Pakistani American women's lives?

Research Question 3: What is the role of Pakistani American women's family members and personal shame in their experience with seeking mental health services?

Setting

The place of worship where the study was advertised is a local mosque known as the Muslim Federation of New Jersey, a recognized place of worship in the state of New Jersey, that approved an invitation to interview that was the same as the social media post. I was the only data collector in this study and conducted all interviews in a conference room of a public library, ensuring both safety and privacy. All interviews were tape recorded and transcribed verbatim.

Data Collection

For the purposes of this project, the age of the participants ranged from 18 to 45. The rationale for this age group was that the focus of this study was adults and not adolescents. The participants were female and of Pakistani background. Convenience sampling was used to gather the data. Creswell (2009) noted that convenience sampling enables recruitment of people who have similar experiences and backgrounds that are convenient to the researcher. There was a total of 10 participants from whom the data were collected. All meetings were conducted in a private conference room in a public library, the exact location of which was disclosed to participants only after an interview had been scheduled. I was the only data collector in this study, and interviews were conducted either over the phone or face-to-face in a location that was private and convenient for the participant. All interviews were taped recorded and transcribed word for word.

Data Analysis

The interviews varied in length depending on the need to explore each interview question. The interview began only after the participant signed an informed consent form. Once the interview was completed, the participant received a debriefing form, which consisted of a summary of what the subject participated in, as well as the option of redacting certain information they supplied to the study. There were no variations in the data collection from the plan that was presented in Chapter 3.

Unusual circumstances that were encountered during the data collection were that there were times when I had completed everything, but at the last minute the participant

felt overwhelmed and decided not to participate. Although all participants were there on their own, there was a sense that they did not want anyone to know about them participating. Once everything was explained to the participant and they understood that no one else would have access to their information, they confirmed their participation in the study.

Evidence of Trustworthiness

The evidence of trustworthiness in this study consisted of five steps, as outlined in Chapter 3. The first was ensuring credibility, which allowed the participants to understand that their personal information and stories were not compromised in any way. Second, trustworthiness was ensured through transferability. In this study, thorough details were provided that allowed the reader to conclude that the findings of this study could be transferred to another situation. The third strategy used was dependability, which allowed readers and other researchers to conduct future research and replicate the current research. This was done using an inquiry audit from an outside source. The point of an inquiry audit was to have an external examiner study the way in which the data were analyzed and to determine whether the results could be consistently replicated. The last step was confirmability. This fifth and final step in establishing trustworthiness was carried out with an audit trail. This ensured that I did not allow my bias to influence the responses of the participants in a way that conformed to a specific theme that I may have been trying to establish. Member checking was also used at the end of the data collection period by having the participants read their answers and results to check for any errors, as

well as to determine whether their responses were an accurate representation of their lived experiences.

Results

Research Question 1

Has seeking help for mental health benefited Pakistani American women in dealing with their issues?

Seeking help for mental health has helped Pakistan American women in dealing with their issues. However, seeking the help and getting the assistance they needed were two different things for these participants. Many of them felt that, if need be, "it would not be an issue for me, because I grew up in the USA and the societal norms seeking help for mental illness is an okay thing; however, for my family it would be a stigma and frowned upon." There was clearly a negative connotation in their minds when it came time to seeking this help in large part due to the stigma attached to being someone who was considered mentally unwell.

Also, it would be beneficial if they got the help without feeling guilty. When there is a constant fear of someone finding out or your heart is not into something fully, it is hard to get the proper results. All of the participants stated that they think that therapy can help, but at the end of the day they get what they put in: "yes I think that therapy can help but I think it depends on the person and the situation they are in." If they are willing to open up to someone about their problems and get the proper guidance that they need,

> I think counseling can help a lot. Sometimes just knowing that you are getting things off your chest can be a relief. Sometimes saying something to a stranger is

better than saying something to a family member because you know with a stranger your secret is safe. However, if you go just to pass your time and not take the other person seriously, then going or not going to therapy is equivalent.

This speaks to the original concept of participants stating that although they believed therapy would assist them in managing their mental health issues, it would only be beneficial if they fully embraced it.

Sub question A

What are the barriers Pakistani American women face when seeking help for mental illness?

The largest impediment noticed in this study was that Pakistani American women were afraid of their families finding out that they may be seeking outside help for mental illness. Gilbert et al. (2004) found that the "concept of family shame played a powerful role in Asian women's experience" (p. 112), which corresponded with the results I obtained from interviews in this study. In this study, when the participants were asked whether they were raised with the idea that they could tell their problems to anyone or just the family, they answered without hesitation "definitely just the family, because no one on the outside should know because then it is like a game of telephone; one person said something, which led to something completely different and wrong and taint the family name." This was a big theme in the responses of most of the participants in this study, this concept of shame and how it would be a representation of their family. Gilbert et al. also noted the concept of reflected shame, which was defined as "the fear of bringing shame to others" (pp. 110–111). About 40% of the participants in Gilbert et al.'s

study reported that they would rather talk to their families about their problems than someone from outside of their social circle. The remaining 60% participants reported that therapy could help an individual deal with their problems, with the caveat being that they were raised with the conception that family should be the first and only outlet when it comes to speaking about their problems. This self-identification within the family construct is referenced when Gilbert et al. stated that "the worth of an Asian girl is defined by how she conducts herself and who her family is" (p. #??). Participants in the current study also reported that their self-worth is derived from how they are perceived by their family.

Sub question B

What are the struggles Pakistani American women face when seeking help?

The struggles Pakistani American women faced when seeking help included the fear of what other people would think. Pakistani American women have the notion that if they are seen coming out of a therapist's office there will be questions that they will have to face from family, friends, and community about seeking such help. Pakistani American women also think that cultural norms cause them not to seek the help they need. According to the participants in the current study, "seeking professional help would not be an issue for me but my family might not take it seriously. Treatments that involve a psychiatrist, psychologist, or a therapist is a taboo in our culture. Another participant stated that "I don't think that would be an issue, but I feel like it would be frowned upon due to the cultural dilemma."

Research Question 2

What meaning does mental illness hold in Pakistani American women's lives?

Mental illness is about the moods and behavior that one displays. Being trapped in their body may result in quick mood changes. As Karasz et al. (2019) stated, "certain South-Asian individuals may tend to understand their depression as a result of poor social support" (p. X), which is understandable when considering that the family structure plays a large role in their self-identity and self-worth. This same theme of family and the role they play in these women deciding to seek mental help was also found in the current participants' responses. Not being able to live the way they want, having a tough time handling everyday situations, being lost and miserable, and the feeling of not being themselves were some of the ways that the participants described how they define mental illness in their lives.

Research Question 3

What is the role of Pakistani American women's family members and personal shame in their experience with seeking mental health services?

This was an interesting question when posed to the participants because they all stated that they believed that they would have no issue with seeking outside help, but most probably would not get the help they need because they know that their families would frown upon that: "seeing professional help would not be an issue for me or my in-laws; however, my own family would see that as I am going crazy or that my in-laws have made me crazy therefore I am seeking outside help." From an outside perspective it may not look like a person is close to their family, but deep down they may be mentally

dependent on them. There was also a sense that participants would like to break the stereotype that their families hold but are afraid of the backlash that they would receive.

Conclusion

Overall, participants thought that seeking help for their mental health played a positive role in their ability to deal with their issues. They also preferred having someone within the family to speak with rather than having an outsider learn about their perceived problems. This tied into Sub question A, where participants reported lack of family empathy as a primary roadblock in their search for help. Participants went into detail regarding struggles they encountered when trying to seek help, including cultural stigmas around women bringing shame on their family with this perceived weakness. Participants detailed how they view mental illness and how they view it in their lives as restricting their ability to live their day-to-day lives with any semblance of consistency. Participants viewed mental illness as being lost spiritually and something that cannot be explained all the time, and the frustration of an unseen burden they believed they were destined to carry alone.

Summary

In the Chapter 4, I reported the findings of the study, including the cultural divide between Pakistani American women's lives and Western culture, from the perspective of the participants. The next chapter focuses on the purpose and nature of this study, which was to understand and examine the lived experiences of Pakistani American women regarding mental illness. The data obtained from the research are examined to determine how they compare to findings from peer-reviewed literature reviewed in Chapter 2.

Furthermore, the data are analyzed to ensure their interpretation does not exceed the data themselves or the original scope of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to understand the lived experiences of Pakistani American women as they deal with mental illness. Understanding the pros and cons that Pakistani American women weigh in deciding whether to seek professional help may help providers better address their concerns and reduce barriers to access. The results may also be used to inform Pakistani American women that it is acceptable to seek professional help for mental health by identifying the stigmas attached to the idea of mental health assistance. The key findings of the study were that there were many women in the research who answered in the affirmative when asked if they would get help for mental illness. This answer came with the stigma of what happens if family members found out. When speaking to the participants, I observed that even though they had lived in the United States for many years, they still held the cultural beliefs that they had been brought up with.

Every participant in the study stated that they would talk to their families before talking to anyone outside. There is a saying that every Pakistani household lives by, which states that people work their whole life to build respect, or izzat in Urdu, with the people around them, but it takes only seconds to lose it. The concept of self-respect, or izzat, plays a huge role in the lived experiences of these women and their role in the family hierarchy (Gilbert et al., 2004). In the current study, I found that the families have a belief that if someone is mentally ill, it should be kept a secret within the family because it is understood that it is something that could detract from their status in the community. Even though many participants have had family members or friends who

have experienced mental illness, it is still extremely hard for them to get the proper treatment they need. Kapadia et al. (2015) stated that women felt they needed to cope with their mental illness alone. There is a sense within Pakistani families that personal, private, and potentially embarrassing issues do not need to be played out in the public eye. Having one's name being mentioned in gossip and rumors can only serve to further inhibit these women from seeking the assistance that they need. This is related to izzat and the idea of protecting one's name and honor ahead of everything else (Kapadia et al., 2015).

The findings of the current study confirmed what was stated in Chapter 2 regarding the stigma with Pakistani American women in seeking help for mental illness. Culture plays a part in Pakistani American women's mental health. Evidence of this can be found in the work of Steptoe et al. (2007), who examined the role of various factors (including culture) in the mental health of their subjects. Steptoe et al. found that cultural beliefs play the largest role in mental health stability. Regardless of how hard people work to have these women look past the stigmas involved, it always reverts to how they have been brought up. The research participants in the current study stated that they all have a strong support group, but when asked what kind of support group, they all stated that it was their family members. Participants also reported that therapy is something that is beneficial to anyone who is going through any kind of mental illness; however, it is something that they are not ready for yet. They do not want to disappoint their families by pursuing mental health care.

Limitations of the Study

The issue of honesty may have been a limitation in the study. Some participants may not have been completely forthcoming regarding their experiences with mental illness. Another limitation of the study was the geographic limitation of sampling from Northern New Jersey. The geographic limitation prevented the findings from being applicable to all Pakistani American women. There was also an issue of minimal or superficial responses from the participants in this study, which impacted the depth of the findings. From participants' individual responses as well as the themes identified across all participants' responses, it was clear that the fear of being outed, the fear of family shame, (i.e., izzat), and participants' general unease in opening up to someone they did not have a relationship with could have played a factor in the lack of depth in the responses. I made a point not to push too hard for more detailed responses because that may have further alienated the participants and jeopardized the study.

Recommendations

There are a few recommendations that I would make for further research on this topic. One recommendation would be to widen the geographic range of the study. This approach would broaden the target participants to include female Muslim Americans across all countries of origin, which would allow researchers to compare and contrast the complex societal and cultural norms with the overarching religious ones that tie all the groups together. This would be a way to further research the issue by examining the lived experiences of Muslim American women across multiple nationalities and examine the commonalities between women of different nationalities and their experiences with

mental health. Another step that could be taken is to address the concerns of this population as they pertain to cultural predispositions toward seeking help for mental illness. This can be done through community outreach programs as well as making mental health conversations feel less taboo for people from this background. This tension between personal and cultural needs is deeply rooted and requires education at all levels of the familial hierarchy, in particular the youth as their attitude toward this subject may impact future generations. Further research could be done in this field by conducting a similar study geared toward men of the same cultural background. Because men in Pakistani American culture are the ones who set the standards for how things are done, speaking with them and trying to delve deeper into their thinking toward mental illness, shame, family, and dishonor are ways researchers can further address this issue.

Implications

This research may bring about positive social change in that even a small step toward improvement within a community may improve the lives of many women. Being able to understand what one group of people must go through and experience when dealing with mental illness and how they cope with it can impact the family structure for further generations, and this can be done by first accepting that the way the Western world views mental health and the way others with roots in different parts of the world are two vastly different issues. Efforts should be made to meet on common ground and in a way that appeals to each party's sensibilities, both culturally and religiously, depending on the scope of any future study that would be conducted. Different people view and react to things differently. Accepting that and trying to bridge the gap through community

outreach programs, online education courses in a language that may be easier for them to understand and making mental health education a requirement in schools so that the youth are educated more at a younger age than older generations may lead to positive social change.

Helping Pakistani American women look past the social stigmas that they grew up with may allow them to break the mold and may positively affect women of future generations and their relationship with mental health. Affecting such change at a grassroots level, within the home, may allow women of future generations to look and feel about things very differently than their mothers and grandmothers did. This may serve to deepen the impact of mental health treatment in communities that the Western world is only beginning to start to connect to regarding the world of mental health.

Summary

The message to take away from this study is that there is still much to understand when it comes to the lived experiences of Pakistani American women who have sought mental health treatment. What researchers still need to know is the depth to which cultural and societal norms from how these families view concepts such as mental health are rooted in their thinking. Conducting a study geared toward men as well as women to determine whether there are differences in their views and responses toward different aspects of mental health may advance the conversation regarding mental health in these communities. The use of a phenomenological approach allowed me to examine the lived experiences of Pakistani American women and analyze their responses to the interview

questions. The interviews were transcribed and examined for themes related to mental illness and participants' exposure to it in their personal lives.

The overarching message from this research was that to reach these women on a level where they feel as if they want to change themselves and seek help for their mental health, there needs to be work done to bridge the societal and cultural divides. The Western world and the cultures that these women come from are separated by much more than geographical distance. To help these women in a way that can affect the way they view mental health, researchers need to further the understanding of what it means to be in that culture and societal norms.

Gilbert et al. (2004) found "fears around confidentiality to be barriers to help seeking" (p. 110). This observation is demonstrated in the disconnect in Pakistani American culture between general wellness and mental health. In this culture, mental health is something that is not tangible and cannot be seen; it is seen as either illusory or something that can be overcome with willpower. The constant fear of being outed is forever in the minds of Pakistani American women.

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Appendix A: Request Seeking Participants for Study

To Whom It May Concern:

I am writing to you today asking for your participation, or for the participation of those you may know, who may be interested in a study to find out the lived experiences of Pakistani American women in regard to mental health. This research will be a part of my dissertation, which is a significant part of the requirement for the doctoral degree at Walden University. I am interested in conducting an interview with members of the female Pakistani American community who have experienced mental illness of any kind personally. This interview will not last longer than 30-45 minutes, and if you are a member of this community, who wishes to participate in the study, please do not hesitate to contact via email, or professional Facebook page, mental health issues in female Pakistani American Communities-You are not alone.

Appendix B: Participant Responses to Question 1

Participant