Title

“Break Down These Walls”: Stories of Mental Health Service Access by Asian Indian Americans

Journal

Asian American Journal of Psychology, 14(1)

ISSN

1948-1985

Authors

Sharma, Himadhari
Consoli, Andrés J
Abdel-Haq, Noor

Publication Date

2023

DOI

10.1037/aap0000269

Peer reviewed

Asian American Journal of Psychology

ISSN: 1948-1985

https://doi.org/10.1037/aap0000269

"Break Down These Walls": Stories of Mental Health Service Access by Asian Indian Americans

Himadhari Sharma, Andrés J. Consoli, and Noor Abdel-Haq
Department of Counseling, Clinical, and School Psychology, Gevirtz Graduate School of Education, University of California, Santa Barbara

The present study sought to gain a multifaceted understanding of the personal stories of Asian Indian Americans when accessing mental health services. Specifically, it explored the difficulties that seven adult participants faced and how they overcame such difficulties when accessing services while focusing on potential family and cultural factors involved. Following Pescosolido et al. (1998) Network Episode Model, a multiple case study approach (Stake, 1995, 2006) was used to explore the uniqueness of each participant's story of access, followed by a thematic analysis identifying specific themes across participants' stories (Braun & Clarke, 2006). The difficulties experienced by participants were systematized into three main themes: stigma and stereotypes of mental illness and treatment, limited mental health awareness, and unfavorable experiences in therapy. What helped participants when accessing services was organized into seven main themes: privacy in services, a positive therapy experience, increased psychoeducation, accessibility, motivation for self-improvement, normalizing of mental health treatment, and support system. These emerged themes expand the conceptualization of mental health service access within this community and highlight the contribution of personal, community, and systemic factors in the access experience. The results can be used to inform mental health providers, community leaders, and policymakers in how to better meet the needs of this growing community.

What is the public significance of this article?
When considering what may make it difficult and help Asian Indian Americans to seek mental health services, the results of this study support the continuation of efforts to redress the stigma associated with mental illness and treatment. Moreover, the motivation for self-improvement partially born out of a wish to heal for one's community was found to be helpful in accessing needed care. For practitioners, the findings support the efforts to promote cultural humility within mental health care service delivery, as well as encourage community leaders and university counseling centers to aid in increasing psychoeducation and normalization of seeking mental health services among Asian Indian Americans.

Keywords: Asian Indian Americans, access, mental health services, multiple case study

According to the United States Census Bureau (2019), in 2017, there were 22.2 million Asian Americans residing in the United States (U.S.). The Asian Indian American community represented the second largest Asian American group, at approximately 20% of the Asian American population. With the Asian Indian American community being the largest growing group of Asian Americans in the U.S. (United States Census Bureau, 2012), it can be expected that there will be a proportional increase in mental health care needs for this community.

Alarmingly, racial and ethnic minoritized individuals are not only less likely to access mental health services, but they are also less likely to receive needed and quality care (Substance Abuse and Mental Health Services Administration, 2015). From 2008 to 2012, while 46.3%, or approximately one in two, of White American adults with any mental illness accessed needed mental health services, only 18.1%, or approximately one in five, of Asian American adults with any mental illness did so. Asian Americans' access is lower than those of other ethnic and racial minoritized groups, estimated at one in three.

Due to a variety of reasons, including reporting biases of mental health issues by Asian Americans, limited culturally sensitive assessment methodology, and harmful stereotypes (i.e., the model minority myth), there remains a gap in understanding access and utilization of mental health services by Asian American communities (Sue et al., 2012). While many studies and surveys often combine Asian American groups, research has found that there is heterogeneity within and across these groups in mental health needs and service use (Lee et al., 2015). Although professional psychology has focused on ways to better serve minoritized populations and single out factors that may prevent underrepresented individuals

Himadhari Sharma https://orcid.org/0000-0003-0713-9817
Andrés J. Consoli https://orcid.org/0000-0002-0828-4293
Noor Abdel-Haq https://orcid.org/0000-0002-1268-6930

Partial funding for this study was provided by University of California, Santa Barbara's Academic Senate Grant awarded to the second author.

Correspondence concerning this article should be addressed to Himadhari Sharma, Department of Counseling, Clinical, and School Psychology, Gevirtz Graduate School of Education, University of California, Santa Barbara, Santa Barbara, CA 93106-9490, United States. Email: himadhari.sharma@gmail.com

from accessing mental health services, more targeted research is needed to better understand specific minoritized communities, such as Asian Indian Americans.

Minoritized communities face many difficulties when seeking healthcare services, with some challenges occurring at demographic and cultural levels, such as limited family and social support as well as specific cultural perceptions of symptomology (Scheppers et al., 2006). When explicitly focusing on access to mental health services, many minoritized individuals may face a variety of challenges, including stigma, acculturation, negative perceptions of mental illness and treatment, limited recognition of psychological distress as different from physical pain, cultural values, physical constraints, and socio-economic factors (Leong & Kalibatseva, 2011).

While studies have not comprehensively explored the struggles that Asian Indian Americans face when attempting to access mental health services, literature has suggested that cultural factors may influence how an individual conceptualizes mental illness (Kumar & Nevid, 2010). Moreover, the existing research may underrepresent the actual mental health needs within the community as they may be masked by cultural factors, such as religious beliefs, stigma associated with mental illness, and greater attention given to somatic symptoms (Conrad & Pacquiao, 2005).

Mental illness can be stigmatized within the South Asian American community (Chaudhry & Chen, 2019). Stigma associated with mental illness can affect an individual at a personal level (e.g., individual help seeking behaviors and beliefs) as well as at a social level (e.g., cultural/community perceptions of mental illness, opportunities and availability of mental health services; Corrigan et al., 2014). There may be other sociocultural barriers, such as language and acculturation, that can impact the experience of accessing mental health services by South Asian Americans. Yet, research has not specifically explored the mental health needs of the Asian Indian American community, let alone their experiences when accessing mental health services, thus leaving a gap in understanding how best to serve it.

Conceptual Framework of Access

Researchers have developed theoretical and data-driven models to understand access and utilization of mental health services (e.g., Andersen, 1995; Consoli, 2000; Pescosolido et al., 1998). They have theorized and documented many paths that can lead an individual to accessing such services. The paths to access may be influenced by a variety of personal factors including health insurance, sex/gender, age, education, race/ethnicity, marital status, and interacting with people who have used services previously (e.g., Farberman, 1997; Greenley et al., 1987). Moreover, access to services can also be affected by community and systemic factors, making it important to develop deeper understandings of various communities' experiences.

Given the dynamic nature of accessing mental health services, including the role of others in the decision-making process as well as an individual's values and beliefs, a culturally sensitive, process-oriented model such as the Network Episode Model, provides a strong framework (Pescosolido et al., 1998; Pescosolido & Olafsdottir, 2013). The Network Episode Model is built on the belief that the pathway to accessing mental health services is influenced by social systems, such as an individual's community (Pescosolido & Boyer, 2010). In this model, mental health service access is best understood through three major categories: choice (voluntary decision-making and accessing of services), muddling through (not actively seeking nor being reluctant to accessing services), and coercion (accessing services despite resistance). Pescosolido et al. (1998) found that accessing services through choice and muddling through were the most common among participants and that the categories could be further explained. Specifically, the category of choice encompassed experiences of individual choice and supported choice, where social support/networks assisted in accessing of mental health services. Considering the sizable gap in understanding mental health service access among Asian American communities and the limited information regarding Asian American communities' relationship with mental health service access (Sue et al., 2012), this process-oriented model can be readily utilized in an effort to understand pathways to care.

The Present Study

The limited existing literature has focused on stigma associated with mental illness (Chaudhry & Chen, 2019), mental health needs (Masood et al., 2009), as well as help-seeking perceptions (Kumar & Nevid, 2010) and mental health service use among South Asian American participants (Lee et al., 2015). The present study takes a different approach altogether by systematically exploring how first- and second-generation Asian Indian American participants were able to access mental health services while overcoming challenges. Consistent with Pescosolido's framework, the term access encompasses various events of accessing services, be that a single instance or repeated instances of access over the years.

The study included both first- and second-generation Asian Indian Americans as previous research has found that, among Asian Americans, the two generational groups tend to have similar patterns of mental health services usage when compared to third-generation individuals (Abe-Kim et al., 2007). By exploring stories of realized access to mental health services, this qualitative study sought to achieve "thick descriptions" and "thick interpretations" (i.e., relatively elaborate understandings; Denzin, 2001) of participants' experiences to gain a better comprehension of what made it difficult and what helped them access services. The study also sought to learn of potential personal, community, and systemic factors that may have either helped and/or made it difficult when accessing services. Additionally, the study explored commonalities among the participants' experiences while honoring their unique individual experiences.

Method

Design

Stake's multiple case approach (1995) was used to strive for depth in understanding Asian Indian American participants' experiences when accessing mental health services. Through a multiple case study approach, researchers note the uniqueness of each case, while at the same time identify broad common themes across all cases (Creswell & Poth, 2018). Stake's approach was selected due to its alignment with a social constructivist framework, which posits that multiple realities are constructed through individual experiences. In this framework, researchers collaborate with participants through qualitative data collection (i.e., semistructured interviews) and then

coconstruct meaning through data analysis. This study is an instrumental multiple case study, that is, a multiple case study with a predetermined objective that aims to increase understanding of a phenomenon by using specified research methods and identifying common themes (Mills et al., 2010). Accordingly, the study focused on the unique quality of each case while also explored themes and commonalities across all the cases (Stake, 2006).

Researchers and Positionality

In accordance to current best practices for reporting findings in a qualitative study, we provide a brief description of authors' positionality and background. The research team consisted of a lead researcher (first author), a senior researcher (second author), and a research assistant (third author). The lead researcher identifies as a cisgender female, second-generation Asian Indian American, born in the United States to parents who immigrated from India. She is a doctoral student in counseling psychology and has accessed and utilized mental health services. She has been actively involved both personally and professionally with the Asian Indian American community, which has motivated her research interests. The senior researcher is a first-generation Argentine American cisgender male who has extensive experience in studying access and utilization of mental health services among minoritized populations, primarily among Latinx communities. He has accessed and utilized mental health services both in Argentina and the United States multiple times. Finally, the research assistant identifies as a nonbinary second-generation Palestinian American who has previously accessed mental health services. She is a third-year undergraduate student and is interested in working with minorities to help improve access and utilization of mental health services. Aligning with a social constructivist framework, throughout the data collection and analysis, researchers regularly met to discuss personal reactions, opinions, and relevant experiences that may influence the research process and outcomes.

Recruitment

After obtaining Institutional Review Board approval, participants were recruited through social media and word of mouth. Each interested individual was asked to complete an eligibility survey. Inclusion criteria consisted of individuals who understood and spoke English, were 18 years or older, identified as an individual who is currently living in or immigrated to the United States from India (first-generation Asian Indian American) or were born in the United States with parents who immigrated from India (second-generation Asian Indian American), and voluntarily accessed mental health services at least once in the past 2 years. A total of 89 individuals completed the survey, which was reduced to 78 after the elimination of potentially fake survey responses (i.e., by robots or trolls), of which 37 people were found eligible. Following Stake's (2006) guidelines that emphasize sufficient interactivity in multiple case studies (i.e., more than four cases yet fewer than ten cases), the researchers conducted interviews with seven respondents that met criteria for the study. Potential participants were contacted by the first author in the order in which they completed the eligibility survey. Once eligibility as well as interest and availability to participate in the study were confirmed, interviews began until reaching the recommended number. If a potential participant indicated that they were no longer interested or able to participate they were not included in the study and the next, chronological survey responder was contacted. Since participants reported voluntarily accessing mental health services, they are considered to be a part of the "choice" category based on Pescosolido et al. (1998) model discussed previously. All participants who completed the semistructured interview were compensated with a $25 gift card to a national retailer.

Participants

The sample consisted of seven adults, of which four were first-generation Asian Indian Americans and three were second-generation Asian Indian Americans. Participants included five female-identifying and two male-identifying individuals, who during the time of the interview were between the ages of 20–39 years. Participants resided in different regions of the United States, with most being either from cities in the East or West coast. All participants reported either being in higher education (college/university) and/or employed. All participants reported having two parents with a bachelor's degree or higher. At the time of the interview, four participants were in the process of completing or had a bachelor's degree and three participants had a graduate/professional degree. When presented with the acculturation options and their definitions, as outlined by Berry (integrated, assimilated, separated, marginalized, or other; 1997), all participants chose their acculturation as integrated, which is when individuals maintain their ethnic identity of Asian Indian culture as well as incorporate characteristics of U.S. culture.

All participants reported having voluntarily accessed mental health services in the last 2 years. Two participants reported accessing mental health services only once while five participants reported accessing services more than once. Five participants initially sought mental health services through their college/university, one sought services using their insurance, and one through a career-related program. Six of the interviews were conducted through an online video-call platform (i.e., Zoom), and one interview was conducted face-to-face. There were no prior relationships among researchers and participants.

Procedure

Participants were asked to complete a demographic questionnaire and engage in a semistructured interview conducted by the first author (protocol available from the first author upon request). Interviews lasted approximately 80–120 min each, with an average interview time of 94 min. Finally, the interviews were transcribed by the third author, and each transcription went through two quality checks by the first and third authors where the transcribed interviews were reviewed and corrected accordingly. Throughout the interview, transcription, and quality check processes, the first author and the third author kept memos to track personal reactions to the data.

Data Analysis

The lead researcher began the data analysis, guided by Stake's (1995, 2006) approach, which entails reviewing the transcripts of the semistructured interviews through the lens of the overarching study objective of exploring Asian Indian Americans' experiences

in accessing mental health services. Then, the lead researcher thoroughly read and took notes on each participants' responses through the lens of the research questions to gain a deeper understanding of each case. Following each case's systematic review, a concise narrative was developed to capture each participant's unique experiences and story. The research assistant also reviewed each case and narrative to increase trustworthiness of the report. An external auditor, the senior researcher, examined each narrative to check for dependability and logic.

Braun and Clarke's (2006) well-outlined and detailed step-by-step thematic analysis method was employed for the across case analysis to explore commonalities among the cases. The lead researcher led the analysis. Acting as an internal auditor, the research assistant reviewed the across case analysis and impressions were discussed until consensus between both the lead researcher and research assistant was achieved for each theme, subtheme, definition, and example. The external auditor (i.e., senior researcher) reviewed the entire analysis and provided feedback. The multiple-level review and auditing processes were used to increase trustworthiness and comprehension of the results.

Results

Congruent with a multiple case study design, the findings from the individual case narratives are provided first followed by those from the across case analysis.

Individual Narratives

Participant 1 (P1) had been interested in pursuing mental health support numerous times before, however, was unable to due to multiple factors. The challenges she encountered when seeking mental health services included internalized and family promoted cultural stigma and negative stereotypes, a norm where "self-care comes second," a markedly limited psychoeducation, and fear/experience of her immigrant story not being understood by the therapist. The factors that helped her decide to seek support included her efforts in "Breaking down the stigma," the normalization of seeking mental health support among her peers, being exposed to "American values," embracing the value to "Speak up," believing that it is important to try " ... something once before you say no," and the ease of accessibility to services.

Participant 2 (P2) has been in therapy, off and on, for approximately 5 years. He has a strong bond with his therapist, to which he credits much of his progress. He described several frustrations that impacted his journey in seeking mental health support including not feeling comfortable to talk to his family regarding mental health issues, uncertain if therapy would be helpful, a sense of cultural stigma around suicidality that he perceived in his religious community, and feelings of "isolation" in family and community. However, several factors offset these frustrations and helped him seek services, including feeling more comfortable speaking with strangers and professionals about mental health issues, being self-motivated to seek support, knowing others who accessed therapy while struggling with mental health issues (i.e., suicidality), having positive experiences in group therapy, not experiencing stigma around emotional expression within his family, and ease of access to services.

Participant 3 (P3) encountered a significant difficulty when accessing services, which eventually led her to stop. It also involved her parents not "accepting" her mental illness as well as them having a "lack of understanding" regarding mental health issues and treatment. She did not feel understood by professionals due to what she experienced as their limited cultural insight along with guilt of portraying her parents negatively. She encountered family stigma around seeking support and feared losing her parents' "respect," as well as being perceived as "a burden," "crazy," and "weak." However, such beliefs also provided her motivation to seek treatment, and a "wanting to avoid becoming them." The financial privacy (i.e., billing information not being accessible to others) and confidentiality in therapy helped her access mental health services, as it allowed her to seek treatment without her parents knowing. She was encouraged by teachers to seek mental health support and was driven to do so to become "an engaged family and community member." She would like to continue therapy after gaining housing and financial independence.

Participant 4 (P4) sought mental health services as an adult. The logistics of accessing services were "relatively easy" for her. However, she faced an "internal struggle" when making the decision. A major factor in this struggle was experiencing "stigma" within the "Indian community" around mental health and treatment. She feared people dismissing her emotional pain, being unsupported by her ethnic community and seen as a "crybaby" or "weak." She also worried that clinicians would not be able to understand the cultural "nuances" of her experience and blame her family. She was "embarrassed" to speak about her experiences, as she did not know how to "verbalize" them. The primary factor that helped her access services was her partner's support, "care," and encouragement. He "pushed" her to rationally think about her decision and to give therapy a chance. His positive experience with therapy also encouraged her to try it. The privacy that comes with seeking mental health services also made her comfortable, knowing that her parents would not need to find out. She hopes that seeking mental health services will be normalized in the "Indian community."

For Participant 5 (P5), having confidence in the clinician's ability was important; thus, before beginning therapy, he consulted trusted doctors in India who recommended him to seek treatment in the United States. His difficulties in accessing mental health services included stigma and limited awareness of mental health issues and treatment. He feared what others would think of him for seeking mental health support, as it is often associated with being "crazy" and incongruent with male gender stereotypes. Although initially the clinician in the United States felt like an "outsider" to him, overall, he described having good experience in treatment owing to the provider's "warmth," "care," and cultural humility. The many factors that helped him access services included his robust support system, specifically his family's encouragement, and receiving trusted input by professionals in his country of origin. Furthermore, mental illness and treatment was normalized and less stigmatized for P5 after learning that his friends and athletic peers also struggled with mental difficulties. Affordability and accessibility of services were also helpful in his experience.

Participant 6 (P6) encountered multiple difficulties when accessing services, including what she experienced as her parents limiting her help-seeking to support from family and to distrust speaking to "a stranger," (i.e., a therapist). She felt like "a burden constantly" and worried that by seeking services she would become more of an

"outlier" in her family due to the "stigma" around mental illness and treatment. She specifically feared that her extended family would "judge" and "pity" her as well as blame her parents for her distress. Mental health was not a priority for her, and she described therapy feeling like a "chore" and another "thing to get up and do" while having an already long to-do list. However, many factors helped her, including the normalization of using services by talking to others in her profession. The support she received from such people as well as her sister and friends made her feel less alone in her struggles. She is "learning to balance" her mental health needs and her career while also worrying less about other people's opinions.

Participant 7 (P7) first accessed mental health treatment through "psychiatric intervention" and later began therapy. She encountered various difficulties when deciding to access services including discomfort in talking about herself, fear of being "studied" in therapy, and the "medicalizing" of mental health. Cultural "stigma" was a major difficulty, which encompassed feelings of "guilt" for having mental health issues despite being "privileged" for living in the United States. She questioned whether her emotional pain was justified and felt "guilt" for potentially "not feeling grateful and satisfied with all the sacrifices and struggle" her parents encountered as immigrants. She experienced culpability for using her parents' financial support to "complain" about them in therapy. In contrast, several factors helped her decide to access services: a concerned support system, a desire to be a "stronger community member and family member," "trust in medical understanding," and experiencing benefits of therapy by being comfortable with her therapist. The normalization of going to therapy through exposure to others who sought services also helped. She felt her family's "Hindu-ness" traditions moved her away from "material connection," which helped her value therapy and healing.

Thematic Analysis of Cases

As recommended by Braun and Clarke (2006), we developed two thematic maps. Figure 1 represents the themes and subthemes that emerged from the cross analysis of the difficulties while Figure 2 represents what helped Asian Indian American participants when accessing mental health services.

With respect to difficulties, three major themes emerged, which were further operationalized by subthemes. The first major theme was stigma and stereotypes, explained as adverse cultural beliefs and perceptions of mental health difficulties and seeking professional support. For example, P3 stated that "[Mental health issues and treatment] were too stigmatized for me so I think [those cultural values] held me back." The theme was further articulated into five subthemes. The first subtheme was guilt, which is defined as feeling regretful for having mental health struggles and potentially negatively portraying family to therapist. P7 said that "I felt like the guilt was all around [the decision to seek therapy]" and P3 said "I kind of felt guilty about the way I portrayed my parents or the way I thought [clinicians] understood my parents." Another subtheme was "Being crazy," described as abnormal behavior, mental distress, and illnesses seen as insanity. For instance, P3 stated, "{ . . . } if you show signs of anything you have the label of crazy, you know?" "You're not strong if you seek help" was another subtheme, where needing and seeking mental health support are perceived as a weakness while emotional problems are expected to be dealt with internally. Illustrative examples include "Getting help is wrong or you're not strong if you need to get help for mental health . . . " (P1). The subtheme losing the respect of others also emerged, defined as the fear of being negatively viewed by others for having emotional needs and accessing mental health services. For example, P3 stated "I think [parents] might respect me less almost because they don't understand why you would need to seek out mental health services." The final subtheme was distrusting mental health services, defined as family and/or participant fearing the provider's intentions in treatment. Supporting examples include "My parents saying why talk to a stranger, who knows what they'll do, who knows what they'll put in your head" (P6) and "I think I was like 'oh am I gonna be studied or something like that?" (P7).

Another major theme that emerged was limited mental health awareness, explained as participants, family, and community members not having enough knowledge about mental illness, treatment,

Figure 1
Thematic Map of the Difficulties Participants Faced When Accessing Mental Health Services

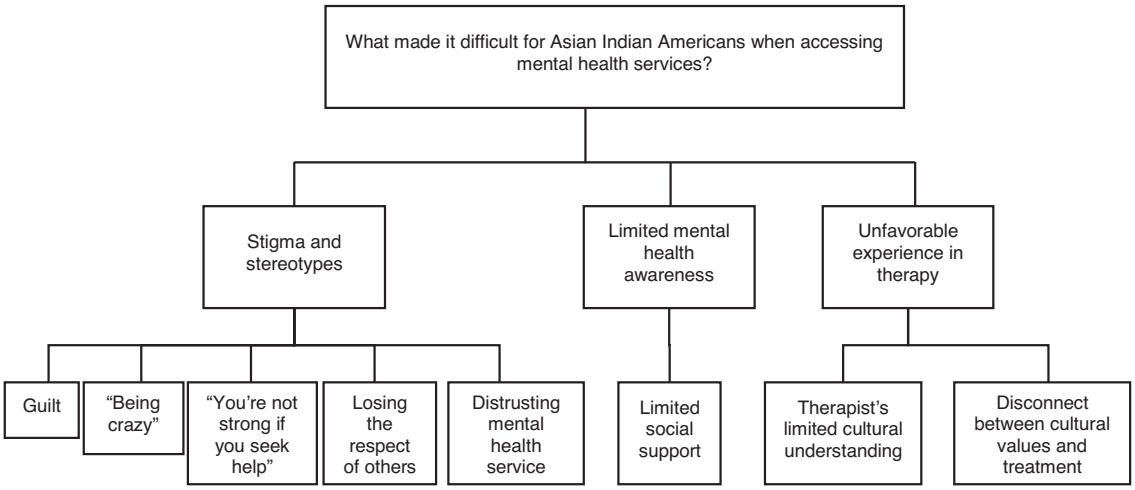
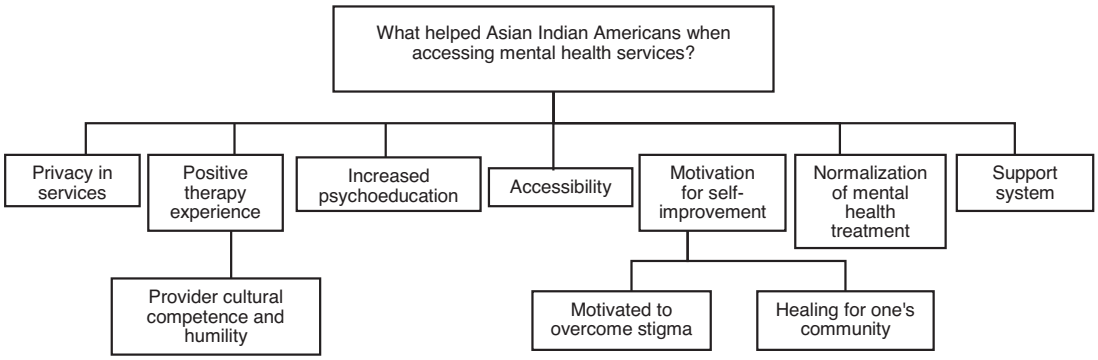


Figure 2
Thematic Map of What Helped Participants When Accessing Mental Health Services



and its benefits, as well as the process of seeking and providing support. Examples included P5 stating "I think the other thing would be a lack of information [about mental illness and treatment]" as well as P2 saying "not knowing how to ask for help or how to seek [mental health] help," and "I didn't know [therapy] would be as helpful as it would be." This theme was further operationalized by the subtheme limited social support, described as experienced limited support from and a struggle to talk with family, peers, or Asian Indian American community members regarding mental health issues. Examples of this subtheme included "I can't really talk to my family about the mental health stuff" (P2) and "But with Indian Americans or Indian immigrants they don't talk about [mental health issues] at all. I've never heard anything about any of my friends speaking about [mental health issues]" (P5).

The final major theme that emerged was unfavorable experience in therapy, defined as participants experiencing the therapist as not understanding and therapy not being helpful. For example: "I just feel like I was not heard whatsoever because [clinicians] just don't understand the issue at all" (P3). This theme was further enhanced by two subthemes. The subtheme therapist's limited cultural understanding was explained as experience or fear of therapists lacking cultural competence, empathy, and/or humility. Examples included "But then when it got to these cultural disconnects between me and my parents, again, [therapist] didn't really get the nuances." (P3) and "I was very hesitant to go [to therapy] because I felt there's a cultural component to all of this. I was just like I don't know if [therapists] understand" (P4). The second subtheme was disconnect between cultural values and treatment, defined as incongruency between salient coping styles, cultural values, and treatment methods due to cultural influences. This was supported by participants' accounts, such as P1 stating that "Counselors always say you need to put yourself first and go more individualist route–but again, that's not part of our culture to be so individualistic."

When exploring what helped Asian Indian American participants when accessing mental health services, seven major themes emerged, some of which were further explained through subthemes. The first major theme, privacy in services, was defined as the opportunity to speak with a mental health professional without parents, family, friends, and/or community members finding out. Examples of this theme included, " . . . the counseling service at my university just made me able to seek it out because of privacy and no cost" (P3) and "I would not have [gone to therapy] if [my parents] could have found out about it" (P4).

The second major theme was a positive therapy experience, explained as having a sound experience with mental health services and experiencing progress in therapy. For example, P3 stated "As I kept going to counseling, I could feel progress and that motivated me to keep going." There was one subtheme, provider cultural competence and humility. It was understood as therapist demonstrated awareness of participants' cultural background and provided space for them to be experts in their personal culture. It was supported by participants experiences, such as P6 stating "I think [clinician] being a female really helped and then she was also Indian American and I think that made my decision a little easier just because I felt like there was a lot of things that she understood" and P2 sharing that "The reason why [clinician] became such a good fit for me, is because I recognized a certain Desi-ness (Indian-ness) about her that I could not share with my own parents."

The third major theme was increased psychoeducation, explained as gaining knowledge about mental health, when services are needed, as well as how and where to access services. P3 shared that upon talking to "teachers and counselors," she gained awareness that mental health struggles are medical issues and that "[depression] was like an actual, medical, scientific, physical thing that was real. So, thinking of it that way helped me justify to myself that I needed to go to a professional." Additionally, P2 said "And I think maybe on some level that [university mental health campaign] was kind of like sitting in the back of my mind somewhere. . . . [counseling services] seems like a safe place to go talk to someone."

The fourth theme was accessibility described as affordability and proximity to mental health services. P1 shared that "[Counseling services] were less than 5 minutes from where I lived so I thought that it was worth the try" and P3 reported that the "No cost was what really enabled me to seek [services] out." Similarly, P4 shared that "It was pretty straightforward. I could just call [the insurance company] and they asked me certain questions and then they set me up with whoever I needed to be set up with."

Motivation for self-improvement was the fifth major theme, and defined as being open to trying therapy as a means to increase mental well-being. For example, P4 stated "It was almost rationalizing the thought process behind [seeking treatment] and kind of just being like I'm not getting anything out of [dealing with emotional distress alone]. I might as well try [therapy], I haven't tried it before." This

theme was further operationalized by two subthemes. Motivated to overcome stigma was a subtheme, understood as accessing therapy in an effort to avoid becoming a negative Asian Indian stereotype regarding mental illness. An illustrative example follows "I would be like 'Oh my god what if I am going crazy?' And that would be the push to have me go to counseling" (P3). Another subtheme was healing for one's community, described as being driven to seek treatment in order to positively contribute and interact as a family and community member. P3 stated that "It's also better for your family because when you're better, you're a better part of the family ... I saw myself getting closer to my family for a bit after counseling." Likewise, P7 shared that "I realized that ultimately the [therapeutic] journey was towards honoring the family."

Normalization of mental health treatment was the sixth major theme and was defined as increased comfort and acceptance toward mental health issues and treatment owing to interactions with peers, mentors, family, community members, and friends who have accessed mental health services. Examples included, "I think kind of seeing that such people can have mental health issues, that was very different and broke away from the stigma ... that was very refreshing, seeing other people have the issue is a new perspective" (P5); and "[my partner] said [therapy] gave him some relief and that he gained something out of it. I mean might as well go see if there's anything there" (P4).

The final major theme was support system, understood as being able to rely on, receive encouragement and reassurance from family, peers, mentors, and providers regarding mental distress and seeking treatment. P5 stated that " ... as long as [family is] supporting me it doesn't matter what someone else says." Additionally, P6 shared that "the doctor did encourage me to go to a therapist."

Discussion

The purpose of the study was to learn from stories of realized access, where participants accessed mental health services through choice, to consider what may facilitate access for others. The results provide insight into Asian Indian American participants' experiences in accessing mental health care and contribute to a deeper understanding of the phenomena by going beyond "walls" or challenges participants faced in accessing services while exploring what helped them "break down" those "walls." The themes that emerged help provide further insight into the dynamic process that characterizes accessing mental health services, together with the role of culture, social systems, and individual characteristics (Pescosolido & Boyer, 2010; Pescosolido et al., 1998; Pescosolido & Olafsdottir, 2013).

One major challenge encountered by participants was stigma and stereotypes associated with mental illness and treatment. This finding is congruent with research stating that South Asian Americans experience higher levels of certain kinds of mental illness stigma when compared to European Americans (Chaudhry & Chen, 2019). Stigmatization makes it difficult for individuals to seek mental health support, resembling the avoidance of help-seeking behaviors found within the larger Asian American community (Leong & Lau, 2001). Of note, stigma and stereotypes were made of five elements in the present study: guilt, "being crazy," "you're not strong if you seek help," losing the respect of others, and distrusting mental health services. For example, P3 feared that she may lose her parents' "respect" as they feel that she is "a burden." Similarly, multiple participants described guilt in unique ways. P3 shared that the guilt of portraying her parents negatively to clinicians made it challenging for her to seek services. Contrastingly, P7 described feeling guilt for having mental health issues given her privilege. While other research has explored the concept of stigma and its relationship with mental health treatment and help-seeking behaviors, the thick description and deep exploration of the phenomena found in this study offers new insight into the challenges encountered by participants. For example, the analysis found that distrusting mental health services was a challenge that some of the participants encountered, paralleling characteristics described by other minorities' experiences, such as Muslim immigrants in the United States (Amri & Bemak, 2013).

The results indicated that having limited mental health awareness acts as a challenge when participants tried to access services. For example, P2 shared that his limited awareness of the benefits of therapy acted as a challenge when deciding to access services. This is congruent with existing literature where increased mental health literacy, psychoeducation, and contact with individuals who have experience with mental illnesses can help decrease the stigma associated with mental illness (Corrigan et al., 2012, 2014). Similarly, a barrier to accessing services includes limited mental health literacy, as it prevents knowing when and how to seek needed mental health support (Collier et al., 2012). These findings expand on the conceptualization that choice can lead to mental health service access (Pescosolido et al., 1998), as increased psychoeducation and limited mental health awareness impacted participants' experience in voluntarily accessing services.

Another major challenge faced by participants was having an unfavorable experience in therapy, which included experiencing providers in a manner consistent with what has been described in the literature as markedly limited cultural humility. The latter construct, first put forth by Tervalon and Murray-García (1998), captures a practitioner's commitment to learning about cultures, being aware of the power dynamics within the therapeutic relationship, honoring the client as an expert in their cultural experience, as well as developing and maintaining a mutually respectful collaboration with the client. For example, P3 reported that she felt mental health professionals lacked cultural competence as they did not understand her perspectives and experiences. How an individual prefers to approach their mental health treatment is often influenced by their cultural background and values. An individual's cultures (i.e., personal, community, and societal) can impact their pathway to accessing services as well as treatment (Pescosolido & Olafsdottir, 2013). Inman et al. (2007) found that, when exploring coping and grief strategies employed by first-generation South Asian Americans who lost a loved one in 9/11, respondents viewed counseling as an American coping method and that there was a gap in culturally sensitive resources. Yeh et al. (2006) found that Asian Americans reported being dissatisfied by mental health services due to lack of cultural relevance and chose not to access them again. Similarly, South Asians in the United Kingdom have reported experiencing cultural exclusion and a lack of cultural competence by mental health providers, which led participants to feel unsafe to engage in services (Bowl, 2007). To better meet the needs of the South Asian community, the researcher supports increasing cultural competence and culturally appropriate services, which may lead to better engagement in services.

Findings that were related to the actual therapeutic experiences expand on Pescosolido et al. (1998) conceptualization of access, indicating that such experiences can facilitate or impede access. Specifically, results indicated that privacy in services was helpful for participants as they sought treatment. Such privacy allowed participants to seek and use mental health treatment without their family or the larger community knowing. For example, P4 felt comfort by the privacy associated with mental health treatment as it allowed her to seek services without her parents knowing. Thus, the professional privacy that characterizes the provision of mental health services may have eased the distress one may feel due to the stigma associated with mental health treatment in the Asian Indian American and Asian Indian community in the United States This is congruent with other research where potential privacy issues associated with accessing mental health services may prevent members from seeking needed professional mental health care (Yeh et al., 2006).

Having a positive therapy experience, including interacting with a provider who has cultural competence and humility, was helpful for participants as they accessed mental health services. For P5, the cultural humility he experienced from his clinician helped him continue with treatment and have a favorable experience when seeking mental health services. This is congruent with the emphasis placed on forming a therapeutic alliance and having a positive experience with the provider as helpful when addressing psychological issues with individuals, including with Asian Indian Americans and immigrants (Chandra et al., 2016). Anderson et al. (2019) found that greater perceived multicultural competence of therapist by clients and stronger therapeutic alliance were both related to lower levels of premature termination of therapy. Additionally, the formation of a culturally sensitive therapeutic alliance is recommended in culturally grounded psychotherapy to promote therapeutic change (La Roche, 2013). Cross-cultural competence has been recommended to be an important aspect of forming a therapeutic alliance when working across cultural lines between the provider and client (Asnaani & Hofmann, 2012). On the other hand, research has found that providers' lack of cultural competence and sensitivity can act as a barrier when accessing services (Collier et al., 2012). Comparable to the findings of the present study, Bowl (2007) reported that South Asian participants in the United Kingdom wanted more culturally sensitive mental health services.

The results of the present study also indicate that increased psychoeducation was helpful when seeking services. This finding synergizes with the theme that having limited mental health awareness can act as a challenge in accessing services. Specifically, as participants learned more about mental illness and treatment, it became easier for them to access mental health services. Additionally, findings indicated that the theme of having accessibility to services was particularly helpful for participants as they sought services. Such results were further enhanced by the individual narratives, where five of the seven participants spoke of initially seeking mental health services through university or college psychological services.

Participants also shared that motivation for self-improvement helped them access mental health treatment. While such motivation may appear to be self-serving, when explored further, the analysis found two major components of motivation: the desire to heal for one's community and to overcome the stigma that was associated with mental illness. The motivation to heal for one's community may stem from the collectivistic and community focused characteristics found within the Asian Indian American community, as research has found that Asian Indian Americans tend to be moderate collectivists, where the family and in-group are valued (Edara, 2016). P7 shared that she wanted to be a "stronger community member and family member," which helped her access mental health services. Similarly, P3 shared that her desire to be an active family and community member fostered in her the seeking of services. The individualistic and collectivistic characteristics of their motivation to seek mental health support may be explained by the integrative acculturation style reported by all the participants. Moreover, family often can be an important factor in South Asian American culture (Masood et al., 2009), which may explain communal motivations in seeking mental health support. These themes and subthemes contribute to the concept of supported choice, when individuals access services with help from their social systems, as a method to accessing mental health services and acknowledges the role culture plays (Pescosolido & Boyer, 2010).

The normalization of mental health treatment was found to be helpful for participants seeking services. This normalization was achieved through positive interaction with others, such as partners, peers, colleagues, friends, family, and community members, who have accessed such services. This finding supports the efforts of organizations to increase acceptance of seeking mental health support, such as those of the National Alliance on Mental Illness's #IStopStigmaBy campaign (Greenstein, 2016). Moreover, as a tool to address the stigma associated with mental health issues and treatment, mental health professionals advocate for increased awareness campaigns and normalization of seeking mental health services (Miller, 2013; Panganamala & Plummer, 1998). This parallels Pescosolido's Network Episode Model and its emphasis on social systems' crucial role in facilitating access to mental health services.

The value placed on family and community was reflected in the findings, as participants expressed that having a support system was particularly helpful, which reinforces the conceptualization that accessing mental health services is impacted by social networks (Pescosolido & Olafsdottir, 2013). P6 shared that the support she received from colleagues, friends, and family helped her access mental health services by making her feel less alone in her struggles. Similarly, P5 reported that his family's support was a major factor that helped him seek treatment for his mental health struggles. In short, support from family, friends, and community members (Masood et al., 2009), as well as from kinship, which goes beyond the immediate family, are important aspects of seeking support among members of the South Asian community (Inman et al., 2007).

Implications

The findings of the study have many implications with respect to ways providers, program coordinators, community leaders, and policymakers can better support the mental health needs, access, and utilization of services by first- and second-generation Asian Indian Americans. Specifically, the findings support current and future efforts on furthering cultural competence and humility through continuing education for mental health providers. Providing culturally appropriate, competent, and humble mental health services can contribute to a positive therapeutic experience and increase access to mental health services by Asian Indian American

community members. Based on the results, providers may explore ways to promote and incorporate social support when working with such clients, as it may aid in increasing willingness to seek mental health support and subsequent treatment adherence.

Given that increased psychoeducation and normalization of seeking mental health support helped participants in accessing services, it would be important for mental health agencies and community leaders to actively provide psychoeducation within this community. In fact, increased psychoeducation and knowledge may help reduce the stigma associated with mental illness (Corrigan et al., 2012, 2014) and can promote access to mental health services. According to the findings in the present study, university counseling centers play a ubiquitous role in the accessing of mental health services among highly educated first- and second-generation Asian Indian Americans. Therefore, these centers can have much influence through the provision of psychoeducation and the normalization of seeking services within this community. Simply having mental health services available is not enough to promote access to treatment, rather increasing mental health literacy can help improve service usage (Jorm, 2012); thus, community leaders and policymakers should develop Asian Indian American centric psychoeducation programs and campaigns. Existing mental health awareness and literacy campaigns such as the South Asian Mental Health Initiative and Network (SAMHIN) and the South Asian Mental Health Alliance (SAMHAA) can be models for such initiatives.

Community centers serving Asian Indian Americans can use their within-group status to aid in disseminating information about mental health, normalizing mental struggles including illness, and the seeking of treatment. The privacy and confidentiality that characterize mental health services were identified as significant facilitators in accessing services. Both are key components of psychotherapy and they can be further emphasized by agencies and providers when working with clients who are Asian Indian American. This includes financial privacy, where individuals can access services without their billing information being accessible to others. For example, university counseling centers provide financial privacy to clients, as services are included in the university tuition. This allows individuals who may be financially dependent on others to anonymously access services. The authors recommend policymakers to consider ways to increase financial privacy for individuals who share insurance plans.

Limitations and Future Directions

While the purpose of the present study was to explore the stories of Asian Indian Americans who have successfully accessed mental health services, it is worth mentioning that all participants were self-selected. This may have resulted in either people with highly positive or negative experiences choosing to participate in the study. While efforts were made to recruit individuals from diverse backgrounds, the sample was relatively young. This may be due to the recruitment method employed (i.e., advertising through social media and word-of-mouth), and future studies may benefit from diversifying recruitment methodologies. Additionally, the present study collected limited information regarding participants' socioeconomic status (SES). Future studies would benefit from collecting such information, including insurance status, as well as using methods to diversify the sample in terms of SES. Participants were also highly educated, which parallels the characteristics of the larger Asian Indian American community (Budiman & Ruiz, 2021). The present study did not employ member checks due to limited resources. Future researchers using a similar qualitative approach as to the present study may try to incorporate member checks to gain additional input from participants.

In order to gain another perspective of what helps and makes it difficult for Asian Indian Americans to access services, future studies may benefit from exploring mental health providers' experiences in interacting with and treating members from this community. The next suggested step would be to build off the foundational and exploratory nature of the present study and utilize methodologies that will allow for the field to develop theory and generalizability. The authors suggest that future studies consider using grounded theory (Charmaz, 2014; Corbin & Strauss, 1990) to expand on the understanding of the phenomena. While the current results may be transferable and provide a deeper understanding of the experiences encountered by members from other communities, future studies may choose to use mixed methods approaches for possible generalizability of findings. Finally, to gain an even deeper understanding of the phenomenon, future research could explore other culturally salient mental health treatment methods employed by members of this community.

References

Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., Appel, H., Nicdao, E., & Alegría, M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health*, *97*(1), 91–98. https://doi.org/10.2105/AJPH.2006.098541

Amri, S., & Bemak, F. (2013). Mental health help-seeking behaviors of Muslim immigrants in the United States: Overcoming social stigma and cultural mistrust. *The Journal of Muslim Mental Health*, *7*(1), 43–63. https://doi.org/10.3998/jmmh.10381607.0007.104

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*(1), 1–10. https://doi.org/10.2307/2137284

Anderson, K. N., Bautista, C. L., & Hope, D. A. (2019). Therapeutic alliance, cultural competence and minority status in premature termination of psychotherapy. *American Journal of Orthopsychiatry*, *89*(1), 104–114. https://doi.org/10.1037/ort0000342

Asnaani, A., & Hofmann, S. G. (2012). Collaboration in multicultural therapy: Establishing a strong therapeutic alliance across cultural lines. *Journal of Clinical Psychology*, *68*(2), 187–197. https://doi.org/10.1002/jclp.21829

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology*, *46*(1), 5–68. https://doi.org/10.1111/j.1464-0597.1997.tb01087.x

Bowl, R. (2007). The need for change in UK mental health services: South Asian service users' views. *Ethnicity & Health*, *12*(1), 1–19. https://doi.org/10.1080/13557850601002239

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Budiman, A., & Ruiz, N. G. (2021). *Key facts about Asian Americans, a diverse and growing population*. Pew Research Center. https://www.pewresearch.org/fact-tank/2021/04/29/key-facts-about-asian-americans/

Chandra, R. M., Arora, L., Mehta, U. M., Asnaani, A., & Radhakrishnan, R. (2016). Asian Indians in America: The influence of values and culture on mental health. *Asian Journal of Psychiatry*, *22*, 202–209. https://doi.org/10.1016/j.ajp.2015.09.011

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Sage Publications.

Chaudhry, T., & Chen, S. H. (2019). Mental illness stigmas in South Asian Americans: A cross-cultural investigation. *Asian American Journal of Psychology*, *10*(2), 154–165. https://doi.org/10.1037/aap0000141

Collier, A. F., Munger, M., & Moua, Y. K. (2012). Hmong mental health needs assessment: A community-based partnership in a small mid-Western community. *American Journal of Community Psychology*, *49*(1–2), 73–86. https://doi.org/10.1007/s10464-011-9436-z

Conrad, M. M., & Pacquiao, D. F. (2005). Manifestation, attribution, and coping with depression among Asian Indians from the perspectives of health care practitioners. *Journal of Transcultural Nursing*, *16*(1), 32–40. https://doi.org/10.1177/1043659604271239

Consoli, A. J. (2000). El contexto de la psicoterapia: Acceso y utilización [The context of psychotherapy: Access and utilization]. *La Psicología Social en México* [Social Psychology in Mexico], *8*, 788–795.

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, *13*, 3–21. https://doi.org/10.1007/BF00988593

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37–70. https://doi.org/10.1177/1529100614531398

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services*, *63*(10), 963–973. https://doi.org/10.1176/appi.ps.201100529

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches*. Sage Publications.

Denzin, N. K. (2001). Thick description. In N. K. Denzin (Ed.), *Applied social research methods: Interpretive interactionism* (pp. 99–118). Sage Publications. https://doi.org/10.4135/9781412984591.n6

Edara, I. R. (2016). Relation of individualism-collectivism and ethnic identity to spiritual transcendence among European Americans, Asian Indian Americans, and Chinese Americans. *Counseling and Values*, *61*(1), 44–63. https://doi.org/10.1002/cvj.12025

Farberman, R. K. (1997). Public attitudes about psychologists and mental health care: Research to guide the American Psychological Association public education campaign. *Professional Psychology, Research and Practice*, *28*(2), 128–136. https://doi.org/10.1037/0735-7028.28.2.128

Greenley, J. R., Mechanic, D., & Cleary, P. D. (1987). Seeking help for psychologic problems. A replication and extension. *Medical Care*, *25*(12), 1113–1128. https://doi.org/10.1097/00005650-198712000-00001

Greenstein, L. (2016, November 16). *I stop stigma by . . .* . National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/November-2016/I-Stop-Stigma-by%E2%80%A6

Inman, A. G., Yeh, C. J., Madan-Bahel, A., & Nath, S. (2007). Bereavement and coping of South Asian families post 9/11. *Journal of Multicultural Counseling and Development*, *35*(2), 101–115. https://doi.org/10.1002/j.2161-1912.2007.tb00053.x

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957

Kumar, A., & Nevid, J. S. (2010). Acculturation, enculturation, and perceptions of mental disorders in Asian Indian immigrants. *Cultural Diversity & Ethnic Minority Psychology*, *16*(2), 274–283. https://doi.org/10.1037/a0017563

La Roche, M. J. (2013). *Cultural psychotherapy: Theory, methods and practice*. Sage Publications.

Lee, S. Y., Martins, S. S., & Lee, H. B. (2015). Mental disorders and mental health service use across Asian American subethnic groups in the United States. *Community Mental Health Journal*, *51*(2), 153–160. https://doi.org/10.1007/s10597-014-9749-0

Leong, F. T. L., & Kalibatseva, Z. (2011). Cross-cultural barriers to mental health services in the United States. *Cerebrum: The Dana Forum on Brain Science*, *2011*, Article 5.

Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research*, *3*(4), 201–214. https://doi.org/10.1023/A:1013177014788

Masood, N., Okazaki, S., & Takeuchi, D. T. (2009). Gender, family, and community correlates of mental health in South Asian Americans. *Cultural Diversity & Ethnic Minority Psychology*, *15*(3), 265–274. https://doi.org/10.1037/a0014301

Miller, A. (2013). Mental health awareness campaign exposes challenges in combatting stigma. *Canadian Medical Association Journal*, *185*(6), E241–E242. https://doi.org/10.1503/cmaj.109-4415

Mills, A. J., Durepos, G., & Wiebe, E. (2010). *Encyclopedia of case study research* (Vol. 1-0). Sage Publications. https://doi.org/10.4135/9781412957397

Panganamala, N. R., & Plummer, D. L. (1998). Attitudes toward counseling among Asian Indians in the United States. *Cultural Diversity and Mental Health*, *4*(1), 55–63. https://doi.org/10.1037/1099-9809.4.1.55

Pescosolido, B. A., & Boyer, C. A. (2010). Understanding the context and dynamic social processes of mental health treatment. In T. L. Scheid & T. N. Brown (Eds.), *A handbook for the study of mental health: Social contexts, theories, and systems* (2nd ed., pp. 420–438). Cambridge University Press.

Pescosolido, B. A., Gardner, C. B., & Lubell, K. M. (1998). How people get into mental health services: Stories of choice, coercion and "muddling through" from "first-timers". *Social Science & Medicine*, *46*(2), 275–286. https://doi.org/10.1016/S0277-9536(97)00160-3

Pescosolido, B. A., & Olafsdottir, S. (2013). Beyond dichotomies: Confronting the complexity of how and why individuals come or do not come to mental health care. *World Psychiatry*, *12*(3), 269–271. https://doi.org/10.1002/wps.20072

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice*, *23*(3), 325–348. https://doi.org/10.1093/fampra/cmi113

Stake, R. E. (1995). *The art of case study research*. Sage Publications.

Stake, R. E. (2006). *Multiple case study analysis*. Guilford Press.

Substance Abuse and Mental Health Services Administration. (2015). *Racial/ethnic differences in mental health service use among adults* (HHS Publication No. SMA-15-4906).

Sue, S., Yan Cheng, J. K., Saad, C. S., & Chu, J. P. (2012). Asian American mental health: A call to action. *American Psychologist*, *67*(7), 532–544. https://doi.org/10.1037/a0028900

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125. https://doi.org/10.1353/hpu.2010.0233

United States Census Bureau. (2012). *The Asian population: 2010 census briefs*. https://www.census.gov/prod/cen2010/briefs/c2010br-11.pdf

United States Census Bureau. (2019). *Asian-American and Pacific Islander heritage month: May 2019*. Census. https://www.census.gov/newsroom/facts-for-features/2019/asian-american-pacific-islander.html

Yeh, C. J., Inman, A. C., Kim, A. B., & Okubo, Y. (2006). Asian American families' collectivistic coping strategies in response to 9/11. *Cultural Diversity & Ethnic Minority Psychology*, *12*(1), 134–148. https://doi.org/10.1037/1099-9809.12.1.134

Received November 12, 2020
Revision received August 18, 2021
Accepted October 12, 2021 ■