OSLO AND AKERSHUS
UNIVERSITY COLLEGE
OF APPLIED SCIENCES

**Sanjana Arora**

---

# Autonomy and Marriage:

# Impact on Mental health

## A study on local Indian women in India and Indian immigrant women in Norway

**Oslo and Akershus University College of Applied Sciences,**

**Faculty of Social Sciences**

Abstract

This thesis aims to understand the factors that contribute to poor mental health among local Indian women living in India and Indian immigrant women living in Norway. By focusing on the interplay of marriage and autonomy in Indian society, I aim to understand how the women experience autonomy, and the impact of it, on mental health. Moreover, since these women come from a collectivist society with traditionally entrenched gender roles and high emphasis on relatedness, we also consider how they negotiate restricted autonomy. Although the two groups of women come from different educational, family backgrounds and live in different societies now, they are related through shared bonds of gender and experiences of belonging to a patriarchal society. By taking them simultaneously, I aim to enrich reflections about mental health issues in lives of Indian women.

In addition to this, the study aims to understand what coping strategies women adopt when experiencing mental health difficulties and why. Furthermore, owing to the gap between prevalence of mental health problems and professional help seeking among Indian women, it becomes imperative to understand these women's perception towards professional help seeking and thus this study aims to understand the same.

I used Postcolonial feminist perspective to look at gender, ethnicity, cultural, social-economic-historical-political factors and their relationship with mental well-being while addressing all aims of the study. I conducted semi structured interviews with 11 Indian women in total to collect data for the study.

The findings of the study illustrate that autonomy was restricted in different ways and extents for both local and Indian immigrant women and had significant impact on their mental health. Many factors influenced their autonomy such as marriage, multiple identities of being daughter, wife and daughter-in-law, living in joint family, conflict between autonomy and relatedness and simply being a woman. Some specific factors attributed to poor mental health of Indian immigrant women such as perceived trade-off between acculturation and passing traditional values among children, the struggle to take care of parents in old age and isolation upon moving to Norway. Many coping strategies were hence adopted by the women such as confiding in family, friends and support from social network along with resilience and adaptability. Perceptions about mental health problems, perceived response of society and experience with mental health problems were varied and found to influence attitudes towards professional help seeking by local and Indian immigrant participants. Furthermore, the need for mental health

literacy and awareness about possible debilitating side of mental health problems was found to be significant in influencing attitudes towards professional help seeking.

On a concluding note, this thesis is particularly relevant for health professionals in India and Norway to gain a better understanding of mental health related needs of Indian women. It highlights some commonly shared experiences of poor mental health, coping and resilience between the women along with specific subjective experiences. It also discusses some specific suggestions for both local and Indian women for improvement of mental health.

Acknowledgement

I would like to begin by thanking the women who participated in the study and shared their thoughts and experiences while infusing their trust in me. This study wouldn't have been possible without their support and involvement.

To my supervisor, Melanie Straiton, thank you for believing in me and helping me explore my abilities. Your research insights have truly shaped my journey. The learning, guidance and motivation provided by you go beyond this thesis, you are a great mentor! Also, my sincere thanks to Norwegian institute of public health for providing the best possible resources and opportunities in facilitating this thesis work. I am grateful to Prof. Sony Pellissery who has had helped me grow academically ever since I stepped in the field of development and research. Thank you for motivating me to enter the MIS program. I would also like to thank Oslo and Akershus University College and Lanekassen for giving me an opportunity to study in Norway. I would like to extend my gratitude to Anne-Marie Mogster of the International Office, Stuart Arthur Deakin of the MIS programme and my teachers for their guidance. To my family, thank you for your invaluable love and support and my nephew for always sending happy thoughts and smiles, especially during the last phases of the writing process. I am ever grateful to my friends who made Norway my second home. Anjuv Baral, Tora Ediassen,Tina Skogmo, Ambari Shams, Bushra Abbas and Ishan Mittal. Thank you for being there for me always.

1. Introduction ........................................................................................................................ 1
1.1 Background ........................................................................................................................ 1
1.3 Theoretical and conceptual considerations ........................................................................ 5
1.3.1 Mental health ................................................................................................................ 5
1.3.2 Mental health and Gender ............................................................................................. 6
1.3.3 Mental health, Gender and Migration ........................................................................... 7
1.3.4 Mental health, Marriage and Autonomy ....................................................................... 8
1.3.5 Mental health care services ........................................................................................... 9
1.4 Research Questions .......................................................................................................... 11
2. Methodology ...................................................................................................................... 12
2.1 Theoretical Orientation: Post-colonial feminism .............................................................. 12
2.2.1 Use of Qualitative method ........................................................................................... 14
2.2.2 My position as researcher ............................................................................................ 14
2.2.3 Sample size ................................................................................................................... 15
2.2.5 Data analysis ................................................................................................................ 17
2.2.6 Addressing Ethical concerns ......................................................................................... 18
2.3 Strengths and Limitations of the study ............................................................................. 20
3. Findings and Discussion ...................................................................................................... 22
Research Questions ............................................................................................................... 23
3.1 How do local and Indian immigrant women experience and negotiate autonomy, what factors influence their autonomy and how does it impact their mental health? ........................... 23
3.1.1 Autonomy, marriage and impact on mental health ....................................................... 23
3.2.2 Autonomy, multiple identities of women and mental health ........................................ 26
3.2.3 Autonomy, Joint family, and mental health .................................................................. 28
3.2.4 Autonomy verses relatedness, impact on mental health .............................................. 30
3.2.5 Coping with restricted autonomy or negotiating autonomy ......................................... 33
3.2 What are the other factors attributing to poor mental health of Indian women? ............. 35
3.2.1 Interplay of employment and mental health ................................................................. 35
3.2.2 Conflict between acculturation and passing traditional values among children ........... 37
3.2.3 Stress and guilt about inability to take care of parents in old age ................................. 38
3.2.4 Adjustment issues ......................................................................................................... 38
3.3 What coping strategies do women use and why? ............................................................. 39
3.3.1 Family members ............................................................................................................ 42
3.3.2 Social network, friends .................................................................................................. 44

3.3.3 Resilience and Adaptability ........................................ 44
3.3.4 Other coping strategies ........................................ 45
3.4 How do women perceive professional help seeking? ........................................ 50
3.4.1Access to care ........................................ 52
3.4.2 Health professionals as detached and lacking empathy ........................................ 52
3.4.3 Stigma in seeking professional help ........................................ 53
3.4.4 Perceived cultural differences ........................................ 54
3.4.5 Perceived linguistic differences ........................................ 55
4. Conclusion and way forward ........................................ 58
5. Appendix ........................................ 62
5.1 References ........................................ 62
5.2 Information letter to the participants ........................................ 69
5.3 Consent form ........................................ 72
5.4 Interview Guide for Local Indian participants ........................................ 73
5.5 Interview guide for Indian immigrant participants ........................................ 78

# 1. Introduction

## 1.1 Background

The increasing pandemic of mental health issues is a cause of concern worldwide. Globally, 1 in 4 (25%) people, suffer from mental disorders in both developed and developing countries. As of March 2016, the World health organization listed on its website that within the umbrella of mental health disorders, depression is one of the leading causes of years lived with disability. Despite having a high prevalence rate, mental health problems remain severely under-diagnosed. The huge burden of mental illness in India has been found to be growing, as data reveals that over 61 million people suffering from mental and behavioral disorders were recorded in 2002 (Central Bureau of Health Intelligence 2011) . However, these cases are perceived to be under-diagnosed and a denial of human right as a much higher number of persons are believed to have mental health problems (Mathur Gaiha et al. 2014). The under-diagnosis in mental health problems either stems from the inability of doctors to diagnose such disorders due to their complex symptom presentation among others or the reluctance of people to seek professional care on account of stigma and shame or lack of knowledge and awareness among others (World health organization 2015).

In the case of common mental health problems, gender is an important determinant, as more women than men in both the developed and developing world are prone to the same. Gender differences occur particularly in the rates of common mental disorders - depression, anxiety and somatic complaints. The power and control that men and women have over social and economic determinants, social position, susceptibility to mental health problems and possibilities for professional health care are decided on the basis of their gender (World health organisation 2000).

As Women worldwide, face gender-based discrimination, their psychological well-being is a cause for great concern (Basu 2012). In India, where gender discrimination is present throughout the lifecycle, the impact on health, can be substantial. In recent times, issues surrounding gender inequality, particularly violence and offences against women, have been raised in Indian society, highlighting gender as an important factor in mental health. The impact on mental health of Indian women becomes increasingly relevant when we consider the interplay of marriage.  A study conducted in India found that compared with single Indian women, married and divorced/widowed Indian women were at significantly higher risk of common mental disorders (Patel et al. 2006).

In addition to marriage, the idea of agency and autonomy is highly influential in determining mental health of women. Research points out that person higher in the traits of autonomy and competence are more likely to report greater well-being on an average (Reis et al. 2000).

Another aspect of feminists concerns comes from the impact of migration on women's mental health. Women are susceptible to facing 'double segregation upon migration, as migrants and as women. Moreover, it has been found that the event of migration increases susceptibility of women to situations of violence, poverty, unemployment, social networks and support, discrimination which in turn has the potential to determine their health behaviours and use of health care services (Llácer et al. 2007).

In this thesis I will aim to further explore these themes and consider how the interplay between marriage, autonomy (and migration) may contribute to Indian women's mental health and well-being. However, the gap between prevalence of mental health problems and professional mental health care is thought to be very wide (Patel et al. 2010). Thus, I will also explore possible reasons for this and the alternative coping strategies women employ.

## 1.2 Rationale and purpose of study

This study ranges over two sets of groups; Indian immigrant women living in Norway and Local Indian women in India. It should be noted that by use of the term groups, I do not intend to ignore the intra group individualistic differences, but is solely used for identification and convenience purposes. Below I will discuss the rationale for selecting both these groups and the relevance of studying them together.

World health organization states that Indians are reported to be among the world's most depressed. The prevalence rates of depression from India range from 1.5/1000 to 37.74/1000. The burden of depression is 50% higher for females than males (Jané-Llopis et al. 2011). Apart from the problems of lack of diagnosis and treatment of mental health problems among Indian women, other problems have been found to be insufficient number of mental health professionals, lack of awareness, stigma, disadvantaged position of women, multiple roles, increased levels of stress, and domestic violence (Bohra et al. 2015). Despite such studies, there is still a paucity of research and data on mental health in India. Previous studies conducted on mental health from India are very few and cross sectional that range over small sample of population (Yerramilli 2012). Therefore, studying mental health issues of Indian women local or immigrant in itself makes an important contribution to this area of research.

In addition to this, to the best of my knowledge, there are no studies on Indian immigrant women around this topic in Norway.

Studies looking at the mental health of Indian immigrant groups in other countries such as U.K and Canada reveal number of stressors perceived by the participant. These include loss of social support, low social status, financial uncertainties, barriers in accessing health services, climate and food change (Bowl 2007). Coping strategies included increased efforts to socialize, use of preventative health practices and self-awareness (Bowl 2007). These studies have also discussed the service users' particular perceptions of mental health services (Ahmad et al. 2005). However, it is highly plausible that there studies are contextually bound. Cultural differences between Norwegian and Canadian societies for instance exist, thus leading to different lived experiences of Indian women.

Thirdly, research on the Indian immigrant group in 'Norway' is all the more significant presently on account of recent changes in structural composition. The process of migration to Norway began in 1970s when Indians started coming mainly as manual labour migrants. After the immigration stop, family reunification became a significant part of the Indian migration. In recent years, many Indians have started coming to Norway for higher education or professional purposes (Horst et al. 2010). Statistic Norway lists that in the beginning of 2016 there were 4973 Indian immigrant women and 5981 Indian immigrant men living in Norway. This shows that 45% of Indian immigrants are women. In 2010 there were 3211 Indian immigrant women, which mean that in 6 years there has been an increase of over 50%. Thus the rise in Indian women immigrant population can create challenges for health service as health professionals may not be equipped to work successfully with different cultural groups. Such challenges are related to prevention, recognition and finding suitable treatment of common mental health problems in primary care which emerge because of differences in language, culture, patterns of seeking help and ways of coping (Borowsky et al. 2000). Thus, knowing more about contextual factors that affect Indian women's mental health may help the identification and treatment of common mental health problems, better suited to their needs.

Fourthly, exploring the topic of mental health with the Indian immigrant women community becomes particularly relevant since despite studies showing impacts of acculturative stress among South Asian immigrant women, there is still cope to study them from an intersectionality perspective of culture and immigration (Ahmad et al. 2008). It should be noted that many studies have studied mental health of South Asian immigrant women as one group, (such as

with Pakistani, Indian, Bangladeshi women together), where not much references have been made to the cultural and contextual nuances of each society, particularly Indian (Hussain and Cochrane 2010, Gilbert et al. 2004). There are also some studies on South Asian immigrant women's lives after migration, but since they tend to focus on post migration lives, little or no understanding is developed about their life before migration (Bowl R 2007; Alvi et al. 2012). Thus, studying local women along with the immigrant group would help to explore pre-immigration factors as well as life of a Indian women in its original environment.

Fifthly, studies indicate that gender and other cultural norms in South Asians can become so internalized that there may be complexity in recognizing such norms (Tummala-Narra 2013). Thus, a simultaneous study on local Indian women will help not only to discern such internalized norms but also get in-depth understanding of pre-migration factors and compliment the retrospective insights received on life of immigrant women, by the same group.

Lastly, the relevance of the study 'at this time' is also related to the transformation that Indian society is experiencing, in various areas such as moving from joint traditional families to nuclear families, changing gender roles, increasing focus on women's education and employment. Therefore, this study can help to explore the mental health issues among women of India, a society on a traditional-progressive continuum.

As an aside, given the diversity of states, it is important to remember that Indian men and women have many characteristic differences in terms of region[1], language, religion, wealth, education , caste[2] as well the geographical area in which they reside (Chakrabart et al. 2007). It is important to note that both these sets of women are different from each other and also have intra group differences, in terms of their age, region of origin, caste, type of marriage arranged or love (as commonly understood in south Asian communities), education, employment status, choices, resources and resilience. However, the commonalities between them are that they share bonds of same gender and have been brought up largely within (though with different shades) of patriarchy[3] and collectivist cultural norms.

[1] Each state in India has its own culture reflected in the form of language, type of food, art,

[2] Caste is method of classification in Hindu society by degrees of purity and social status.

[3] Exception to historical form of patriarchy in India are the two states of Kerela and Meghalaya where matrilineal system is followed

## 1.3 Theoretical and conceptual considerations

In this section, I will be outlining some of the concept and theories that are important in the thesis. This will also help to establish understanding of the phenomenon under study by the reader and thus contribute towards transferability (external validity), subject to contextual factors (Shenton 2004).

### 1.3.1 Mental health

The term 'Mental health', though widely used can carry different meanings cross cultures along with varied understanding about symptoms and impact on life. It is pertinent to understand that mental health is a significant aspect of well-being and quality of life. Mental health thus, cannot be understood solely in the binary form of mental illness versus mentally healthy. It should be thought of as a continuum with different shades of positive and negative mental health.

> "*Concepts of mental health include subjective wellbeing, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential''*
>
> *-World health organization, 2003*

Thus, we adopt a broader perspective towards the understanding of mental health "a state of equipoise where the individual is at peace with themself, is able to function effectively socially and is able to look after their own basic needs as well as higher function needs''(Bhugra et al. 2013,2). While doing so, we further our understanding of mental health and associate it with the larger concepts of well-being and quality of life. Well-being has multiple dimensions, but from the perspective of mental well-being, literature points out that "The idea of mental well -being includes both how people feel-their emotions and life satisfaction- and how people function, their self-acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy" (Scottish government 2009,3).

By focusing on the well-being aspects of mental health we try to emphasize that absence of mental disorder does not strictly imply mental well-being (Keyes 2012). A positive state of mental health is an important component for overall quality of life and well-being. This is also the reason why in this process, we try to look at factors including, but not limiting to social, individual, biological and historical and explore the mental health in the lives of the participants beyond the binary lens of mental illness and mental health.

International organizations such as World health organization have also paved way for broadening the conceptualization of mental health from an absence of mental disorder towards relationship between mental, physical and social health. WHO also puts forward mental health as a continuum with the two poles of optimum mental health and poor mental health (World health organization 2001).

On a concluding note, since, our understanding of mental health is beyond mental disorders, we focus on Indian immigrant women and explore self –reported mental health status, factors that can be attributed to poor mental health and coping with poor mental health. Since we do not conceptualize mental health as mental illness per se, we did not adopt any specific criteria such as having experienced a mental health problem for selection of the participants. It was only in the course of the interviews that some participants reported having gone through mental health problems such as depression. The selection of participants has been discussed further in detail in Chapter 2 'Methodology'.

### 1.3.2 Mental health and Gender

As of March 2016, the World Health Organization states on its website that "gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks". Studies of gender and mental health consistently show that women experience higher rates of affective disorders like anxiety and depression (Seedat et al. 2009). Moreover, as the prevalence of mental health problems such as depression has been found to fluctuate between countries, the intersectionality of other social, economic political factors in determining mental health of women becomes significant (World Health Organization 2014).

There are many theories which seek to explain the supposed gender differential in mental health, including biological, psychological and sociocultural explanations (Bhugra et al 2013). For example, socio cultural theories include women's greater responsibility for private sphere, regardless of employment status, results in overload of demands. This might result in greater level of depressive and anxiety symptoms. Apart from the higher prevalence of mental disorders among women, gender has also been found to influence the risk, timing of onset and course, diagnosis, treatment and adjustment to mental disorder (World Health Organisation 2014). Furthermore, in relation to coping with mental health problems, evidences point out that 'men more often use problem focused coping strategies, which change the stressor itself,

while women use more emotion-focused coping such as sharing and seeking social support which change their perceptions about the stressor' (Matud 2004,1403). However, these differences in coping strategies are again thought to be due to two theoretical hypotheses. Firstly the gender based prescriptions may call for women to cope in certain ways such as in emotion focused strategies that resonate with femininity more than masculinity. This hypothesis is called dispositional hypothesis (Tamres et al. 2002). The second is that the different coping styles may be due to differences in the factors that can attribute to poor mental health of men and women, called as situational hypothesis (Rosario et al. 1988).

Overall, literature points out to many significant differences in mental health status, the risk factors and coping strategies for men and women, which makes it relevant to have a gender perceptive in mental health related studies.

### 1.3.3 Mental health, Gender and Migration

A prominent theory prevailing immigrant health called healthy immigrant effect postulates that upon arrival, most immigrants are generally in better health than their native-born counterpar (Davies et al. 2009) However, the healthy immigrant effect has been found to deteriorate over time, especially with respect to mental health (Missinne and Bracke 2012). The process of deterioration of immigrants' mental health is given by disillusionment model. According to disillusionment model, 'immigrants' psychological adaptation has predictable phases "During the first phase, called euphoria of arrival, the mental health of immigrants is equal or even better than that of host population. In the second phase, which is disillusionment and nostalgia for the past, immigrants' mental health deteriorates and finally adaptation takes place and immigrants' mental health approximates to that of native born. However, there is a decline in both mental health and physical health of immigrants' overtime'. This decline has been attributed to many factors including socioeconomic status, financial and employment constrains, resettlement and acculturation challenges, multiple responsibilities, discriminatory treatment, and difficulty obtaining services in a timely manner due to language differences (Davies et al 2009, 9).

This pattern of decline in health of immigrants over time is varied for different host countries and also for different sets of migrant populations. Moreover, this disillusionment model may infact not be applicable for all countries (Kennedy et al. 2015). However, it highlights the influence of environmental factors such as social, cultural, economic and political, embedded in an ecological perceptive that influences mental health as discussed before. Thus, theories

have suggested that suggest that migration can negatively impact mental health (Berry & Kim 1988). A study conducted in the U.S found that acculturative stress was a risk factor and increased risk for mental health problems among Asian Americans (Hwang et al. 2008). Now let's discuss the intersection of gender with migration by taking the case of South Asian immigrant women in particular. Depression has been found to be more common in people of South Asian origin in the UK. Moreover, South Asian women (Pakistani) and not men, of South Asian (Pakistani) origin living in UK were found to have an increased prevalence of depressive disorder compared to white Europeans (Gater et al. 2009). Another study also found that South Asian immigrant women face acculturative stressors, such as language/communication barriers, separation from close friends and family, and adapting to new cultural norms. Such acculturative stressors are exacerbated as the women are raised in their country of origin with a different social, economic, political and other environmental context and migrate to a host country as adults. However, South Asian women may experience an increased sense of sexual freedom along with alterations in cultural ideals (Tummala-Narra 2013). Therefore, these altering cultural ideals and being stuck between different sets of values can increase frustration and feelings of anxiety.

On the question of the relationship between immigration and professional health care seeking, studies in Asian communities have suggested that structural barriers about location, costs and information about services or differences in cultural conceptions of health care could lead to difficulties in professional help seeking (Alexander, 2001; Netto et al. 2001). Thus, professional help seeking remains an area of concern for South Asian immigrant communities.

### 1.3.4 Mental health, Marriage and Autonomy

Many common theories about the relationship between marriage and mental health have been found to exist. On one hand, studies suggest that, compared to never getting married, getting married is protective for both men and women in terms of most mental disorders. It is therefore postulated that marriage can insure one against psychological breakdown (Simon 2002; University of Otago 2009). On the other hand, research also points that marriage demands a sustained level of adaptation from both partners. Events that can influence marital roles such as the birth of a child, an abortion or miscarriage, economic stress, migration, episodes of illness, major career changes among others, can lead to stress (Nambi 2005). As stated earlier, a study conducted in India found that compared with single Indian women, married and divorced/widowed Indian women were at significantly elevated risk of common mental disorders (Patel et al. 2006). Another study on severe mental distress found that those who were

ever married, that is, married/widowed/widower or separated, suffered more than those who never married (Nambi 2005). Thus, marriage may be stressful for some and could increase the risk of mental health problems.

It should also be noted that the impact of marriage on mental health of men and women may vary. Traditionally theories have indicated that for men, marriage confers more protection against mental health problems than for women. This has been attributed to women's greater role obligations within family and marriage that surpasses the benefits marital environment could provide (Bierman A, 1999). In recent years too, there has been some evidence even that within marriage, the traditional role of the female is constrained, which may lead to depression (Nambi 2005). In the case of India, where traditional gender roles are still not completely dismantled, marriage may affect mental health of Indian women in multifaceted ways. Moreover, married women are considered as 'Paraya dhan' in India which means 'somebody else's wealth or property' and is considered a transitory member of the family (Juyal 2005). Thus marriage is a significant even in the life of an Indian woman as she leaves her traditionally considered transitory family of her parents. In this context, it becomes interesting to see how women walk through the social expectations and norms entrusted by marriage and how it influences their mental health.

Moreover, marriage builds up and adds to the multiplicity of roles of being a daughter, wife, mother, daughter –in –law, each with its set of socially expected roles and duties. Research cites that upholding of multiple roles by Indian women can contribute to stress, make them susceptible to depression, which is often under-reported due to stigma (Bohra et al. 2015). Thus, marriage adds to the socially determined gendered norms. Interestingly, socially determined gender norms, roles and responsibilities place women, far more frequently than men, in situations where they have little control over important decisions concerning their lives, reducing their autonomy. The feeling of a lack of autonomy and control over one's life is known to be associated with depression (World health organization 2002) and to emotional well-being (Reis et al. 2000). Thus, autonomy also becomes an important factor to examine in the lives of married Indian women who up hold multiple gender roles and responsibilities.

### 1.3.5 Mental health care services

In the following paragraphs, I would be discussing the structure and status of mental health care services in India and Norway. It should be noted that the idea is not to compare the different health systems but to set the context for availability of mental health services in each of

the two countries. This will also pave way for discussion on gap between prevalence of mental health problems and utilization of professional mental health care services by Indian women.

Norway's health service is publicly funded and available to all citizens and residents, with regular medical consultations on small fees, emergency treatment and hospitalization. General practitioners (GPs) play a large role in the diagnosis and management of mental health care, and are gate-keepers to accessing specialized mental health services. Thus, professional mental health care is routed through primary health care (Straiton, Reneflot, and Diaz 2014) and is thus extended throughout the country for all Norwegian residents.

In India, the health service is not publicly funded and the availability of mental health care at primary level is both limited and compromised. The district implementation of the National mental health program which operationalizes mental healthcare integration into primary care has only been implemented for 20 percent of the districts (127 districts out of 626 districts) (Ginneken et al. 2014). Thus, unlike Norway, primary mental health care is not extended throughout the country. Moreover, for every 1 million people, there are only three psychiatrists, with psychologists even more scarce in India, while in Norway there are approximately 29 psychiatrists for every 100,000 people and 240 mental health workers for every 100,000 people (World health organisation 2014).

Gender appears to heighten the discrepancy between prevalence and utilization in many contexts. The use of professional mental health care is limited for South Asian immigrant women particular. For example, in Norway studies report that immigrants are less likely to use a GP or emergency primary care (EPC) services for mental health problems compared to Norwegians. Pakistani women in particular were less likely to have consulted with a GP or with EPC services in relation to a mental health problem (Straiton et al. 2014). Given that Pakistani immigrants report more mental distress than Norwegian immigrants, the authors argued that these women experience greater barriers to care. In India, psychiatric epidemiological data cite a ratio of one woman for every three men attending public health psychiatric outpatients' clinics in urban India (Malhotra and Shah 2015). Thus, professional help seeking for mental health is limited for both local Indian women and South Asian immigrant women in Norway. Attitudes to professional help seeking play an important role as positive help-seeking attitudes are positively associated with intentions to seek mental health care (Seyfi et al. 2013). This

raises important question of perceptions of professional help seeking, which will also be discussed in this study.

To summarise, marriage is a significant event in both local and immigrant Indian women's lives, and there exists strong presence of gender inequality in various spheres of Indian society. Women are also increasingly expected to uphold multiple roles and responsibilities, which may have consequences for both their experiences of autonomy and their mental health. Additionally, Indian women appear to lack access to appropriate mental health care. This gap in mental health needs and service use needs to be addressed.

## 1.4 Research Questions

In light of this, I aim to consider how the interplay between marriage, autonomy (and migration) may contribute to Indian women's mental health and well-being. With an overarching goal of promoting women's well-being and improving help-seeking, I explore the coping strategies women use and their perceptions of help-seeking. More specifically, in this study I seek to explore the following research questions:

1. How do local and Indian immigrant women experience and negotiate autonomy, what factors influence their autonomy and how does it impact their mental health?
2. What are the other factors attributing to poor mental health of Indian women?
3. What coping strategies do women use and why?
4. How do the women perceive professional help seeking?

# 2. Methodology

This chapter will discuss my theoretical perspective, the use of qualitative methodology, procedure for data collection and analysis. Throughout the discussion, I will also be outlining ways in which this study ensures its trustworthiness in the form of credibility, confirmability and dependability. Issues of generalizability are discussed in strengths and limitation of study.

## 2.1 Theoretical Orientation: Post-colonial feminism

This study has postcolonial feminism as its theoretical underpinning. I will now discuss the rationale and relevance behind using this approach, in line with the research aim and research questions.

To reiterate, my first research question strives to understand how local and Indian immigrant women experience autonomy, its impact on their mental health and how they negotiate their autonomy in life or cope with restricted autonomy. I also wish to understand other factors that contribute to their poor mental health and the coping strategies, along with factors influencing choice of strategy. Lastly, I aim to understand their perceptions of professional help seeking.

In all these research questions, I seek to understand the mental health experiences of women. Experiences are constructed subjectively and can be influenced by multiple environmental factors: social, economic, political, cultural and historical as well as gender (Anderson 2004). My background as researcher is Indian. Yet, studies have shown that there is still a need for a perspective that speaks the lives of these women (Anderson 2004). By relying on approaches exclusively considering gender or culture, I would fail to capture the experiences and meanings created by intersection of all such environmental factors, leading us to essentialism[4] Mahalingam and Leu discuss the drawbacks of gender essentialism and have suggested intersectionality perspective that can help to develop a feminist psychology of gender and migration (Mahalingam and Leu 2005). Thus gender essentialism can be overcome by considering the influence of environmental factors such as ethnicity, socioeconomic status and other historical factors that shape experiences and beliefs of mental health. O'Mahony and Donnelly note that ethnicity cuts across different categories and can also be used to make assumptions about other people in subtle ways (Maureen and Donnelly 2010). For example, Indian society is perceived to be collective in nature. This can translate into perceptions that women tend to prefer discussing their mental health problems with family than with a doctor. Although similar evi-

[4] Essentialism is the supposition that a woman's consciousness is somehow constituted by the characteristics of a woman's body (Kuykendall, 1991).

dence is also found in our interviews (as shall be discussed later), it has also been revealed that a self-imposed guilt of passing on the worries to family members may restrict women from sharing their problems. As a result, they may find themselves unable to disclose to anyone. Thus, cultural concepts of health care may misguide health personnel in forming assumptions about health care seeking by such women and attention may not be drawn to them. This makes our theoretical perspective relevant for all ethnic groups with simultaneous understanding of assumptions. The concept of White feminism has further highlighted that women's experiences are multifaceted and complex and universalization of peoples experiences should be avoided (Lewis 2000). Such representations of South Asian women under a single category masks their diversity, and as Indian and Indian women have diverse characteristics of regions, class among others, postcolonial feminist perspective becomes important to acknowledge such differences.

Another rationale behind using this perspective is also to highlight the specific circumstances of women belonging to a certain context, shaped by historical, social, cultural and economic influences. This is in contrast to an overarching approach such as feminism per se  For example in India, dowry, patriarchy, preference for male children, stigma associated with female widowhood are all products of some Indian context and are specific social processes putting women under multiple layers of marginalization. Thus, taking a postcolonial feminist perspective helps in the exploration of women's mental health experiences. .

It should be noted that both the subjective experience and the socio-economic context take the centre focus in postcolonial feminism. This is significant as the life of each individual carries its own set of vulnerabilities to poor mental health. Vulnerabilities or factors that attribute to poor mental health have been found to extend beyond cultural and gender lines (Anderson 2004). Socioeconomic conditions impact both health and opportunities. This may be particularly important in the case of India, where diversity unfolds in all spheres of life, showing multiple blurred marginal lines. For example the mental health experiences and the factors attributing to poor mental health of a divorced single mother in a rural area would be shaped by some specific complex realities that may not apply to all Indian women.

Lastly, as discussed in the rationale for the study, we had stated earlier that this study strives to provide a fresh perspective of mental health of Indian women, by steering away from the binary lens of viewing Indian women as traditional or modern and mental health as illness or healthy. This corroborates with our use of postcolonial feminist perspective as it focusses on

the deconstruction of binary categories and challenges how structural systems like gender and ethnicity influence thinking (Given 2008). For example, this perspective attempts to deconstruct how certain roles are allocated to gender or socially accepted gendered ways of experiencing and coping with mental health problems. This has implications for how research is conducted.

By understanding that factors contributing to poor mental health and coping strategies for mental health, are constantly shaped and influenced by this nexus of social, political, economic, cultural and historical factors, with a cross cutting theme of gender, we locate our theoretical assumptions in postcolonial feminism.

## 2.2 Methodological considerations

### 2.2.1 Use of Qualitative method

Since the unit of analysis in postcolonial feminism is the connections between individuals and social structures of ethnicity, gender, class and other forces, rather than social structures per se (Given 2008), a method of data collection focusing on in-depth subjective experiences was needed. The meaning of lived experiences is better unravelled through one-to-one transactions between the researcher and participants with the help of attentive listening and interaction (Danuta M. Wojnar 2007). Therefore, semi-structured interviews were conducted to collect data and information from participants. In the following paragraphs, I will outline the detailed procedure for collection of data through semi-structured interviews and the context of the findings that can help to ensure transferability of my study's findings (Shenton 2004).

### 2.2.2 My position as researcher

Epistemologically, postcolonial feminism believes that knowledge is shaped by social and external factors and thus, recognizes multiple truths. Since these truths are constructed partially or viewed through one's positionality, it was also important for us to take my background as researcher in relation to the participants and how it could possibly affect the knowledge production and research process(Given 2008).

The power relationship between the researcher and participants is one such issue in positionality (Given 2008). Too much distance between the informant and the interviewer can lead to an imbalance of power, where it becomes difficult for the participant to talk about personal things. To overcome this, consistent with feminist interview approaches, I also shared some information about myself and my background. On the other hand, a high degree of closeness

could create and illusion of friendship and lead the participants to say more than they intend (Kvale and Brinkmann 2009). To reduce the risk, I was sensitive to the participants' needs and vigilant in observing discomfort during the interview. The balance was further maintained as the participants identified with me to a certain extent since I am myself an Indian immigrant living in Norway. However, I am unmarried. Thus we have similar experiences of having moved to a foreign country with a foreign language, away from family and friends but our specific circumstances are different. Familiarity helped in building a rapport with the participants, while my position as a researcher helped to maintain a professional distance. In the terms of Lincoln and Guba, this contributes to credibility which in in qualitative research implies congruency of findings with reality (Shenton 2004).

Moreover, my experience of working on gender sensitive research projects such as on issues of contraception, family planning, HIV&AIDS and experience of conducting some prior interviews, helped me to balance my positionality and at the same time sensitive to the participants' needs. On an academic front I had also undertaken courses on gender and development and development theories and practices and research methods, which may have influenced my analysis and interpretation of data.

### 2.2.3 Sample size

Experts in the field of qualitative methodology state that sample size dependent on theoretical underpinnings of the study (Baker & Edwards 2012). Having a post colonialist feminist theoretical underpinning, the intention was to explore details through the intensive analysis of relevant themes of social constructs shaping mental health experiences of a small number of participants. World Health Organization also states that there no rules for sample size in qualitative research. It can depend on what one wants to know, the purpose of the study and practical factors. One can also use pragmatic criteria in defining sample size, considering the length of time it takes to do and transcribe the interviews and the number of sub-groups from which one will select respondents (World health organisation 2004).

In addition to this, in a study 'how many interviews are enough' a number of experts from diverse academic backgrounds have reflected on the same. The broad understanding among experts has been that this should depend on both internal i.e. methodological and epistemological perspectives along with external one i.e. time and scope for the thesis, institutional demands among others (Baker and Edwards 2012).

With this pragmatic approach of practical considerations as well as a postcolonial feminist stance, I took into the scope of this Master thesis and collected data from 11 participants, with 6 Local Indian women and 5 Indian immigrant women.

### 2.2.4 Data Collection

#### *Selection criteria*

Married Indian immigrant women in the age group of 18-35 years who have lived in Norway for 1-10 years and married Indian women living in India formed the selection criteria for the study.

#### *Interview guide*

While formulating the interview guide, a parallel research project on Thai and Filipino women by Melanie Straiton from the Norwegian institute of Public health has intellectually influenced and guided me towards exploring some pre formulated relevant themes such as autonomy, conceptualization of mental health, adjustment issues upon migration and perceptions to seeking professional health care which also align with a postcolonial feminist lens.

Along with this, some open-ended questions were also included to further explore the stated research questions. I have focused on themes of self -reported health status, conceptualizations and symptoms of poor mental health as well as coping strategies (including treatment under taken, if any) adopted by these two groups. Participants were also probed for understanding their experiences of living in India and Norway from a gender perspective. Issues of society's response to people with mental health problems were also discussed. In addition to the interview guide, a questionnaire to capture background information and the Hopkins symptoms check list-25, a measure of psychological distress was used.

#### *Procedure for data collection*

The participants were recruited through snowball sampling with the help of personal contacts who were also key informants in community. They were then able to refer to other prospective participants. The initial contacts were made through phone calls or emails, followed by sending of an information letter containing details on purpose of the study, areas of study, and potential advantages and disadvantages. Considering the sensitive nature of the study, participants were requested to meet either in the comfort of their homes in a private room or in a

---

[5]The HSCL-25 is a symptom inventory, originally by Parloff, Kelman and Frank at John Hopkins University, which measures symptoms of anxiety and depression. It consists of 25 items: Part I of the HSCL -25 has 10 items for anxiety symptoms; Part II has 15 items for depression symptoms.

quiet coffee shop. Prior to beginning of the interview, participants signed a consent form. The consent form also asked for permission to audio tape the interview.

Native fluency in Hindi aided smoother interaction with the participants. Owing to some participants belonging to southern linguistic parts of India, English was used to conduct interviews. Thus, the interviews were conducted in Hindi, English or a mix of both, depending on the comfort of participants.

#### *Characteristics of participants*

**Local Indian women-** The local Indian participants ranged from 27 years to 32 years of age. They had been married for 1.5 to 8 years. All participants hailed from Northern and Western part of India. Their Hopkins symptoms checklist-25 scores varied from 1.24 to 2.04. It should be noted that a cut-off point of 1.75 is recommended as a valid predictor of mental health problem (Strand et al 2009; Weaver et al.2011).

**Indian immigrant women-**The Indian immigrant participants ranged from 27 years to 35 years of age. They had been married for 2 to 10 years. All participants hailed from Central and Southern parts of India. Their Hopkins symptoms checklist-25 scores varied from 1.28 to 2.48.

### 2.2.5 Data analysis

As discussed earlier, postcolonial feminism analytical approach has been used to guide data analysis. Through the qualitative analysis, we aim to explore the intersectionality of social, economic, cultural historical factors.

Each interview lasted for about 45-90 minutes which were later transcribed in their original language i.e. either Hindi, English or a mix of both. Some Hindi interviews were translated into English to facilitate discussion between myself and my supervisor. Such meetings helped me to discuss my ideas and interpretations emerging from data, to recognise my biases and preferences as a researcher.. Since my supervisor belongs to a non-Indian origin and has considerable knowledge of Norwegian society, I was able to get fresh perspectives of looking at the data from our discussions. Thus, having frequent meetings with my supervisor helped increase dependability and confirmability of the study (Shenton 2004).

My analysis was based on the original transcriptions. I read the transcripts multiple times to gain familiarity with the data and to achieve an overall understanding. Nvivo was used to assist in the analysis process. I also maintained an account of reflective commentary about my

first impressions of the data in the form of notes after each interview. According to Lincoln and Guba, such reflective commentary plays a key role in the monitoring of the researcher's own developing constructions and helps to develop credibility of the study (Shenton 2004)Furthermore, the process of re-reading and subsequent familiarity with the data helped to develop initial coding of data coding of data through Nvivo and explore relationships between the different themes identified and developed. Having a postcolonial feminist analytical approach, the intersectionality between different themes was identified.

The analysis of data took place as a mix of inductive (bottoms up) and theoretical (top down) approaches, I began with an inductive analytical approach without existence of any pre-existing nodes in the data or fitting the data in pre conceived categories. Morra-Imas and colleagues note that qualitative data are typically analysed inductively in the early stages (figuring out categories, patterns and themes) (Imas and Rist 2009). When some preliminary patterns and theories started to emerge from the data, I also asked participants about reasons for emergence of such patterns so as to verify them. This is another form of member checks that helps to ensure credibility of qualitative research (Miles and Huberman 1994). Once these categories, patterns and themes are established, deductive analysis was performed. In the process of analysis, engagement and dis-engagement was frequently done to increase sensitivity to the more subtle features of the data (Tuckett 2005). Having a postcolonial feminist stance, the engagement with themes of ethnicity, gender, socioeconomic status and historical factors, enabled me to infuse a deductive approach later, and identify categories related to the same. I also went back and forth between the data and literature to better understand the emerging themes and refine them further. I had continual discussions about the analysis and themes with my supervisor. Moreover, the deductive phase also helped to test and affirm the authenticity and appropriateness of the inductive analysis(Imas and Rist 2009). I have also included verbatims from the interviews in the chapter Findings and Discussion that will help to ensure conformability and credibility as defined by Lincoln and Guba and affirm that the findings emerged from participants ideas, experiences and interpretations of the same (Shenton 2004).

### 2.2.6 Addressing Ethical concerns

Notification of this study was sent to the Norwegian Data Protection Officer and the research was conducted in line with their regulations and ethical guidelines in India.

Understanding the sensitivity of the research topic in question, steps were taken to ensure a comfortable experience complying with ethical norms for the participants in the following ways:

1. **Information to participants about voluntary participation and right to withdraw or not respond was provided.** The information sheet also provided contact details of my supervisor who can be contacted at any point during the study for queries.

2. **Detailed information to participants about purpose and topic of study**: A cover letter explaining the purpose of the project along with a consent form covering topics of discussion. The possibility of moving beyond those stated topics, depending on nature of discussion, was highlighted. The letter and consent form informed the participants about the sensitive and personal nature of the study. The names of the participants were only mentioned in the consent form and codes were allocated to each for confidentiality purposes. Participants were then asked to complete the background questionnaire before the interview.

3. **Sensitivity and responsiveness to women's distress** Although the study did not actively seek women who have had a recognized mental health problem, we were aware that I may nonetheless meet women who have had difficult experiences. Therefore, it was important that I was sensitive and responsive to participants' distress. I also shared an information sheet with help resources, wherever necessary.

4. **Maintaining confidentiality** Care was taken during writing up the findings so that the participants are not directly identifiable. Pseudonyms or codes for information that is identifiable in transcription, such as name or residence were used. Interview data was thus processed without names or other direct identifiable information. Information from the questionnaire was stored separately and securely and used only to describe the sample. The interviews were recorded on tape and transcribed which also helped as proxy to member checks and contribute to credibility of findings and the study in general (Shenton 2004).The recording was deleted afterwards. They were only temporary stored in the password protected external drive. It was only me and my supervisor, who had access to this.

Note: The information letter and consent form are attached as appendix 5.2 and 5.3, respectively.

## 2.3 Strengths and Limitations of the study

I have already described some methodological challenges above but before continuing it is useful to consider some other strengths and limitations of the study. First of all, the findings of a qualitative project are based on a small number of particular environments and individuals, which makes it challenging to extrapolate the findings to other situations and populations. However, some theories in the past have acknowledged that, in practice, even conventional generalisability is never possible as all observations are defined by the specific contexts in which they occur (Erlandson 1993). It thus becomes important to understand the results of a qualitative study within the context of the particular characteristics of the organisation or organisations and, perhaps, geographical area in which the fieldwork was carried out. (Shenton 2004). Therefore considering the study's findings in relation to those in similar populations can increase validity and transferability. For example all participants were well educated so the study's findings might not be applicable to women with less education and fewer resources. Other particular characteristics of selected participants such as being married, age group among others also need to be considered to increase validity and transferability.

Secondly, as discussed in procedure of data analysis earlier, we acknowledged the possibility that the work findings can be influenced by characteristics and preferences of researcher, instead of coming from experiences and ideas of participants (Shenton 2004). In addition to describing my personal characteristics and interests, intermittent discussion meetings with my supervisor helped to reduce the risk of researcher bias. I have also used rich citations from the participants throughout the findings which reflect that the study's findings are grounded in the data and helps increase transparency in the study. Moreover, inclusion of such citations directly from the participants' has helped to give these women a voice in the study.

Additionally, although there were some complications in taking the two groups of Indian women together in this study, this is simultaneously strength. The women now live in different societies of India and Norway, and in a different social, cultural, economic political context. Moreover, they come from different educational, family background and regions in India. However, they were all related through shared gender and experiences of belonging\having belonged to a society with traditional gender norms, collectivism[6] and emphasis on relatedness. Thus, we acknowledged that that the life situations and experiences of the two

---

[6] Collectivism refers to the philosophic, economic, or social outlook that emphasizes the interdependence amongst human beings. It is the basic cultural element for cohesion within social groups, which stresses on the priority of group goals over individual goals in contrast to individualism (Spielberger and Sarason 2013)

groups cannot be looked through a comparative lens, but parallel understanding of the two can help in enriching the reflections about mental health issues in lives of Indian women. Thus, taking the two groups of women together is a unique approach and has provided an opportunity to look at diversity of Indian society along with the common factors that attributed to their poor mental health, choice of coping strategies and attitudes towards professional help seeking, despite both of them living in different societal contexts now.

On a concluding note, this thesis has also helped me explore and reflect on opportunities for further research in the area of mental health of Indian women. This study raised important questions on the need for research on autonomy and mental health of Indian women. To the best of my knowledge, there is paucity of research in examining this important relationship. Moreover, further research can pave way for understanding different aspects of autonomy over financial matters, autonomy over decisions related to health care, autonomy over reproductive decisions and their relationship to mental health of Indian women. It was interesting to understand the commonality of preferred coping strategies such as confiding in with family and attitudes towards professional help seeking, despite them having different situational aspects and resources in India and Norway. This highlights the need for further examining the influence of culture and coping strategies. To find strategies for coping that mediates with cultural, individual and professional mental health care aspects can also improve the mental well-being of Indian women.

# 3. Findings and Discussion

**Participants' perception of their mental health**

Four of the local Indian participants reported having experienced depression or anxiety at some point in their life after marriage. Feelings of suffocation in life, loss of control, excessive crying, physical weakness and uncharacteristically aggressive reactions to little things were described by women. These participants described their constant attempts to hide the symptoms in ways such as not crying in front of their spouse and made deliberate efforts to socialize in hopes of reducing the impact on their well-being. Overall, four out of the six local Indian participants scored above the cut off 1.75, on the HSCL scale, indicating they were experiencing significant levels of distress around the time of the interview. None of the participants had sought professional mental health care during times of distress.

In the case of Indian immigrant participants, three reported having experienced depression, or anxiety. The participants discussed how they struggled in conducting their daily life's tasks, experienced excessive crying and sleeping, loss of appetite or comfort eating, aggressive behaviour and irritableness, impacting the overall quality of their life. While two other Indian immigrant participants also reported excessive stress and at some point, being close to depression, they attributed their resilience and deliberate efforts to having overcome their difficulties. Overall, two out of the five Indian immigrant participants had score above 1.75 on the HSCL scale, indicating significant level of stress. None of the participants had sought professional mental health care during times of distress.

Thus, in this context, it becomes imperative to understand the factors that attribute to the self-reported poor mental health of the women. During this study, I found that, one of the main factors attributing to their poor mental health appeared to be reduced autonomy experienced in their life after marriage. On further exploration, I also found that autonomy was multifaceted for different women and marriage did not necessarily reduce it for all women.  Thus, the participants experienced autonomy in different ways, both before and after marriage and it therefore had different impacts on their mental health.

Autonomy can be understood as the level of personal control a woman has over her life. It is interesting to note that despite the presence of patriarchal elements even in the domain of choice of marriage partner, marriage ceremonies among others. The interplay of marriage and autonomy can have different impacts; positive, negative or varying shades of both, on Indian

women and their subsequent mental well-being. Below I will address my first research question on the experience of autonomy and impact on mental health of the women.

## Research Questions

## 3.1 How do local and Indian immigrant women experience and negotiate autonomy, what factors influence their autonomy and how does it impact their mental health?

### 3.1.1 Autonomy, marriage and impact on mental health

Some local Indian participants questioned the basic levels of freedom upon marriage and felt that the whole idea of 'women moving out of their homes' and going to their 'husband's home', while 'leaving everything behind' takes away their freedom to make basic choices, This could induce emotional vulnerability, dependence, and reduce their autonomy over simple basic decisions of life and was specific only to women upon marriage.

> *"[The woman] Stays at home most days and then everything of her gets left behind and if she gets stuck at the wrong [home] then her problems increase. What is it for a guy, okay it's his home, he will live according to his ways, you can't say to him that he can't wear jeans, or can't wear t shirt. For him, rest of the things atleast go as per his wishes right? If you torture him even a little then he will start living estranged from you, only this will happen. But for a girl then everything has ended. She has left everything and then if she doesn't get anything after coming here, then what should she do?*
>
> *-Local Indian participant*

Apart from reduced emotional autonomy and autonomy over basic decisions, financial autonomy was also perceived to be compromised by some. One participant for instance, questioned the lack of legal rights of a woman on share of her husband's or husband's family property, as that becomes the real home for an Indian woman, instead of her father's transitory home. Literature also points out that ownership of assets is one of the major determinants of female autonomy (Debnath 2015). Financial autonomy was also compromised where women felt lack of control over their financial decisions. In one such instance, a local participant explained about a loan that she had to take up jointly with her husband without her consent. Her frustration over the decrease in her financial autonomy was further heightened by her husband's emotional indifference towards her. *"And now after marriage I am like..my whole salary part ..we are giving a loan which I was never..you know interested. And I was giving everything*

*what I can but still if I was feeling that..that person is not ..not responding"-Local Indian participant*

However, contrary to such excerpts and traditional notions of loss of autonomy after marriage, some participants reported feeling an increase in autonomy upon marriage. *"Here I have full freedom, atleast it's more than at my father's place, my father's place is like a village, so we have grown up in very strict environment. you won't believe the dresses that we were not allowed to wear"-Local Indian participant*

Autonomy is thus multifaceted. It is interesting to note that this findings is also gaining its corroboration in media, engraining the consciousness of the society., As Dhwani Desai noted in a *Times of India* article on October 8, 2015 that 'marriage is increasingly become as a form of escape from parent's well meaning, but misplaced protective, and sometimes suffocating, grasp'. This recent change strongly challenges the traditional notion of marriage as inducing restrictions and loss of autonomy.It was also interesting to note that in the case of Indian immigrant women, moving from a patriarchal society to a more gender equal and safer society for women, led to experiences of enhanced autonomy in their lives.

*"that was a big change for me, when I was in India, I used to get worried very often and obviously we have rules like you have to come [home] early and things like that, but here, first of all I am not a person who would stay out all night, but still many times I would work late at dark and I would just come back, I have never felt that insecure feeling"*

*-Indian immigrant participant*

However, although living in a more egalitarian society, some women attributed changes in autonomy to the marriage per se and not the move.

> *"But I think after marriage it changes and the amount of freedom I have here, I would have had the same [in Norway] , if we were in India . After marriage. The marriage would have changed it and not moving to a different country, definitely. Because then my dad is like, then your husband can decide it's like that. So we don't have minds of our own you know, either dad decides, or the brother decides or the husband decides*."

*-Indian immigrant participant*

The patriarchal nature of Indian society transfers the control of autonomy of the woman from her father to her husband after marriage. Thus, questions of a woman's identity and the boundaries built up for her as a daughter or a wife were raised by participants. Therefore, this may suggest that Indian women have difficulties navigating autonomy within marriage simply because they are a 'woman', regardless of their current environment. For some, the experience of living independently outside of India, which required greater self-reliance, lead to increase in self-confidence and self-esteem. Some participants also felt that they were less restricted to their traditional gender tasks that were allocated to and expected of them, in India.

While discussing autonomy, it becomes imperative to also talk about ' Relatedness' , the need for connecting with significant others, a concept often perceived in contrast to autonomy in collectivist societies. However, both autonomy and relatedness[7] have been found significant for personal growth, integrity and people's emotional and mental well-being in daily life (Reis et al. 2000). 'Factors in the person or situation that facilitate autonomy, and relatedness are thus expected to enhance well-being, whereas factors that detract from fulfilment of these needs should undermine well-being. The need for autonomy involves perceiving that one's activities are endorsed by or congruent with the self, and the need for relatedness pertains to feeling that one is close and connected to significant others' (Reis et al. 2000, 420).

Evidence points that the relatedness and concern of prioritizing others' needs before self translates into behaviors in the form of 'should' rather than 'want', with the sense of psychological well-being reduced in former. It is possible that for people in collectivist cultures, the duties and obligations become self-motivated wants and desires, which make them, derive pleasure from behaving dutifully (Janoff-Bulman and Leggatt 2002). Indeed though both local and Indian immigrant women desired their roles as a good daughter, wife and daughter-in–law, they, at the same time, struggled to manage the duality of their traditional and progressive roles.

In the presence of such ideal identities and duties, and the intersectionality of these, it is interesting to note how women navigate personal autonomy. Do the multiple social obligations imparted by collectivist cultures or self-internalized by women themselves, lead to conflicts and impact personal autonomy?

[7]Deci and Ryan also talk about the need for competence along with autonomy and relatedness, however for the purpose of our study, we have focused on the other two.

### 3.2.2 Autonomy, multiple identities of women and mental health

The gendered expectations of a role of an Indian woman are constructed along the lines of being an ideal daughter, an ideal wife and ideal daughter-in-law. Despite opening up its doors to western influences and the resulting changes in traditional beliefs, the internalised social and cultural norms are still prevalent in society. The intersectionality of women's diverse ideal roles makes it challenging to uphold autonomy and may result in poor mental health. It has been reported that conflicting responsibilities emerging from entrenched traditions are present even in Indian women living and working in Western countries (Rana 2013).

Duggal and Mehar note that this is the first paradox referring to the call for women to be productive employees while still retaining their traditional roles in the family (Duggal and Mehar 2011). They are expected to change their roles spontaneously when they are at work and when they are at home with their family members. In the current study, the struggle to manage work and/or household tasks and the subsequent burden and pressure was a common factor among most interviewees, influencing mental health.

> *"I manage…have to adjust...though I also hope that my husband helps me a little and understands everything. One should be helpful but he is not. [He] Doesn't help me, for example I am thinking of joining school again to start teaching, I am trying to make myself strong for that. I...have to make my children ready for school in the morning, then I also have to go to school and have to finish all housework before leaving"*
>
> *-Local Indian participant*

Owing to societal expectations, a conflict between progressive and traditional roles was also seen, as women found themselves torn between desire to become an ideal daughter-in-law as well as fulfil their career aspirations and obligations. One woman highlighted how she was able to overcome her internal conflict and multiple idealistic identities by challenging traditional gender roles and re-negotiating what it meant to be a good daughter–in-law.

> *"In my eyes a good daughter-in-law is not one who cooks for you at home, but I am of the belief that she feeds everyone with the food that they all like…in whichever way. That in total I feed you with nutritious food, it's not like I am in my own fun world or I don't care, that you are ill and I am not concerned. Whenever my family needs me then I am there but this doesn't mean that I stay engrossed in kitchen for the whole day according to you or I stay covered up in a saree..."-Local Indian Participant*

In contrast, others choose to stick with more traditional roles. Studies have found that immigrant women tend to renegotiate their roles and expectations to better suit their new circumstances and make sense of their new social identity (Graham and Thurston 2005). Such renegotiation of roles could also be from progressive to traditional roles. For example, the excerpt below is from an Indian immigrant woman who renegotiated her role as a homemaker after migration to better fit her life circumstances:

> *"To be frank I am …more of Indian kind of wife...because I don't want him to feel like I am something different, I have to make him feel homely, I love to prepare food for him and I need…I will have to serve him. He will not even put his food on his plate because I will have to serve food for him, because I need him to feel homely"*
>
> *-Indian immigrant participant*

It should also be noted that social changes are taking place in Indian society, reflected in the adoption of individualistic elements such as increasing nuclear family set ups and the multiplicity of roles along the traditionalist-progressiveness continuum. The question is how the balance between Individualistic and Collectivist identity is maintained or desired to be maintained by men and women and if gender roles get exacerbated when the living arrangement is collectivist, in other words, in a joint family where relatedness is emphasized and forms the basis of living together. Most of the participants reported living or having earlier lived in a joint family living arrangement[8].

It was felt that one's autonomy in one's own family is not what would determine the boundaries for a woman, but one's autonomy in her husband's family or husband's joint family. Research points out that husbands in nuclear families are more likely to help their wives in household familial responsibilities than husband in joint families. It has been found that because of family members' ideas about role of men conflict; they are likely to make men feel uncomfortable while helping their wife (Spielberger, C and Irwin G. 2013). Thus, Gender roles and gendered ideal behaviour could be more significant when the living arrangement is that of a joint household. This can create more struggle for autonomy of a woman while she struggles to uphold her multiple ideal identities in a joint household. This can create more conflict and confusion which impacts mental well-being.

[8] For the purpose of the study, joint family is defined as the living arrangement where husband, wife and parents in all reside together. Other members such as husband's brother or extended relatives could also be part of it.

### 3.2.3 Autonomy, Joint family, and mental health

An Indian immigrant participant recounted the difference in behaviour of her spouse and his reluctance to help around the house in the presence of family visiting from India and living jointly, which differed entirely while living in a nuclear arrangement in Norway. This made her confused about her husband's identity. *"when you and your spouse are here then you understand that we should work together, we should do everything together, but somehow the parents coming, brings back that feeling that, "no I am like superior and I should do less work" and stuff like that"-Indian immigrant participant*. The participant attributes this not to the personal desire of a man to dominate women but on Indian cultural set up which positions girls as subordinates and gender socialization in childhood where boys are not expected to work around the house. It was felt that that this 'hardwiring' of gender division of labour does not get completely dismantled after moving to a more gender egalitarian society, despite having mutual decision-making and equal division of responsibilities otherwise. A study on patriarchy and female subordination recognised family as a 'brewery' for patriarchal practices by socializing the young to accept gender differentiated roles (Kambarami M 2006, 2). Another Indian immigrant participant expressed confusion about her husband's identity and his ability to undermine her when around her husband's family[9]. Due to the restricted and gender unequal environment there, she was expected to behave submissively as a woman, which affected her well-being:

> *"In my husband's place, girls...they are the least positioned in the society. They…are not supposed to talk with their husbands, they are not supposed to talk...in public and...husband and wife can't go alone, can't go together outside. Of course we can go but… elders will look at us like...we are doing something illegal… He is a completely different person in Norway and he will be a completely different person when he is at home. He will just change...I can't just believe that this is the person I am living with, I need to question for myself because he will change just like that. Even if I ask something or even if I try to speak with him sometimes, he will just reject my voice. He is just disrespecting his wife in front of other people, how can a wife digest that? I just...hate that change in him"*
>
> *-Indian immigrant participant*

[9]A married Indian immigrant women may face multiple cultural contexts in her life, starting from her parents home to her husbands family and the cultural context of the country of migration.

Thus, joint family which symbolizes relatedness in society often exacerbated gender behaviour and roles, which in turn, created stress and impacted well-being. In another instance, an Indian immigrant participant recalled the influence of joint family on her mother's subsequent mental health problems:

> *"My mother had become a little bit quiet, ..it's that thing with women...you can call it Indian...that she stays a bit quiet and in fear…because…my mother has gone through a lot of injustice. My father was there, but my father was the middle son, he was the fourth one, he didn't voice his opinions and needs, whatever the elder brother said…only that will take place, so many times my mother wanted to do something but because of [the] joint family, she wasn't able to do those"*
>
> *-Indian immigrant participant*

The patriarchal social set up of the society and relatedness of collectivist culture which calls for positioning family needs above individuals' may withhold the woman from speaking up about her needs and desires, resulting in repressed feelings. Coupled with other subjective negative life experiences this can contribute to depression in the later stages of life. A study attributed the increasing incidence of mental health disorders in India (such as somatoform and dissociative disorders) to the passive and silent resentment experienced on account of inability to go against traditional collectivist norms by some family members (Chadda and Sinha 2013).

The above examples are evidence of the not only the strengthening of gender roles when living in a collectivist form of family but also highlight the emphasis on relatedness in a collectivist society. Thus, in the case of Indian society or collectivist cultures in general, a conflict can exist between relatedness verses autonomy. From a postcolonial perspective, when we weave other environmental and social strands, such as culture, into the discussion about autonomy and relatedness, we find evidence from literature that the implications for mental health vary across cultures. Studies have demonstrated that Indian family systems which are Collectivistic in nature value group solidarity and putting needs of others before oneself (Chadda and Sinha 2013) thus emphasize more on relatedness (rather than autonomy). Their relevance is also exemplified today and it has been found that strivings for autonomy conflict with the social values of maintaining bonds and group harmony in a collectivistic culture (Schwartz and Bardi, 2001; Singh, 2010). Thus, in collectivist cultures, autonomy and relat-

edness could be envisaged as being at two ends of spectrum; translating into women negotiating their autonomy consistently in their daily lives.

### 3.2.4 Autonomy verses relatedness, impact on mental health

In the following paragraphs I will further discuss the conflict and dilemma between autonomy and relatedness, subsequent negotiation and factors attributing to the participants' poor mental health. To illustrate this, I will firstly take the example of joint family living arrangements again and then to one traditional form of control (mother-in-law). These examples maintain the conflict between autonomy vs relatedness in the lives of Indian women and contributes to poor mental health.

Joint family acted as a support system in times of need by interviewees across the two groups, helping to share the burden of roles between women, such as child care. Previous research also corroborates the same, citing that such households may confer benefits on all the family members through household public goods with the patriarch exercising greater control over resources (Debnath 2015). In instances where the joint family resided together, it was felt that it acted as a support in child-rearing or the sharing of household tasks, and also fulfilled the need for relatedness. However, this set-up brought upon gender-based expectations for them, which the women felt unfairly curtailed, their basic autonomy within a joint living arrangement. One example was the extra burden and stress placed on the women due to their joint family's lack of ability to understand their professional work commitments.

> *"You are working, imagine you are doing a job, you come from work so after coming back you have to fulfil all responsibilities. You have to do cooking after coming back, you have to look after the house also, take care of the children, all those things are there, even if you don't have enough working hours to do it. You also have to do late hours at work, the male person with you, if he also comes back from work, it's the same thing, but he will come back, he will rest, everything will be made available for him, and an environment would be created such that -oh he has come back from work, he will rest now, he is tired, don't disturb, though the female member has also come back from work, but this thing is not supported anywhere, that's why this happens to the working women and for those who are housewife.. they say that it has become like an endless and thankless job in India, it is just not even considered"-Local Indian participant*

Therefore, on one hand, although the participants expressed the need and significance for relatedness contrasted it with their need for autonomy. The participants' autonomy in decision making within the household varied. Research cites that women residing in joint households are less likely to have decision-making power and they need permission more often from other household members to execute some routine household activities (Debnath 2015). In instances where joint family resided together, some women reported having mutual decision making in their households with other elder members such as father, mother-in-law or elder brother, who also took part in decision making. Others reported that their husbands made all decisions, although reported that their spouses consulted with them either before or after taking the decision.

Songuga-Barke and Mistry, found that in joint families, the power differences between men and women coupled with the power of in-laws can lead to the significant subordination of married women and which can attribute to mental health problems (Sonuga-Barke and Mistry 2000). However, the women in this study whose husband made the decisions expressed contentment with this arrangement as they believed that the decisions taken by their husbands would always be in the best interests of family.

Another such example of difference in power relations was presented by the women in the traditional form of control of mother-in-law. While describing the stress caused on herself because of her mother in law's perception about her professional job commitments and the perceived power imbalance between herself and her mother in law, a local participant noted:

> *"They were not satisfied with (my management of both household and professional work duties). While I do that, the in-laws think only that "what does she do after all at work?", Especially my mother-in-law thinks like that. Initially my mother-in-law used to bother me for some things but then I cleared it [with] her straightaway that this is not possible for me, and it's not acceptable that you would want to rule anyone"*
>
> *-Local Indian participant*

It was also interesting to explore if such traditional forms of control such as mother-in-law also existed for women who migrated out of India and no longer lived in a joint household with their mother-in-law. For some, geographical distances from home and migration to Norway also symbolized being free from social controls, whether it is related to day-to-day decisions, choice of clothes or even career:

*"Because in India, my husband did not do any injustice with me, to be frank. Means there is no reason to hide but my father-in-law, mother-in-law - they used to interfere in our each and every decision and like I said my mother, means my mother-in-law is heart patient so we were like…okay...we will do it like this so that she doesn't get hurt, thinking about her health issue. But after coming here, things are entirely different, because they are not able to interfere"*

*-Indian immigrant participant*

However, not all the immigrant women experienced being free from social controls upon migration and felt that the interference of traditionally accepted forms of control over self-decision making still existed.

*"I was supposed to do my Master's but I just dropped that because of family plans. My husband actually is the one who encouraged me to do my Master's. And now he is influenced by, his mother and he is the one who convinced me to drop my Master's again. This is also because of other responsibilities but I think there is no time limit to that responsibility, having a baby, at least in my case, because I am just 27 years old (..). Yeah… since elder peoples are looking forward to seeing a baby…we need to take this decision"*

*-Indian immigrant participant*

The above excerpt shows the loss of control over decisions was felt by the participant despite being geographically away from traditional forms of control. Thus, it reflects that entrapment can be within a physical environment but also within a set of values. Such entrapment in traditional values or in a physical environment has been found to attribute to mental health problems (Sen 2002).

This dilemma between the prescriptions of a collectivist patriarchal society about putting the needs of others before your own and favouring the greater good of the family and on the other end, focusing on the welfare of an individual, i.e. relatedness vis a vis autonomy, should be taken into account while understanding the well-being of an Indian women. Previous studies have corroborated that strivings for autonomy conflict with the social values of a collectivistic culture (Singh 2010).

In this section I have shown how both local and Indian immigrant participants found themselves negotiating their way between autonomy and relatedness in their daily lives. Though patriarchy remains as the root factor for this conflict, it is not this alone which influences or subjects women to compromised mental health. Rather, it is also the complex factors embedded in a collectivist culture that influences women's mental health. I have therefore attempted to understand the interplay of gender with multiple facets of a collectivist society and not to simply go by the assumption of Indian women being overburdened by patriarchal norms (although it is well-established that overlapping of collectivism and patriarchy impacts women more than men). The significant question for us now is to understand how women negotiate their autonomy, as they are not passive agents.

### 3.2.5 Coping with restricted autonomy or negotiating autonomy

Both sets of women, though being raised in diverse shades of patriarchal set up within India, now live in two entirely different social and cultural spectrums. On one hand, it was interesting to note the different meanings of autonomy that they acknowledged and the level of autonomy that they experienced. On the other hand, it was equally challenging to interpret the interpersonal evaluations of autonomy by the women. For instance, consider the statement below:

> *"I experience full freedom here…the only thing is that if I have to go anywhere, then it always has to be with the husband. I don't go anywhere alone, but with him only. I lived in joint family, and feel more freedom here than in the joint family. (I ) have my own time, whenever free, can manage my own time, go any time, come any time, but have to come and go with him only, not alone"*
>
> *-Local Indian participant*

The participant went on to explain that she did not know her way around or how to use the transport system to be able to commute independently and also emphasized getting permission from her spouse to travel alone. Thus, that this woman feels she has full freedom yet is not free to travel anywhere without her husband depicts the diverse ways in which women understand their autonomy. It may be argued that this woman re-negotiated the meaning of her autonomy, by forming a false mental health satisfaction and delineating her focus from the real autonomy that she actually has.

On the other hand, it could be that the freedom felt now is judged relative to her previous situation and therefore the participant did in fact, experience 'full freedom'. A woman may be

content in her life because of lower expectations that she has due to being a woman (Robeyns 2003) may mentally adapt herself to the situation and thus report overstated levels of autonomy. Research indicates that the patriarchal nature of society shapes and inculcates gender inequality in such subtle socialization ways that makes male domination and female subordination as given and unquestionable in society (Kambarami 2006).

Indeed, some women noted there were instances where women were given the opportunity to negotiate their autonomy but due to self-internalization of gender roles, coupled with idealistic identities and pressures of being a good wife or daughter-in-law they were unable to act on this opportunity. For instance, a participant expressed her frustration over another woman, who, when asked if she wanted to work upon marriage, said that decision would be left to her in-laws.: *A girl who (had a good professional position), her family's proposal for marriage had come..[They] asked her, "Would you like to work after marriage?"She says "if you allow [me] then I will work". I was like "stupid, you are [professional]! It's not a small thing..Are you a stupid girl?-Local Indian participant*

Thus, self-internalization of ideal roles by women itself hindered their negotiation of autonomy. Internalization of gender roles was also reflected in instances where women's employment was not perceived as adding significant monetary value to the household and was thus considered insignificant. A local Indian participant talked about the employment opportunities she had received but did not take up on her husband's insistence which also reflected self-internalization of her gender role as homemaker *"I tried a lot, infact I got offers from many places too, but my husband said that I should live my life and should not take worries for just Rs.6000-7000"-Local India participant.* The same participant described her husband's insistence to be strictly present at home upon his arrival to be able to spend quality time with his wife and child. Eventually, the particular participant decided to take home tuitions for neighbouring children and attempted to negotiate her autonomy in the context of her husband's lack of approval for taking less monetarily incentive job outside home and being always present at the house upon his arrival.

There were also some women were able to directly address issues of autonomy with their joint families. A local Indian participant, while reflecting back on her adjusting phase to a new house post-marriage, described how she managed the power imbalance felt between herself and her mother-in -law " *No, I had already informed..those people [in-laws] that I will be*

*going to office daily..and I mean..I don't like such a boundary-filled life..full freedom should be there, so they agree to such things and then only I got married" -Local Indian participant*

Thus, we see that autonomy was a major factor influencing mental health of both local and Indian women, in varying degrees. A postcolonial feminist stance reveals many factors that influenced autonomy for these women such as marriage, multiple identities of a woman, joint family , the conflict between autonomy and relatedness and simply being a woman. Though some Indian immigrant women felt more independent and self-reliant upon migration and felt less constrained by traditional social forms of control, but such controls were not completely dismantled for all. Some Indian immigrant women continued experiencing restricted autonomy, which subsequently impacted their mental well-being. Therefore, though these two sets of women are now living in different forms of society and geographically distanced from social traditional forms of control, they are tied together with the common bonds of being 'simply a woman' and belonging to a collectivist, patriarchal society with emphasis on relatedness. Hence, they commonly experienced restricted autonomy and mental well-being in differed degrees. This poses a pertinent question on the significance of autonomy and its impact on mental health for local women living in India and immigrant Indian women living in a gender equal society like Norway. It also brings into light the subtle but significant factors influencing autonomy of Indian women and its impact on their mental health, despite evidences of Indian society progressing forward on all economic, political and social fronts.
Now we will discuss some other factors that were found to attribute to poor mental health of India n women in this study and address my second research question.

## 3.2 What are the other factors attributing to poor mental health of Indian women?

### 3.2.1 Interplay of employment and mental health

Research points that a significant relationship exists between employment and mental health. Studies point out that among both men and women, those who were employed are less likely to have poor mental health(Artazcoz et al. 2004). In the case of a local Indian participant, it was found that gaining employment was not only a means to achieving a distinct identity other than being a housewife and adding a purpose to life but also to developing a supportive social circle of people she could rely on. A study showed that working outside home extended social networks of women and helped them learn to cope with problems and frustration (Valk et al. 2011).

On the other hand, another local Indian participant described how managing her job placed strain on her relationship with her husband as they had to live in distant locations: *"Some tension always remains, like I told you that since last one to two months I have been feeling that a huge gap is taking place between me and my husband, we are not able to stay together, not able to manage things, I have to stay alone"-Indian immigrant participant.* A Study on Indian women showed that though women expressed their willingness to make compromises in their personal lives, they felt strained in trying to maintain a work-family balance (Valk et al. 2011)

For Indian immigrants, obtaining employment was associated with stress. Language differences can be a significant barrier in gaining meaningful employment and social integration in the new country. Previous studies note that because skills and qualifications from the country of origin are not recognized, isolation and underemployment can contribute to poor mental and physical health of recent immigrants (Graham and Thurston 2005). Most Indian immigrant participants either reported being underemployed or unemployed. An Indian immigrant participant who decided to take up a part-time lower skilled job despite her husband's lack of approval talked about the significance of a job to make her meaningfully occupied. *"It's my own decision, infact my husband doesn't want me to work in a part time job...[..] he doesn't want me to work hard in physical way to earn money. My view is not about earning money. I need to spend time, and meanwhile it's a good thing that I earn some money*". Studies on immigrant women have noted the common issue of underemployment. While prior to migration immigrant women often held professional jobs such as accountants, engineers among others, their post migrations jobs were described by them as 'survival jobs'. Such survival jobs were viewed as a coping mechanism in a new country to keep one from feeling isolated and minimally financially supported temporarily (Graham and Thurston 2005).

Indian immigrant participants who were involuntarily unemployed and neither had part-time survival jobs, felt lack of employment contributed to their poor mental health, as they struggled to renegotiate their role as a homemaker upon migration: It has been found that individual skills, dispositions and attributes such as language can confer the ability to participate in particular organizational or societal contexts. Freedom has been found to depend on the options a person has in deciding what kind of life to lead and the opportunities to integrate, and thus studies have shown that the potential benefits to human capital may be undermined by language barriers (Fanning 2011,8). Below is an excerpt from an interviewee which highlights the impact of barrier to integration on the freedom and opportunity to live a professionally

content life *"I used to remember them a lot, crying on skype every time, what should I do now? Here a language barrier was also there, it's not like that you search for job and you just get it, you have to be very fluent in Norwegian"-Indian immigrant participant*

Some other factors attributing to poor mental health specifically for Indian immigrant women were the following:

### 3.2.2 Conflict between acculturation and passing traditional values among children

Research on immigrant parents found that parents face conflicts in childbearing leading to struggle while striving to strike a balance between two different cultures (Ganapathy and Hemalatha 2013). While doing so, they try to maintain a balance between enculturation (i.e. continuing the norms and values of the ethnic culture) and acculturation (i.e. adapting the norms and the values of the dominant culture) (Londhe 2015).

In traditional collectivist societies, traditional cultural values are deemed important to be upheld and the inability to pass on such values to the next generation, especially to girls, can cause shame and guilt in the society. This situation can therefore be perceived as a trade-off between acculturation with the local society and a continuance of traditional values.

Traditional Indian beliefs about child-rearing and relationships were constantly mentioned in contrast with 'how things work in Norway', indicating the stark cultural differences between the two societies felt by some participants. Expectations regarding 'ideal child upbringing' from family back home also added to the pressure in maintaining balance between enculturation and acculturation.

> *"Initially it was like culturally. ..like I told you before [about public displays of affection in Norway], that issue was the biggest for me and I had also heard it a lot. Family members are like that only. ..that it is a very big tension, she is a child, a daughter on top of that, there are responsibilities of having a girl child. So I was feeling a lot that...if she sees things like that, then she will also become like them. That's why I was feeling like that"*
>
> *-Indian immigrant participant*

Thus, while families and individuals make adjustments to a new life in the host country, they also perceive a loss of cultural values, practices and identifications (Schwartz, 2010)

In the present study, it was clear that the gender of the child also plays a role in their parents' enhanced stress over acculturation. This is consistent with past research, which has indicated that, in South Asian immigrant families, sons and daughters were both subject to continuance of family's honour but the responsibility was much higher on on the daughters (Gilbert et al. 2004).

It was also found that a constant procrastination over the decision to migrate back to India exists in the lives of the women, emerging from the feeling of guilt over not being able to provide a similar childhood to the offspring in Norway. Such feelings of shame and guilt as highlighted from excerpt below have been associated with mental health issues (Clark 2012) This can be extremely distressing and debilitating eroding the capability to live a healthy mental life over the period of time *"By looking at my daughter, I realized that she is alone, I should go back there (India), everyone of her [relatives]grandfather, grandmother, she is very attached to them, so maybe if she stays there, it's better for her"-Indian immigrant participant*

### 3.2.3 Stress and guilt about inability to take care of parents in old age

Some Indian immigrant participants also reported feeling stressed because of an inability to take care of parents in their old age. However, this responsibility was considered greater for sons.

> "*Because my mother is alone, I don't have dad he has expired, my mother is alone so sometimes I get tensed, now she is old...[in relation to her in-laws] [my] husband has his sister there, so his parents visit them in US also. But he is only child, he is a son so that responsibility comes, that he has to see his parents in any circumstance"*
>
> *-Indian immigrant participant*

While studies have documented the guilt immigrants experience due to their inability to care directly for their aging parents (Baldassar 2015), it has been found that migrants are still able to maintain close family ties and provide their parents with significant emotional support (Kalavar et al 2015).

### 3.2.4 Adjustment issues

A major issue upon migration felt by Indian immigrant participants was social isolation. Studies point out that post-migration challenges are exacerbated by stressful experiences of social isolation (Fung and Dennis 2010) Studies have shown that social isolation and exclusion contributes to mental health problems among diverse immigrant groups (Ahmed et al. 2008)

Even though some participants attributed their outgoing and friendly personality traits in developing friend circle in Norway, it was not the case for all women. One participated noted her inability to form a similar social network in Norway as she had in India. This led to greater perceived dependence on spouse, and subsequent emotional vulnerability:

> *"Since past one and half year, I lived like just a wife...that's it. Because I didn't know any people outside apart from few friends of my husband…I need him (husband) every time, but he is a person like...you have your own life, you are here, apart from married life, you have your own life. Try to make it. But I need a way to make my own life... I would have appreciate him in India, because I will be having more choices in India because I would be having my own friends in India, but here I am lacking of friends"*
>
> *-Indian immigrant participant*

A study on Indian immigrants in the U.S showed that the loss of similar social network upon migration made immigrant Indian couples depend much more on each other for companionship and emotional intimacy than they would have in India (Hondagneu-Sotelo 2003). However, in this study I found that this mutual dependence could be absent in cases where one of the spouses (husband) had the advantage of being a first mover in migrating to Norway and had already established a professional and social life here before the arrival of his wife. This could have made the Indian immigrant participant depend much more on her husband than her husband would on her, in the same way.

On a summarising note, apart from the interplay of autonomy and marriage, other factors that attributed to poor mental health of local and Indian immigrant participants emerged from the issues of employment, underemployment, unemployment and mental health. Specific post migration stress factors such as the stress of passing traditional values among children, struggle to take are of parents in old age among others adjustment issues existed in the lives of India immigrant participants. This highlights the diverse nature of social, economic, cultural and other environmental factors and their role in contributing to poor mental health of Indian women. Now I will address third research question on coping strategies.

## 3.3 What coping strategies do women use and why?

More than 30 years ago, coping was defined as the cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts among them.(Lazarus and Folkman 1984). Furthermore, a noteworthy model on stress and coping has shown that

individuals often use a variety of coping strategies in response to a stressful situation as coping strategies can and do interact with one another and the choice of coping strategies is dependent upon individual and situational aspects including ones resources (Lazarus and Folkman 1984). In this study, many coping strategies were discussed and/or adopted by participants. It should be noted that no concrete inferences can be made about the effectiveness of coping strategies in terms of ability to resolve problems or reduce and alleviate stress (Carver and Connor-Smith 2010). Still, the discussion on coping strategies is extremely relevant as Lazarus and Folkman's model on stress and coping has shown that, stress alone could not cause a stress related disorder such as depression. Other factors such as an ineffective coping strategy, would need to be present for stress to lead to depression (Lazarus and Folkman 1984). Moreover, the discussion of coping strategies was important as studies have shown that coping strategies can play a significant role in influencing professional help seeking and can also influence the time at which a person decides to seek professional help and the extent to which such help is sought (Hussain 2003). Thus, it becomes important to examine the different coping strategies adopted by the participants.

It should be noted that beliefs about mental health, including stigma prevalent in society may influence the response and ways of coping of an individual to a mental health problem (Ward et al 2009). For this reason, it is first important to understand generally held beliefs and perceptions about mental health problems in order to understand how these perceptions might influence the choice of coping methods

**Participants' Perception of mental health problems**

Most local participants talked mostly about softer forms of mental health problems that could often be overcome with the help of social support and, through sharing one's problems. They perceived that depression was a result of internal bothersome issues, coupled with not confiding in anybody. It was perceived that if such internal issues are shared, depression can be alleviated or avoided. With the help of supportive surroundings such as people (particularly one's spouse) to confide in, the women believed it would be possible to overcome the need for professional health care. Thus, depression was sometimes equated with sadness, a temporary state rather than an enduring health issue.

Nonetheless, the women felt that the awareness of mental health problems such as depression had increased awareness in society in recent years. Some participants attributed this to higher number of people experiencing stress on account of their surroundings and lifestyle. Mental

health problems were perceived as inevitable because of human tendency to get stressed and impossibility to stay positive all the time. Resultantly, the key to positive mental health was perceived lie to within the individual's control, their level of resilience and ability to cope.

Similar perceptions were echoed by Indian immigrant participants as most of them talked about how a supportive environment at home and the 'right person' to confide in could delineate stress and prevent mental health problems. Most of them have emphasized on having an affectionate and supportive relationship with spouse as one of the prime needs to stay mentally healthy. It was believed that the absence of such people in your life can lead a person to depression.

**Society's Perception of mental health problems**

Most of the local Indian interviewees believed that society would react negatively towards a person with depression or other mental health problem. Some believed that people may be sceptical to sudden behaviour change and may try to distance themselves from the person. Although the women believed that most people would initially be sympathetic, enduring symptoms of poor mental health would later be understood as sickness. It would be at this point, the individual would be stigmatised.

Some participants also felt that social withdrawal can be seen as signs of personal trouble/stress, arrogance or inability to handle problems in life. The latter, perceived as a weakness could result in ridicule by kinship network, neighbours and society. This may be because of the nature of Indian society, where despite changes in living arrangements becoming nuclear, often clusters of relatives live as neighbours and strong networks of beneficial kinship ties exists with other community members. In this context of persistent social communication, social withdrawal is viewed in conflict with normal behaviour in the society (Organization of Social Life in India,n.d.)Yet, depression or other mental health problem, following a particular event such as death of family member, would be warranted as having a 'genuine' cause and thus, less stigmatised.

Although most Indian immigrant participants felt that people nearby would be supportive if the loneliness within someone is recognizable, one particular interviewee, who had observed her mother's severe depression in India, felt that people (even extended family members) were unable to understand or empathize. She explained that some people perceived her mother's depression as madness, something superstitious ('badha pad jana') or false illness (not really

there). Lack of awareness and understanding of depression resulted in people being unable to empathize with the depressed individual and a belief that it did not exist.

> *"Like it (depression) was happening to my mother.. I tried a lot to explain to my mother in law that this is the problem, but she didn't even notice.(she said) "This doesn't even exist, what is this, I don't think that something like this is there, so severe? So much can happen?" I said "no she(mother) is depressed". So she wasn't ready to believe (my mother's condition). May be that kind of attitude is there in a lot of people, that they don't believe it initially."*
>
> *-Indian immigrant participant*

Low awareness also constrained coping which we will discuss later in this section. To summarise, we see that most of the participants reflected on the need for a supportive environment at home to achieve a good mental health, which also translates into reliance on family for coping as we shall discuss below. The reliance on family for coping was further strengthened by their expectation of a possible negative or unempathetic response from society, given recognizable symptoms. Isolating oneself contrasted with the norms of collectivist society and was stigmatised.

Now we have an understanding of the women's perceptions of the mental health problems and expectations about society's response, let's discuss the coping strategies the participants adopted or considered important.

### 3.3.1 Family members

For most of the women, family members aided coping in varying ways and degrees; ranging from sharing to seeking advice and to offering practical help in day-to-day tasks. Confiding in a family member, such as a parent, was described as one of the coping mechanism by most of the participants, reinstating their sense of security and belongingness, even in cases where advice was not particularly sought.

> *"yeah…and that way I must say that you know my parents have been very encouraging, not that I come from a very rich background, but my dad is like, he is always being supportive of me. He is like "okay if you want to quit your job, it's okay, you can always come back to us. It's like it's not an issue to feed you, every month", so that kind of.. I think that is what kept me going. Though I was feeling so low"-Indian immigrant participant*

However, sharing with family was also constricted. The women confided in selected family members, with selected thoughts and feelings; those which were perceived less stressful for parents to know.

> *"I tend to share with [my mother] but not if I am angry. And so mothers, as usual they are like, "no child, it happens like that" you know, trying to patch up "no it's fine, that's what marriage is, Quote – A vehicle doesn't work with one tyre". And you know the standard dialogues that they have. So she says that but if something is very serious, then I don't tell her"*
>
> *-Indian immigrant participant*

In other instances, the women avoided reaching out to their parents due to worries of burdening them with their stress. *"Because we don't want to give them tension. They have enough worries of their own. If we share our [problems]...they got us married, now by passing worries from here to them, their tension increases"-Local Indian participant*

Thus though their preferred choice of coping was family, the collectivist nature of society which though emphasizes interdependence but also putting up family's welfare before one's own indifference hindered confiding in with family. This inability to share with parents coupled with instances where there was participants' husband's indifference to listening, aggravated feelings of hopelessness among participants as they were unable to confide in with anyone.

In the case of Indian immigrant women, sharing with family members back home, or consistent communication about daily life acted as a coping mechanism. Social support networks are not necessarily tied to a geographic location such as a neighbourhood (Berkman et al. 2000). Apart from sharing, support from family members in other ways also acted as coping mechanism. For example, some interviewees reported that their spouses worked from home in order to spend more time with them while they were going through tough times. Suggestions from family to spend time with them in India, to go on a holiday, to find alternate activities to keep occupied helped to alleviate loneliness during difficult times. Practical help in household tasks along with moral support from family members during stressful times also helped some.

> *"My father-in-law is very helpful, when I share it with him so he said that try, if it can't happen then come here, stay with us, stay with your mother a bit..uhh have a change or go for a holiday. Even he helped me a lot. Even at my mother's side they*

*were like, tell him to take you on a holiday, do this, do that, try online, take online courses, so I received help from both ways, so I never felt like I was alone"*

*-Indian immigrant participant*

### 3.3.2 Social network, friends

The social network consisted of both strong and weak ties, but often without an emotional relationship. It was used as a way to keep busy, or a distraction from stressful times, rather than sharing their intimate stress causes.

In the case of Indian immigrant women, social networking was helpful for obtaining employment. Social networks also offered some practical help such as bringing food or giving rides in times of need. It was also felt that sharing immigrant-related problems (though not personal in nature) was much easier with other immigrant friends living in Norway, due to sharing similar experiences.

However, in instances where advice on personal matters was sought, the experience was described as disappointing, resulting in feelings of regret

*"I was so eagerly waiting to share my feelings...and once I ...said everything to them, I didn't get any response, I didn't get any guidance or support or something like that...but they just hear for the sake of hearing. But after sharing all my feelings with them, I felt like probably I said too much"*

*-Indian immigrant participant*

### 3.3.3 Resilience and Adaptability

Both Local and Indian immigrant participants displayed resilience and reported taking active problem-focused measures to improve their mental health. For example, a local Indian participant talked about her willpower to cope with her multiple roles of being a homemaker and child carer while simultaneously preparing to be an employed professional, despite the lack of her husband's practical support.

Indian immigrant participants who either reported being underemployed or involuntarily unemployed, talked about taking active problem-focused steps. They adapted their expectations and displayed willingness to go down the skill ladder, acquire new skills and qualifications or change careers to fit the job market needs. This enabled a meaning other than being 'simply a housewife' in their lives and increased feelings of self-dependency and self-worth. *"I think*

*that's the mentality, my mentality so I have been brought up like, you know you can fend for yourself, you don't have to depend on people"-Indian immigrant participant*

### 3.3.4 Other coping strategies

On question of other coping strategies, most local and Indian immigrant participants mentioned crying as a coping method. In another study too on Asian women it was found that the women would cry to release the pressure of anxiety/stress and perceived crying as a coping mechanism (Hussain and Cochrane 2003). However it should be noted that crying could also be a sign or symptom of a compromised health status or that suppression of crying could be a risk factor for the development of health problems. This has been found to depend on intra and inter/individual differences (Vingerhoets 2007).

### 3.3.5 Religious and Spiritual beliefs/practices

Participants reported engaging in various religious and spiritual beliefs and practices to help them cope. For instance, many participants visited pundits[10] to seek solutions to their life problems. This included showing Janmkundli (The Horoscope[11] ) to pundits (Temple Priests) to know about the future course of their life or getting a prayer done (offerings) to get rid of such problems. Many participants also reported their belief in fatalism and how 'things happened as per will of god'; ideas that also resonate with theory of karma in Hinduism. Studies have shown that Indians beliefs in spiritual origins of mental illness such as belief in Karma, makes them often turn to spiritual or religious rituals as a means of treatment (Mukalel and Jacobs 2005) Research suggests that these are two different aspects of religiosity, religious beliefs, such as placing trust in God or seeking comfort in religion and religious behaviour including visiting traditional/alternative healers (Woods et al. 1999).

To understand religion as a coping method, we will discuss the relationship between religion (or religious beliefs and practices) and mental health. It is debatable if religion (or ideas and beliefs related to religion) has a positive or negative impact on mental health. Pilgrim and colleagues discuss two competing hypotheses. The first hypothesis discusses the positive impact of religious or spiritual ideas on mental health. The first hypothesis says that religious involvement is related to better psychological adjustment or mental health as it may provide a

10 Priests worship at the temple and may also have knowledge of astrology and read kundlis, horoscopes. They are often referred to as Pundits, implying someone who is learned

11 Horoscope or Birth-chart (also known as Janam Kundali) is a map of the heavenly bodies, which shows the positions of the planets at the time of birth, It is based on the belief planets and their positions at the time of an birth effects how the events in life go on

sense of meaning and a supportive community network and that it may provide ways to still anxieties by the recourse of reassuring practices, beliefs or facilities (Pilgrim et al 2011).*"yeah I tried one or twice to show my janmkundli to the pundit, but neither my husband believe in it nor I. ..when I feel that I am troubled a lot, then I go for such things, like going to the pundit, finding out how the days are going, how stars are positioned. Keeping a fast*[12]*(vrat) .. I also do that"-Local Indian participant.* On question of the kind of help a pundit can provide, the particular participant reported as follows:

> *"the help that he provided was such that...a person becomes alert about the coming situation. And it got proved to a great extent that when we went to the pundit, the pundit said that (my husband) will get hurt in the leg and he met with a bike accident. Then we felt a little that yes the pundit's words were true so we thought that the pundit said the right thing"*
>
> *-Local Indian participant*

The foretelling of possible happening of a bad incident provided comfort to the participant in that an explanation was immediately available, lessening the impact of the shock and worry. This reinstated the faith in pundit, which simultaneously reinstated faith in the solutions he provided to her problems. It also relates to the belief in fatalism as the participant felt that her husband's accident was bound to happen and that nothing could have prevented that. This belief in fate and the resulting belief that the situations and problems are predetermined (fatalism) can lead to religious action and practices (Pilgrim et al 2011). Thus in the event of bad situations in life, fatalism was used to cope.

Now I will discuss the second hypothesis given by Pilgrim and colleagues which discusses the possible negative impact of religious or spirituals beliefs and practices on mental health. The second hypothesis is that a high degree of religiosity is associated with increased mental health problems. The belief that God exercises control over the life of an individual can discourage self-directedness and self-acceptance (Piligrim et al. 2011).

> *"I believe in destiny yes, so whatever has to happen will happen I think and whatever god does is for the best... I have a belief that we have very limited free will, meaning god has written down everything that is going to happen in your life and you are mere-*

12 Vrat is fasting on a particular day in the worship of particular Diety

*ly doing it, just acting it. In Hindi we say that not even a leaf moves without the will of God, which I think is true"*

*-Indian immigrant participant*

Moreover the concept of life's circumstances been determined by past actions (as in some other religions and also in theory of karma) may cultivate feelings of guilt and self-doubt. (Piligrim et al. 2011). Thus, belief in such situations may lead to understanding of feeling of loss of control over one's life and capability to enjoy a mentally healthy life. Below is an excerpt by an Indian immigrant participant on her belief in fatalism.*"In my life, if I try to get something from my hard work, I will never get that ..because I am not...refusing people who believe in hard work but ...fate works lot for me"-Indian immigrant participant*. In further conversation, another participant also told of how her mother had went to the Pundit for removing dosha (all possible problems in important vocations of life such as marriage and birth of child). The act of conducting such practices by family and surrounding society, reinforces the belief in loss of control over one's own life, and has the possibility of weakening willpower and the strength required to overcome challenging circumstances.

The above examples highlight the risk that religious/fatalism coping could carry by driving more belief in destiny than self/directedness and exaggerating feelings of loss of autonomy over one's life. Belief in fatalism could thus be the only way of coping for women who already feel loss of autonomy over their own life.

It is also possible that participants' belief in destiny or religious coping versus self-directedness is situational dependent. For example, in situations beyond control, coping mechanisms such as belief in fatalism could be a positive influence. A local India participant noted that though she does not strictly believe in religious practices for coping, desperate circumstances make her lead to it as a last resort. In contrast to the two possible relationships between religion and mental health, theories suggest that there is one also possible pathway known as the collaborative style, that has been linked to better pshychological adjustment (Zinnbauer et al. 1997). In a collaborative style, an individual simultaneously basis his or her beliefs in religion or fatalism along with self-directedness, to cope with stresses in life. This was exemplified by one Indian immigrant participant who though did not relate such practices strictly to religion but believed that they could act as external aids which help in building motivation and creative positive feelings. She simultaneously felt that the meaning of such practices has been misunderstood by many as being superstitious

Spirituality, such as mindfulness or practicing vedic chanting was also used as a coping mechanism. It was believed this could keep the mind composed and calm. It is debatable if spirituality is related to religion. Participants who reported practicing spirituality spoke of this as different from religiosity. It should be noted that the common aspects of spirituality are meaning and purpose in life, connections with others, peacefulness, existential well-being and comfort and joy (Koenig 2009).

To summarise, multiple coping strategies were adopted by both local and Indian immigrant women based on their individual, situation and resource based aspects. However, the study also found some factors that hindered coping for local and Indian immigrant participants, discussed further.

**Constraints on coping**

During the discussion on coping, I have briefly referred to some instances where the women felt unable to employ particular coping strategies to their full potential. These appeared to relate to issues of autonomy, gender roles and societal expectations. It is interesting to explore further the instances where women were restricted in their coping strategies. Research suggests that gender specific coping styles may be explained partly by gender differences in the expression of distress but can also symbolize gender roles and accepted behaviour (Goldberg and Huxley 2003)

> *"For women, it is basically that you have to find something within the house's environment for example spending time kids, or with husband or family, people with whom you have good relationship, there are less options for a female to go out because she has to fulfil family responsibilities also during that period. It's not like that you have problem from depression so you get free from such responsibilities*
>
> *-Local Indian participant*

This becomes more significant when thinking about Indian society in particular. Local Indian women for instance, reported feeling hindered in sharing personal information within their social network. They reflected that it was important to uphold the idea of a successful marriage for fear of shame and talked about how this inability to share in Indian society was due to maintaining a façade and being better off in front of others

> *"it's like she won't tell (in reality) to anyone, because ... that...fake show happens a lot in the society here, they must feel that "my sasural (husband's home) is very good.*

*I got married in a big house". So half of them are not even able to share their problem when they go home or with their friends. Because they will feel insulted from inside that "see I got a good (home)", though everyone is troubled from inside. This is the reality here, everyone is troubled"*

*- Local Indian participant*

This participant believed that people maintain a façade in society and are ashamed to admit if things are going wrong in their life, if their husband does certain things. They therefore hide their problems. This notion of bringing shame to oneself and others has been described as 'Reflected shame'(Gilbert, Gilbert, and Sanghera 2004). Though all women felt that sharing is a good, or in some cases the best coping mechanism, some were inhibited during times of need *No I didn't share with anyone… That time I did not find any such friend with whom I could share*"-*Local Indian participant.*

Thus, it was found that some women are unable to share with friends for fear of reflected shame and believe that problems should be solved in within families. At the same time, some of the women experience frustration over their restricted autonomy and societal gender roles. Holding the family's honour makes it difficult to speak out about difficult marriages or situations. Despite changing times, the continuity of marriage is still deemed traditionally significant in Indian society, more so for women. Thus, traditional gendered behaviour of coping, such as staying calm and composed and the views on continuity of marriage were put forward by family members, leading to feelings of frustration over the traditional set up. In times of stress related to marital problems, it was also observed that Indian social set up, which accorded utmost significance to continuity of marriage, involved comprising and adjusting beliefs and attitudes in participants, facilitating coping during such times:

"*my parents tried telling me "no no you should stay calm". There is this feeling, right, girls should always be calm and composed so..."things will be fine in a few years"… I couldn't accept such things because they are talking [from an external perspective] If you were there, if you are seeing what is happening day to day and even though they knew sometimes , they would just say this because I had to continue life along( with the marriage) so I was not convinced by it, not that I was against them, but I was not very convinced about this whole idea and the set up"*

*-Indian immigrant participant*

Such women may be left in powerless and hopeless situations. Unable to change the situation, the have to change their thought processes about it. As such some women engaged in cognitive strategies that readjusted their expectations. *“But here in India like at least you know the setup is such that you will learn to adjust and compromise in life”-Indian immigrant participant.*

On a concluding note, this study found many coping strategies that were adopted by the women ranging from confiding in with family, to limited or no sharing with family members, social networking, crying along with display of resilience and adaptability. Religious beliefs and practices along with belief in fatalism were also used as a coping strategy in some instances. The use of some of the coping strategies were in turn constrained by the expected norms of ideal gender behave , fear of reflected shame which were often managed by applying cognitive strategies of readjusting expectations.. It should also be noted that as discussed earlier, no concrete inferences can be made about the effectiveness of coping strategies in terms of ability to resolve problems or reduce and alleviate stress among the participants (Carver & Connor-Smith, 2010). It can be inferred however that women were found to use more emotion-focused coping such as sharing and seeking validation of feelings. This also corroborates with studies that show women use more emotion focused strategies to cope with mental health problems (Matud, 2004).

## 3.4 How do women perceive professional help seeking?

Estimates indicate that a significant "treatment gap" exists in India; as 80 per cent of the 20 million individuals with mental health problems fall outside the umbrella of mental health care and treatment (Nagaraja and Murthy 2008). Previous studies indicate that both demand-side factors, such as lack of knowledge or negative public attitudes towards professional help-seeking and supply-side factors, such as the scarcity and uneven distribution of mental health resources in the community, lead to this treatment gap. In addition to this, as previously noted, immigrants in Norway are less likely to consult with a GP for mental health problems compared to Norwegians (Straiton et al. 2014). Pakistani South Asian women in particular were less likely to have attended a doctor for a mental health problem than a Norwegian woman. Further, among the Pakistani women who have, they are less likely to use psychotropic medicine or receive conversational therapy from a doctor (Straiton et al. 2015). Thus this suggests different cultural and linguistic barriers to health care and management of problems, highlighting the significance of differences in understandings of, and appropriate treatment for, mental health. Other studies also point out that attitudes toward mental health help-seeking

may play an important role because positive help-seeking attitudes are positively associated with intentions to seek mental health care (Seyfi et al. 2013).Further, understanding attitudes towards, and barriers for, help-seeking can help to identify where intervention strategies to improve access to care should lie. Thus, here I address my third research question on how the women perceive professional help-seeking.

There were significant variations amongst the participants about the acceptability of seeking health care; from participants who reported they would only seek professional health care as a last resort, to those who could use it as complimentary to family support care and lastly those who would prefer it as the first choice of method. No participant indicated absolute resistance towards seeking professional mental health care.

In order to better gain understanding of their attitudes, it is important to bear in mind the participants' perceptions about mental health problems as I outlined in the coping section. Research points that there are associations between conceptions of mental distress and the attitudes that people have towards help seeking for their mental health problems(Hall and Tucker 1985).

It is important to note that participants who reported having experienced depression or anxiety or seen a close family member going through the same, had more awareness, understanding and thus, more open attitudes towards professional help seeking. This was in contrast with participants who perceived depression as temporary states of sadness that pass quickly by sharing problems. Those who had better knowledge of depression saw that it is much more debilitating and enduring than everyday stresses or fluctuations in mood and recognised that professional intervention was sometimes necessary. This highlights the significance of health literacy in influencing attitudes towards professional mental health care. Higher mental health knowledge has been found to be associated with increased likelihood to seek help, (Yu et al. 2015). Studies have also shown that higher health literacy can help an individual to obtain health information and use health care services which in turn could lead to fewer depressive symptoms and healthier lifestyle (Omariba and Ng 2011).

Now let us look at the common perceptions and attitudes of the two sets of participants on professional help-seeking reflected in different facets such as costs, processes and stigma among others.

### 3.4.1Access to care

Firstly, there was a question of accessing care. Although some immigrant participants felt confident about how to access care in Norway and felt that if they sought help, they would receive it, this was not the case for all though. One participant expressed a lack of awareness about the process, location and cost of such services: *"I didn't knew about the process of that..probably I thought it's quite expensive here, so I didn't knew the process and…yeah..*"
-*Indian immigrant participant*. Studies report that not knowing about available health services, and how to access these services were major barriers for immigrant women to seek help in Canada (Reis et al. 2000). Learning to navigate the health service in a new country can be a major challenge for immigrants, especially those who come from countries with very different health systems. It should be noted this particular participant had lived in Norway for a shorter duration than the other Indian immigrant participants who felt confident about navigating their way through health system in Norway. Studies point that it is likely that over time immigrants may become more familiar with how to navigate the health care system and this could subsequently result in greater accessibility(Asanin and Wilson 2008). It is also important to note that Information about services in Norway is usually only available in Norwegian or (to some extent) English. Given the loss of energy and reduced concentration capacities associated with mental health problems such as depression, the challenge of understanding how and where to access services in another language is heightened further. Indeed this participant also indicated disinterest and lack of enthusiasm to look up information on mental health help sources.

In the case of local Indian participants too, the question of barriers to care was present which not only came from lack of knowledge of where to go for professional mental health care but was coupled with stigma, which I will also discuss later in detail. A local Indian participant described her friend's experience as below. *"She said that her husband doesn't want her to go and take their daughter, but she asked me if I could find out a doctor, so I found one through the internet and informed her that this where you can take your daughter, so she took her there and said that it helped her a lot" -Local Indian participant*

### 3.4.2 Health professionals as detached and lacking empathy

There were also opinions that poor mental health required moral support which is, and can very well be, given by family members. Health care practitioners were mainly viewed as professionals doing their job, unaware of the context of the person's life and may not have as much empathy for them as the family would have. This may be reflective of the type of help

the women expect to receive; emotional support. A previous study on Indian immigrants in the U.S affirms that cultural norms within the population promote help seeking within family or the local community rather than from strangers (Leung et al. 2012).The same study further found that most Indian immigrants do not seek help from mental health professionals or from professional counselling services. An Indian immigrant participant described her perceptions about professional health personnel as below:

> *"yeah they are professionals, so they are doing their job, so the empathy level in them, when they are listening to you is not as high as family, because the family really wants to help and you feel that empathy towards you, which those people might not feel is what I think. Not just about Norwegian doctors, it's about Indian doctors as well. Anywhere in the world, I would say that talk to your family, instead of going to the doctor, I think that"*
>
> *-Indian immigrant participant*

In stark contrast, for some participants, the very notion of accessing help from an outsider was preferable on account of anonymity; being able to speak freely and maintain harmonious relationships with family members when family itself was a factor contributing to poor mental health:

> *"The thing with us is that that we are very reserved so we are not able to share with anyone. We share within family, but are not able to share with every member. [You] can share some things with someone, you would share things at some level, with another person, you would share things at another level, other topics, but the whole thing that you need to share, you aren't able to. Doctor is an unknown person, you think that by sharing with him your other things (relationships) will not get affected. When we go to share with a doctor, we think that he is an unknown person then we share everything, everything comes from inside, that thing is the most helpful for us"*
>
> *-Local Indian participant*

### 3.4.3 Stigma in seeking professional help

In the coping section we discussed the stigma associated with having a mental health problem. Here we see that negative perceptions were also associated with professional help-seeking. Most local and Indian immigrant participants reported that accessing such services may be stigmatising. *"because first and foremost, they will have the ego, and people have misconceptions about such counselling sessions, they either think you know, they are branding me to be*

*mentally retard, many people think like that, but it is not at all that"-Indian immigrant participant.* Previous studies also corroborate that fear of discrimination and stigmatization by their ethnic community members and health care providers were the biggest barriers to immigrants(Reis et al. 2000).

Moreover, the local Indian women suggested that societal understandings of mental health problems were often equated to madness or deviant behaviour of an individual. Research points that on the demand-side, lack of knowledge and stigma or negative public attitude is a major barrier in help-seeking behaviour for mental health concerns in India. Studies have shown that stigma related to mental health makes people not disclose their sufferings and this can accentuate mental health problems, curb self-esteem and hinder access to treatment. (Shrivastava et al. 2012).

It was also felt that accessing care from health practitioners is like accessing help from an outsider which symbolizes loss of control over one's life and feelings of weakness. *"Many people would start thinking okay..I don't need some other person who is not at all part of my life to come and give me some…sessions on this. I think I can handle it"-Indian immigrant participant*

Corroborating to this was also the belief that the locus of control of life is within the self. It was felt that although such practices could help, the locus of control is within the self and thus, may only work when the individual is determined to take action. This perception could also be due to fear of reflected shame on family upon accessing professional mental health care or could be a cognitive appraisal strategy to help one deal with mental health problems better. *"Because I believe and I know that every solution which we are..every problem which we are facing, solution is always within yourself"-Local Indian participant*

On a summarizing note, both local and Indian immigrant participants varying attitudes towards professional help-seeking were reflected in their perceptions about processes, costs and stigma towards it. Below, we discuss some specific perceptions towards help-seeking by immigrant Indian participants.

### 3.4.4 Perceived cultural differences

In the context of Indian immigrant women, some felt that cultural differences could be a barrier in effective communication with a mental health professional, recognising differing understandings of mental health care problems and needs.. None of the Indian immigrant participants, who had experienced lack of autonomy and control from her in-laws in various spheres

of her life, contrasted the life of Indian immigrant women to the life of Norwegian women, highlighting that social and cultural circumstance differ drastically. *"They are more independent; they will never worry about their problems about something like that. This is like very typical, Indian related problems. I don't think so, they can deal with family issues"- Indian immigrant participant*

Although other participants did not report cultural barriers as a barrier in reporting or discussing mental health issues with health personnel, the contrast between Indian and Norwegian society was reiterated several times during the interview. Research cites that lack of access to culturally competent healthcare is one of the most significant barriers to reducing health disparities for minority populations (Smedley et al. 2003; Betancourt and Green 2007)

However, there were also participants who felt that cultural barriers do not play much role as the focus should be on impact of poor mental health on the individual rather than the nature of factors or problems attributing to it.

> *"Though there are cultural differences, ultimately it is an individual as a person whom you see. Because the problem might be different but more or less the effects that the person has on his mental health will be the same. Be it from any culture, the reasons could be different for that so I don't think I would, you know stop myself from seeking some help."*
>
> *-Indian immigrant participant*

### 3.4.5 Perceived linguistic differences

Previous research indicates that non –similarity of linguistic background between health professional and patient may hinder sharing of information, along with potential to contribute to misdiagnosis and lack of mutual decision making (Suurmond and Seeleman 2006).

However, none of the Indian immigrant participants felt that language could be a barrier in communicating with the health professional as they all could at least speak English and believed that the health practitioners are able to communicate in the same *"I think doctors can speak much fluent English, and here if the doctor who can speak your own language (Hindi) is not available, then they will try to get you someone who can talk in your language".-Indian immigrant participant.* However, there was also an opinion that non- fluency in English or lack of education could be a hindering factor for some. Coincidently, all the participants could speak in English with different levels of proficiency. Moreover on a general note, participants

tended to trust the Norwegian health care system and felt that given the need, it is flexible and proactive enough to arrange a native speaking doctor for them. In other words, the women were aware of their rights to request an interpreter.

To summarize, the discussion on attitudes to professional help seeking has revealed some significant issues. Perceptions about mental health problems, perceived response of society and experience with mental health problems was found to influence attitudes towards professional help seeking. There was difference between openness of attitudes towards professional help seeking by participants who reported having experienced depression or anxiety or seen a close family member going through the same and those who had not. Moreover, there was also a question of how to access professional mental health care which further highlighted the relevance of health literacy. On a general note, participants had varying perceptions towards professional health care on stigma, cultural and linguistic differences as barriers to professional mental health care. It was also interesting to note that most of them preferred to seek emotional care and support during stressful times. This further highlighted the need for awareness on much debilitating side of mental health problems for both local and Indian immigrant women. (Note: Based on the findings of the study, I have developed a conceptual framework as depicted in the next page)

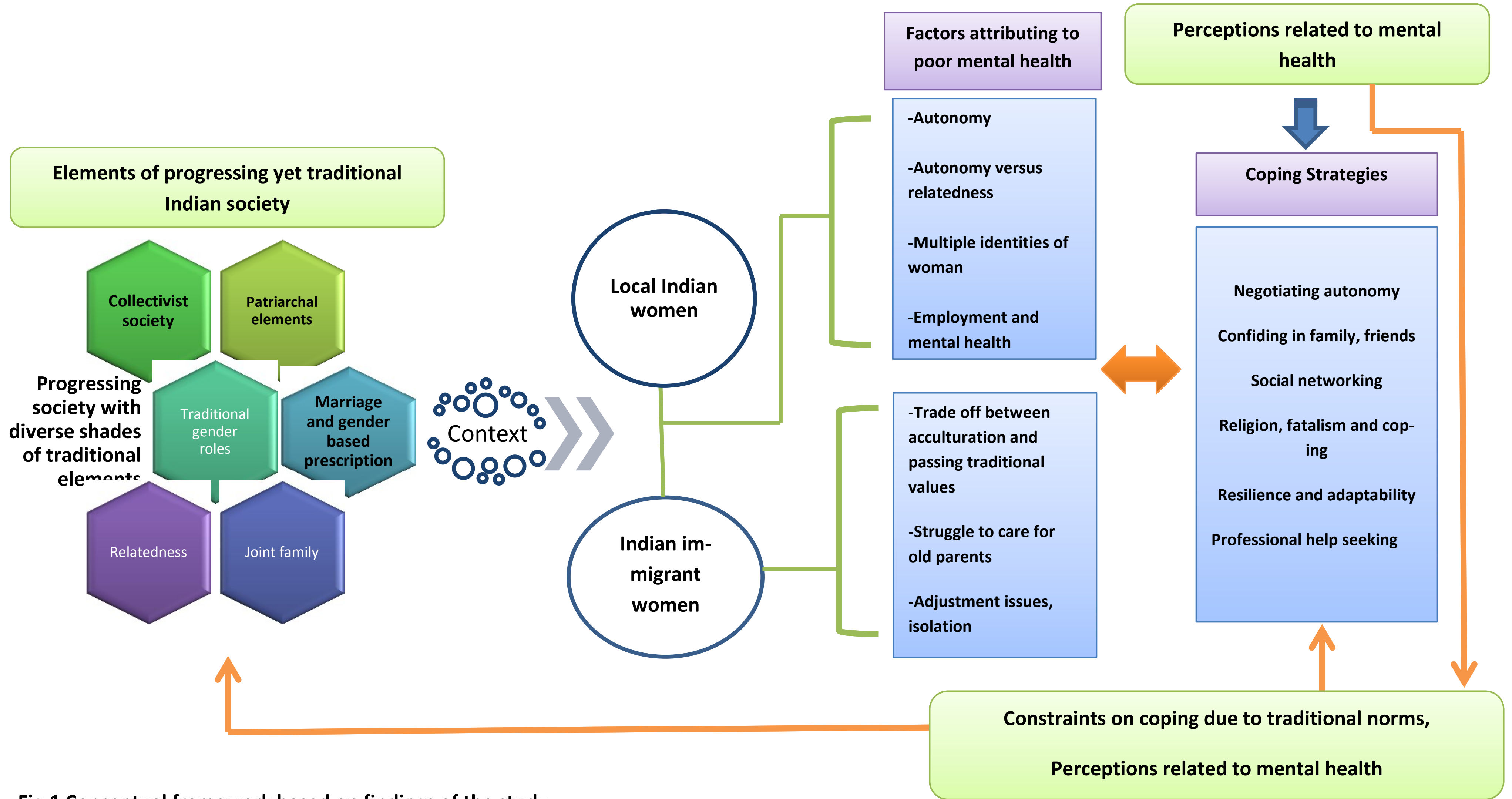


Fig.1 Conceptual framework based on findings of the study

## 4. Conclusion and way forward

Through this study, I have tried to highlight some relevant issues from the perspective of better mental health for local and Indian immigrant women.

Firstly, I found that the conceptualization and experience of marriage differed for different participants, which had different impacts on their autonomy and mental health. There is an urgent need to de-construct the idea of marriage as *leaving everything behind* for an Indian woman and make efforts to enhance autonomy in their lives after marriage. There also needs to be more awareness of gender equality on domestic fronts. As women are increasingly taking up newer roles, their traditionally allocated responsibilities need to be lifted and shared with spouses. At the same time, for Indian immigrant women who migrate to a more gender equal society such as Norway, the transition for both husband and wife could be made easier by counselling on gender equality and management of cross-cultural gender role expectations in the society.

This study also highlighted the significance of acknowledging the social difference between men and women which allocated different roles and responsibilities such as child rearing, household tasks among others which can influence mental health of women. As joint living arrangement was found to be the focal point where gender based norms, prescriptions and roles were heightened, which attributed to poor mental health of women, the non-socialization of gender roles urgently needs to be emphasized there. While on one hand there needs to be awareness about non-gendering of roles that men and women take and adopt a more egalitarian perspective, there also needs to be promotion of labor market policies aimed at making management of their multiple biological, social and professional roles better. For example, presently maternity leave in India is for 3 to 6 months[13], as compared to societies such as Norway which has maternity leave for 9 months that helps in balancing multiple roles of women better. Moreover, paternity leave is hardly present in Indian work places as compared to Norway, which helps to emphasize men's role in child care. The inclusion and extension of of paternity in India can help to increase awareness that though reproduction is a biological role but child care is a social one which should have involvement of both men and women.

[13] Public sector organisations in India usually provide maternity leave for 6 months as compared to private organisations which usually provide for 3 months.

It was also found that mental health problems such as depression were often conceptualized as temporary states of sadness that could pass over with support of people to confide in. The severe form of mental health problem was often dismissed or perceived as equivalent to deviant behavior. Thus, while there is definitely a need to understand mental health problems and increase awareness among people, it is also relevant to develop a different language for conceptualizing and addressing mental health problems in both English and Hindi in order to reduce stigma. Today, promotion of professional mental health care is often seen being made under quality of life or well-being centers. Similar promotion could be made for mental health care centers in Hindi and other regional languages in India and more emphasis on well-being centers for immigrant women could be given in Norway.

The study also found that the different conceptualization of mental health by the participants influenced the choice of coping methods such sharing or not sharing with family for fear of reflected shame or burdening others. It also brought the focus on different coping methods adopted by Indian women, such as beliefs in fate and other reassuring practices related to one's faith, their impact on perceptions of mental health problems and subsequently on professional help seeking. While previous studies have suggested, and explored, possibilities to involve religious or spiritual coping in health care, health practitioners need to be aware of the nature and rationale behind the choice of religious, spiritual or fatalism-based coping, which could be adopted for two reasons. Firstly when an individual perceives no control over the stressful situation and thus uses it as a last resort coping strategy. This can help to take the blame away from one's self and thus reduce risk of poor mental health. Secondly pre-existing beliefs in fatalism could inculcate loss of control over one's life, which increases the likelihood of also adopting a belief in fatalism or religious practices as a coping strategy. This can reduce motivation to strive for change and better circumstances which can lead to poor mental health. Therefore, health practitioners should be mindful of the extreme sides at both ends and push for a collaborative style, maintaining a balance between ones beliefs, faith and self-determination. The study also found the traditional beliefs and social expectations such as adjusting and compromising in marriage was used as a cognitive appraisal strategy. While this acted as another layer of resilience for Indian women at times, it could also lead to feelings of loss of control and entrapment which could constrain their capability to cope with it and lead to poor mental health.

The study also found the collectivist cultural elements present in the Indian society and its interplay with mental health and coping for Indian women. On one hand, the women asserted

their need for autonomy and on the other, relatedness was also deemed important. A conflict between autonomy and relatedness often occurred. This conflict was also reflected in their preferred ways of coping. Thus, although women regarded family members as their preferred choice of sharing and coping, some women also felt the desire for anonymity and to be able to speak freely without feeling fear of harming their relationships in family. Thus, it would be wrong to assume that family involvement or no family involvement in mental health care is suited for Indian women in general. Instead it is important for health practitioners to acknowledge the diversity of sub/cultural, familial, personal factors along with nature of cause of stress, mental health issue that influences choice of family as coping method. They should instead strive to mutually decide with the patient whether the involvement of family for treatment and counselling should be made.

The Indian immigrant participants' perceptions towards professional help seeking revealed that a perceived barrier was the inability for health practitioners to understand Indian specific problems, such as mother-in–law's traditional form of control. Moreover, since most participants expressed the need for validation of their feelings, and to be understood, health practitioners need to be not only sensitive, but also attempt to, understand the sociocultural aspects of immigrants' country of origin, interact more with the patients and gain familiarity with their life situation. This could help them appear more empathetic and alter the perceptions of them 'simply professionals doing their job'. Moreover, as health literacy was found to be an important factor that influenced attitudes to professional mental health care, efforts need to be made for both local and Indian immigrant women to enhance the same. The reach out and dissemination of heath literacy information should be at the community level which can help mental health become a familiar topic to talk about in neighborhoods and also reduce stigma. Moreover, for immigrant women, since language was highlighted as a barrier in looking up help resources for poor mental health, it becomes important to have health literacy information in local languages of immigrant populations.

The study found that immigrant Indian women renegotiated their roles upon migration to cope with their life after migration. For Indian immigrant women specifically, the study also highlights the transnational lives lived by them, with ties back in India such as the forms of traditional control and sociocultural based standards of raising children. This can help health practitioners to be aware of, and to untangle the different sociocultural and personal factors while trying to understand and treat the mental health of these women better.

Moreover, having a postcolonial feminist approach has highlighted various social, cultural and historical factors such gender roles, gender identity, marriage and autonomy among others for Indian women, which can be attributed to poor mental health and are specific to the contexts of the women. Therefore, this study could help in developing ground work for operationalizing variables which are relevant in determining the mental health status of both local and Indian immigrant women in Norway.

This study also shows the diversity and depth of patriarchal elements present in the life of local and Indian immigrant women, impacting their mental health in different ways and levels. This study then helps to highlight the traditional -progressive continuum in Indian society and how Indian women are located differently on it, reflecting the ever present diversity of Indian society. Health practitioners thus, need to be aware of the changing traditional norms.

Lastly, the study sheds light on commonalities of restricted autonomy, conflict between autonomy, multiple identities and conflict between autonomy and relatedness among other factors that influenced their mental health. These two groups of women now live in different societies of India and Norway. However, the subjective experiences of women and their respective negotiation with autonomy should be acknowledged. The resilience showed by each woman in her life is a matter of study in itself. There could be community level initiatives which bring together local and Indian immigrant women in Indian and Norway respectively, through which their experiences of resilience can be shared.

# 5. Appendix

## 5.1 References


Ahmed, Amal, Donna Stewart, Lilly Teng, Olive Wahoush, and Anita Gagnon. 2008. "Experiences of immigrant new mothers with symptoms of depression." *Official Journal of the Section on Women's Health of the World Psychiatric Association* 11 (4):295-303. doi: 10.1007/s00737-008-0025-6.

Ahmad, Farah, Angela Shik, Reena Vanza, Angela M. Cheung, Usha George, and Donna E. Stewart. 2005. "Voices of South Asian Women: Immigration and Mental Health." *Women & Health* 40 (4):113-130. doi: 10.1300/J013v40n04_07.

Anderson, Joan M. 2004. "Lessons from a postcolonial-feminist perspective: Suffering and a path to healing." *Nursing Inquiry* 11 (4):238-246. doi: 10.1111/j.1440-1800.2004.00231.x.

Artazcoz, Lucía, Joan Benach, Carme Borrell, and Immaculada Cortès. 2004. "Unemployment and mental health: understanding the interactions among gender, family roles, and social class." *American Journal of public health* 94 (1):82-88.

Asanin, Jennifer, and Kathi Wilson. 2008. ""I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada." *Social Science & Medicine* 66 (6):1271-1283. doi: 10.1016/j.socscimed.2007.11.043.

Baker, Sarah Elsie, and Rosalind Edwards. "How many qualitative interviews is enough." (2012).

Baldassar, Loretta. "Guilty feelings and the guilt trip: Emotions and motivation in migration and transnational caregiving." *Emotion, Space and Society* 16 (2015): 81-89.

Basu, Sarah. 2012. "Mental Health Concerns for Indian Women." *Indian Journal of Gender Studies* 19 (1):127-136. doi: 10.1177/097152151101900106.

Berkman, Lisa F, Thomas Glass, Ian Brissette, and Teresa E Seeman. 2000. "From social integration to health: Durkheim in the new millennium." *Social science & medicine* 51 (6):843-857.

Berry, John W., and Uichol Kim. "Acculturation and mental health." (1988).

Betancourt, Joseph R, and Alexander R Green. 2007. "Cultural competence." *Immigrant Medicine: Text with CD-ROM*:99.

Bhugra, Dinesh, Alex Till, Norman Sartorius, Jocelyn Catty, Sarah White, Sarah Clement, Naomi Cowan et al. "What is mental health? 3." *International Journal of Social Psychiatry* 59, no. 1 (2013).

Bierman, Alex. *Handbook of the sociology of mental health*. Edited by Carol S. Aneshensel, and Jo C. Phelan. New York:: Kluwer Academic/Plenum Publishers, 1999.

Bohra, N., S. Srivastava, and M. S. Bhatia. 2015. Depression in women in Indian context. In *Indian J. Psychiatry*.

Borowsky, Steven, Lisa Rubenstein, Lisa Meredith, Patricia Camp, Maga Jackson-Triche, and Kenneth Wells. 2000. "Who is at risk of nondetection of mental health problems in primary care?" *Journal of General Internal Medicine* 15 (6):381-388. doi: 10.1046/j.1525-1497.2000.12088.x.

Bowl, Ric. 2007. "The Need for Change in UK Mental Health Services: South Asian Service Users' Views." *Ethnicity & Health* 12 (1):1-19. doi: 10.1080/13557850601002239.

Central Bureau of Health Intelligence ( 2011 ), National Health Profile, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, New Delhi .

Chadda, Rakesh K., and Koushik Sinha Deb. "Indian family systems, collectivistic society and psychotherapy." *Indian journal of psychiatry* 55, no. Suppl 2 (2013): S299.

Clark, Andrew. 2012. "Working with guilt and shame." *Advances in psychiatric treatment* 18 (2):137-143

Danuta M. Wojnar, Kristen M. Swanson. 2007. "Phenomenology An Exploration." *Journal of Holistic Nursing* 25 (3):172-180. doi: 10.1177/0898010106295172.

Dasgupta, Shamita Das, and Sujata Warrier. 1996. "In the Footsteps of "Arundhati" Asian Indian Women's Experience of Domestic Violence in the United States." *Violence against women* 2 (3):238-259.

Dasgupta, Shamita. 1998. "Gender Roles and Cultural Continuity in the Asian Indian Immigrant Community in the U.S." *A Journal of Research* 38 (11):953-974. doi: 10.1023/A:1018822525427.

Davies, Anita A., Anna Basten, and Chiara Frattini. "Migration: a social determinant of the health of migrants." *Eurohealth* 16, no. 1 (2009): 10-12.

Debnath, Sisir. 2015. "The Impact of Household Structure on Female Autonomy in Developing Countries." *The Journal of Development Studies* 51 (5):485-502. doi: 10.1080/00220388.2014.983909.

Deci, Edward L., and Richard M. Ryan. 1985. *Intrinsic motivation and self-determination in human behavior*, *Perspectives in social psychology*. New York: Plenum.

Desai, Dhwani. "Does Marriage Mean Freedom for Young Women?" *The Times Of India.* October 08, 2015. Accessed May 16, 2016. http://timesofindia.indiatimes.com/life-style/relationships/man-woman/Does-marriage-mean-freedom-for-young-women/articleshow/47662818.cms.

Druss, Benjamin G., Philip S. Wang, Nancy A. Sampson, Mark Olfson, Harold A. Pincus, Kenneth B. Wells, and Ronald C. Kessler. 2007. "Understanding mental health treatment in persons without mental diagnoses: results from the National Comorbidity Survey Replication." *Archives of general psychiatry* 64 (10):1196.

Duggal, Taranjeet, and Harpreet Mehar. 2011. "Paradoxes Faced by Indian Working Women and their Strategies." *Journal of Psychosocial Research* 6 (1):71-75.

Erlandson, David A. 1993. *Doing naturalistic inquiry: A guide to methods*: Sage.

Fanning, Bryan. 2011. *Immigration and social cohesion in the Republic of Ireland*: Oxford University Press.

Fung, Kenneth, and Cindy-Lee Dennis. 2010. "Postpartum depression among immigrant women." *Current opinion in Psychiatry* 23 (4):342-348.

Ganapathy-coleman, Hemalatha. 2013. "Raising "Authentic" Indian Children in the United States: Dynamism in the Ethnotheories of Immigrant Hindu Parents." *Ethos* 41 (4):360-386. doi: 10.1111/etho.12029.

Gater, Richard, Barbara Tomenson, Carol Percival, Nasim Chaudhry, Waquas Waheed, Graham Dunn, Gary Macfarlane, and Francis Creed. 2009. "Persistent depressive disorders and social stress in people of Pakistani origin and white Europeans in UK." *The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services* 44 (3):198-207. doi: 10.1007/s00127-008-0426-x.

Gilbert, Paul, Jean Gilbert, and Jasvinder Sanghera. 2004. "A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby." *Mental Health, Religion & Culture* 7 (2):109-130. doi: 10.1080/13674670310001602418.

Ginneken, Nadja Van, Sanjeev Jain, Vikram Patel, and Virginia Berridge. "The Development of Mental Health Services within Primary Care in India: Learning from Oral History." International Journal of Mental Health System, July 16, 2014. Accessed May 16, 2016. doi:10.1186/1752-4458-8-30.

Given, Lisa M. 2008. *The Sage encyclopedia of qualitative research methods*: Sage Publications.

Goldberg, David P, and Peter Huxley. 2003. *Mental illness in the community: the pathway to psychiatric care*. Vol. 3: Psychology Press.

Graham, Jennifer, and Wilfreda Thurston. 2005. "Overcoming adversity: resilience & coping mechanisms developed by recent immigrant women living in the inner city of Calgary, Alberta."

Guba, Egon G., and Yvonna S. Lincoln. 1989. *Fourth generation evaluation*. Newbury Park, Calif: Sage.

Hall, Lena E, and Carolyn M Tucker. 1985. "Relationships between ethnicity, conceptions of mental illness, and attitudes associated with seeking psychological help." *Psychological Reports* 57 (3):907-916.

Hondagneu-Sotelo, P. 2003. *Gender and U.S. Immigration: Contemporary Trends*: University of California Press.

Hussain, Feryada, and Ray Cochrane. 2003. "Living with depression: Coping strategies used by South Asian women, living in the UK, suffering from depression." *Mental Health, Religion & Culture* 6 (1):21-44. doi: 10.1080/1367467021000014864.

Hussain, Feryad A., and Ray Cochrane. 2010. "Depression in South Asian women: Asian women's beliefs on causes and cures." *Mental Health, Religion & Culture* 5 (3):285-311. doi: 10.1080/13674670210130036.

Hwang, Wei-Chin, Julia Y. Ting, and Gordon G. Nagayama Hall. 2008. "Disaggregating the Effects of Acculturation and Acculturative Stress on the Mental Health of Asian Americans." *Cultural Diversity and Ethnic Minority Psychology* 14 (2):147-154. doi: 10.1037/1099-9809.14.2.147.

Imas, Linda G Morra, and Ray C Rist. 2009. "ROAD RESULTS." *The World Bank*.

Jané-Llopis, Eva, Peter Anderson, Sarah Stewart-Brown, Katherine Weare, Kristian Wahlbeck, David McDaid, Cary Cooper, and Paul Litchfield. "Reducing the silent burden of impaired mental health." *Journal of health communication* 16, no. sup2 (2011): 59-74

Janoff-Bulman, Ronnie, and Hallie K. Leggatt. 2002. "Culture and Social Obligation: When "Shoulds" Are Perceived as "Wants"." *Journal of Research in Personality* 36 (3):260-270. doi: 10.1006/jrpe.2001.2345.

Juyal, Pooja, ed. *Women's Studies in India: Some Contemporary Contours*. Ewha Womans University Press, 2005.

Kalavar, Jyotsna M., Steven H. Zarit, and Brian J. Ferraccio. "Transnational Support of Asian Indian Elderly in India: Examining Patterns of Exchanges."*Care Management Journals* 16, no. 3 (2015): 141-149.

Kambarami, Maureen. "Femininity, sexuality and culture: Patriarchy and female subordination in Zimbabwe." *South Africa: ARSRC* (2006).

Kennedy, Steven, Michael Kidd, James McDonald, and Nicholas Biddle. 2015. "The Healthy Immigrant Effect: Patterns and Evidence from Four Countries." *Journal of International Migration and Integration* 16 (2):317-332. doi: 10.1007/s12134-014-0340-x.

Keyes, Corey L. M. 2012. *Mental Well-Being : International Contributions to the Study of Positive Mental Health*, *Mental Well-Being*. Dordrecht: Springer.

Koenig, Harold. 2009. "Research on Religion, Spirituality, and Mental Health: A Review." *Canadian Journal of Psychiatry* 54 (5):283-91.

Kuykendall, Eleanor H. "Subverting essentialisms." *Hypatia* 6, no. 3 (1991): 208-217.

Kvale, Steinar, and Svend Brinkmann. 2009. *Interviews: Learning the craft of qualitative research interviewing*: Sage.

Lazarus, Richard S., and Susan Folkman. 1984. "Stress, appraisal, and coping." In. New York: Springer.

Leung, Patrick, Monit Cheung, and Venus Tsui. 2012. "Asian Indians and depressive symptoms: Reframing mental health help-seeking behavior." *International Social Work* 55 (1):53-70. doi: 10.1177/0020872811407940

Lewis, Gail. *'Race', gender, social welfare: encounters in a postcolonial society*. Polity, 2000.

Llácer, Alicia, María Victoria Zunzunegui, Julia Del Amo, Lucía Mazarrasa, and Francisco Bolůmar. 2007. "The contribution of a gender perspective to the understanding of migrants' health." *Journal of Epidemiology and Community Health* 61 (Suppl 2):ii4-ii10.

Londhe, Rucha. 2015. Acculturation of Asian Indian parents: relationship with parent and child characteristics. Routledge.

Mahalingam, Ramaswami, and Janxin Leu. 2005. "Culture, Essentialism, Immigration and Representations of Gender." *Theory & Psychology* 15 (6):839-860.

Malhotra, Savita, and Ruchita Shah. 2015. "Women and mental health in India: An overview." *Indian Journal of Psychiatry* 57:205-211. doi: 10.4103/0019-5545.161479.

Mathur Gaiha, Shivani, Greeshma Ann Sunil, Rajeev Kumar, and Subhadra Menon. 2014. "Enhancing mental health literacy in India to reduce stigma: the fountainhead to improve help-seeking behaviour." *Journal of Public Mental Health* 13 (3):146-146.

Matud, M. Pilar. "Gender differences in stress and coping styles."*Personality and individual differences* 37, no. 7 (2004): 1401-1415.

Maureen Omahony, Joyce, and Tam Truong Donnelly. 2010. "A Postcolonial Feminist Perspective Inquiry into Immigrant Women's Mental Health Care Experiences." *Issues in Mental Health Nursing, 2010, Vol.31(7), p.440-449* 31 (7):440-449. doi: 10.3109/01612840903521971.

Miles, Matthew B., and A. Michael Huberman. 1994. *Qualitative data analysis : an expanded sourcebook*. 2nd ed. ed. Thousand Oaks, Calif: Sage.

Missinne, Sarah, and Piet Bracke. 2012. "Depressive symptoms among immigrants and ethnic minorities: a population based study in 23 European countries." *The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services* 47 (1):97-109. doi: 10.1007/s00127-010-0321-0.

Morra-Imas, L.G., L.G. Morra, and R.C. Rist. 2009. *The Road to Results: Designing and Conducting Effective Development Evaluations*: World Bank.

Nagaraja, D, and Pratima Murthy. 2008. *Mental health care and human rights*: National Human Rights Commission New Delhi.

Nambi, S. 2005. "Marriage, mental health and the Indian legislation." *Indian Journal of Psychiatry* 47 (1):3-14. doi: 10.4103/0019-5545.46067.

Omariba, D. Walter Rasugu, and Edward Ng. 2011. "Immigration, generation and self-rated health in Canada: on the role of health literacy.(Quantitative research)(Report)." Canadian Journal of Public Health 102 (4):281.

Organization of Social Life InIndia. "Indian Societies and Ways of Living." Asia Society. Accessed May 16, 2016. http://asiasociety.org/education/indian-society-and-ways-living.

Patel, Vikram, Betty R. Kirkwood, Sulochana Pednekar, Helen Weiss, and David Mabey. 2006. "Risk factors for common mental disorders in women." *Population-based longitudinal study* 189 (6):547-555. doi: 10.1192/bjp.bp.106.022558.

Patel, Vikram, Mario Maj, Alan J Flisher, MARY J SILVA, MIRJA KOSCHORKE, Martin Prince, Raymond Tempier, Michelle Riba, Mauricio Sanchez, and Fabrizio Delgado Campodonico. 2010. "Reducing the treatment gap for mental disorders: a WPA survey." *World Psychiatry* 9 (3):169-176.

Pilgrim, David, Bernice Pescosolido, and Anne Rogers. *The Sage Handbook of mental health and illness*. SAGE Publications, 201

Rana, Haq. 2013. "Intersectionality of gender and other forms of identity; Dilemmas and challenges facing women in India." *Gender in Management: An International Journal* 28 (3):171-184. doi: 10.1108/GM-01-2013-0010.

Reis, Harry T., Kennon M. Sheldon, Shelly L. Gable, Joseph Roscoe, and Richard M. Ryan. 2000. "Daily Well-Being: The Role of Autonomy, Competence, and Relatedness." *Personality & Social Psychology Bulletin* 26 (4):419.

Repetti, Rena L., Ingrid Waldron, and Karen A. Matthews. 1989. "Employment and Women's Health: Effects of Paid Employment on Women's Mental and Physical Health." *American Psychologist* 44 (11):1394-1401.

Robeyns, Ingrid. "Sen's capability approach and gender inequality: selecting relevant capabilities." Feminist economics 9, no. 2-3 (2003): 61-92.

Rosario, Margaret, Marybeth Shinn, Hanne Mørch, and Carol B. Huckabee. "Gender differences in coping and social supports: Testing socialization and role constraint theories." Journal of Community Psychology 16, no. 1 (1988): 55-69.

Ross, Catherine E, Jaya Sastry, Carol S Aneshensel, and Jo C Phelan. 1999. "Handbook of the sociology of mental health."

Scattolon, Yvette, Janet M. Stoppard, Victor Cantano, Janet M. Stoppard, and Linda M. McMullen. 1999. "“Getting on with Life”: Women’s Experiences and Ways of Coping with Depression." *Canadian Psychology/Psychologie canadienne* 40 (2):205-219. doi: 10.1037/h0086837.

Schwartz, Seth J., Jennifer B. Unger, Byron L. Zamboanga, and José Szapocznik. "Rethinking the concept of acculturation: implications for theory and research." *American Psychologist* 65, no. 4 (2010): 237.

Scottish government (2009). Towards a Mentally flourishing Scotland: Policy and Action plan 2009-2011. http://www.scotland.gov.uk/Resource/Doc/271822/0081031.pdf (accessed 21st March 2016).

Scott, Dr. Kate. "Marriage Good News for Mental Health, but Separation and Divorce Have Negative Impacts." Onlineposting. December 15, 2009. University of Otago. Accessed May 17, 2016. http://www.otago.ac.nz/news/news/otago006366.html.

Seedat, Soraya, Kate Margaret Scott, Matthias C. Angermeyer, Patricia Berglund, Beth-Ellen Pennell, Evelyn J. Bromet, Traolach S. Brugha, Koen Demyttenaere, Giovanni De Girolamo, Josep Maria Haro, Robert Jin, Nancy A. Sampson, Ronald C. Kessler, Elie G. Karam, Viviane Kovess-Masfety, Daphna Levinson, Maria Elena Medina Mora, Yutaka Ono, Johan Ormel, Jose Posada-Villa, and David Williams. 2009. "Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys." *Archives of General Psychiatry* 66 (7):785-795. doi: 10.1001/archgenpsychiatry.2009.36.

Sen, Mala. 2002. *Death by fire: Sati, dowry death, and female infanticide in modern India*: Rutgers University Press.

Seyfi, Feyza, Krishna C. Poudel, Junko Yasuoka, Keiko Otsuka, and Masamine Jimba. 2013. "Intention to seek professional psychological help among college students in Turkey: influence of help-seeking attitudes." *BMC research notes* 6:519. doi: 10.1186/1756-0500-6-519.

Shahid Alvi , Arshia Zaidi , Nawal Ammar, Lisa Culbert (2012): A Comparative and Exploratory Analysis of Socio-cultural Factors and Immigrant Women's Mental Health within a Canadian Context*: J Immigrant Minority Health* 14:420–432 DOI 10.1007/s10903-011-9567-1

Shenton, Andrew K. 2004. "Strategies for Ensuring Trustworthiness in Qualitative Research Projects." *Education for Information* 22 (2):63-75.

Shrivastava, Amresh, Megan Johnston, and Yves Bureau. 2012. "Stigma of mental illness-1: Clinical reflections." *Mens sana monographs* 10 (1):70.

Simon, Robin W. "Revisiting the relationships among gender, marital status, and mental Health1." *American journal of sociology* 107, no. 4 (2002): 1065-1096.

Singh, Shweta. 2010. "Women's autonomy in rural India: Need for culture and context." *International Social Work* 53 (2):169.

Smedley, Brian D, Adrienne Y Stith, and Alan R Nelson. 2003. Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press.

Sonuga-Barke, E. J., and M. Mistry. 2000. "The effect of extended family living on the mental health of three generations within two Asian communities." *The British journal of clinical psychology / the British Psychological Society* 39 ( Pt 2):129.

Spielberger, Charles D., and Irwin G. Sarason, eds. *Stress and emotion: Anxiety, anger, & curiosity*. Taylor & Francis, 2013.

Straiton, Melanie, Anne Reneflot, and Esperanza Diaz. 2014. "Immigrants' use of primary health care services for mental health problems." *BMC Health Services Research* 14:341. doi: 10.1186/1472-6963-14-341.

Strand, Bjørn Heine, Odd Steffen Dalgard, Kristian Tambs, and Marit Rognerud. "Measuring the mental health status of the Norwegian population: a comparison of the instruments SCL-25, SCL-10, SCL-5 and MHI-5 (SF-36)." *Nordic journal of psychiatry* (2009).

Suurmond, Jeanine, and Conny Seeleman. 2006. "Shared decision-making in an intercultural context: Barriers in the interaction between physicians and immigrant patients." *Patient Education and Counseling* 60 (2):253-259. doi: 10.1016/j.pec.2005.01.012.

Tamres, Lisa K., Denise Janicki, and Vicki S. Helgeson. "Sex differences in coping behavior: A meta-analytic review and an examination of relative coping." *Personality and social psychology review* 6, no. 1 (2002): 2-30.

Tuckett, Anthony G. 2005. "Applying thematic analysis theory to practice: a researcher's experience." *Contemporary Nurse* 19 (1 2):75.

Tummala-Narra, Pratyusha. 2013. "Psychotherapy with South Asian Women: Dilemmas of the Immigrant and First Generations." *Women & Therapy* 36 (3-4):176-197. doi: 10.1080/02703149.2013.797853.

Valk, Reimara, and Vasanthi Srinivasan. "Work–family balance of Indian women software professionals: A qualitative study." *IIMB Management Review* 23, no. 1 (2011): 39-50

Van Ginneken, Nadja, Sanjeev Jain, Vikram Patel, and Virginia Berridge. 2014. "The development of mental health services within primary care in India: learning from oral history." *International Journal of Mental Health Systems* 8. doi: 10.1186/1752-4458-8-30.

Vingerhoets, A. J. J. M., and Lauren Bylsma. "Crying as a multifaceted health psychology conceptualisation: crying as coping, risk factor, and symptom." *The European Health Psychologist* 9, no. dec (2007): 68-74.

Ward, Earlise C., Le Ondra Clark, and Susan Heidrich. 2009. "African American Women's Beliefs, Coping Behaviors, and Barriers to Seeking Mental Health Services." Qualitative Health Research 19 (11):1589-1601. doi: 10.1177/1049732309350686.

Weaver, Lesley Jo, and Craig Hadley. "Social pathways in the comorbidity between type 2 diabetes and mental health concerns in a pilot study of urban middle-and upper-class Indian women." Ethos 39, no. 2 (2011): 211-225.

Woods, T. E., M. H. Antoni, G. H. Ironson, and D. W. Kling. 1999. "Religiosity is Associated with Affective Status in Symptomatic HIV-infected African-American Women." *Journal of health psychology* 4 (3):317. doi: 10.1177/135910539900400302.

World Health Organization. "Women's mental health: An evidence based review." (2000).

World health report .2001: ʻʻMental health : new understanding, new hope." In. Geneva: World Health Organization.

World Health Organisation. "Gender and Mental health" 2002. Accessed December 10, 2015, http://www.who.int/mental_health/prevention/genderwomen/en/

World Health Organization. "How to investigate the use of medicines by consumers." *How to investigate the use of medicines by consumers* (2004).

World Health Organization. 2011. "Mental health atlas 2011." In. Geneva: World Health Organisation.

World Health Organization. "Mental disorders" Accessed March 15, 2016 , http://www.who.int/mediacentre/factsheets/fs396/en/

Yu, Yu, Zi-Wei Liu, Mi Hu, Hui-Ming Liu, Joyce P. Yang, Liang Zhou, and Shui-Yuan Xiao. 2015. "Mental Health Help-Seeking Intentions and Preferences of Rural Chinese Adults." *PloS one* 10 (11):e0141889. doi: 10.1371/journal.pone.0141889.

Zinnbauer, Brian J, Kenneth I Pargament, Brenda Cole, Mark S Rye, Eric M Butter, Timothy G Belavich, Kathleen M Hipp, Allie B Scott, and Jill L Kadar. 1997. "Religion and spirituality: Unfuzzying the fuzzy." *Journal for the scientific study of religion*:549-564.

## 5.2 Information letter to the participants

My name is Sanjana Arora. I am a post graduate student in Hogskolen I Oslo Akershus (HiOA). Under the supervision of and in collaboration with Researcher Melanie Straiton at the Norwegian Institute of Public health, I am conducting a study on health and migration among Indian women in Norway and India. Through this study, we are trying to understand the life situations' and experiences of Indian women with a particular focus on mental health and help- seeking and other coping practices.

In this regard, you are invited to take part in this Research study. All the participants in this study are being reached through a snowball sampling technique. This means we are contacting Indian women through their neighbors, friends, colleagues etc. In this case, (name of person) has suggested you as a potential informant in the study.

Notification to this study was sent to the Norwegian data protection officer and the research will be conducted in line with their regulations. However, your participation in the study is completely voluntary.

Below you will find all information concerning your voluntary participation in the study and our contact details for further information, if needed. If you agree to participate in the study, please complete the information below and return to me and / or contact me by telephone or email (details below)

**Your involvement in the study project and Confidentiality**

We are interviewing married Indian women who have lived in Norway 1-10 years/ married women in India. Interviews are likely to last for 45-75 minutes. The topics of discussion in the interview will revolve around conceptualization of mental health and perceptions about it, self -reported health status, coping mechanisms, experiences of living in India and Norway from a gender perspective, Issues of stigma and people's reaction towards those with mental health problems .Though these are the interview topics, there is a possibility of divergence from the interview schedule considering the interactive and dynamic nature of discussion that goes between researcher and participant. The interviewer will be sensitive to your needs. In addition to the interview, you will be asked to fill out a questionnaire with questions on background information and Hopkins symptoms checklist which is measure of psychological distress. Your responses will be kept strictly confidential and if you feel uncomfortable in re-

sponding to any of the questions, you can ask the interviewer to skip the question or discontinue at any point of time.

Please note: The interview can be conducted in Hindi, Punjabi or English as per the choice of the participant.

**Voluntary participation and right to withdraw**

Please note that your participation is voluntary and you have the rights to withdraw from the study at any point.

**Recording of interviews and taking notes**

With your consent, we would like to voice -record our interview and the researcher may also take notes during the conversation. The voice recording will be strictly kept within the research team and will not be shared with any outsider, your peers, spouse or family. The recording and subsequent transcription of the same will be taken only with a view to correctly remember details of the interview, to allow analysis of the data and to facilitate the research team in understanding women's life situations and experiences better. The data and the voice recording will be stored securely at the Norwegian Institute of Public Health and only the student researcher and supervisor will have access to it.

**Associated Risks**

We do not envisage any direct risks in participating in the study. However, you may be asked personal questions which you may find sensitive. You do not have to answer any questions that make you feel uncomfortable. You can also discontinue the interview at any point. You do not need to give any reason for not responding to a question or for discontinuing the interview. Please note that the interviewer will be sensitive to your needs at all times.

**Associated benefits**

Though there will not be any financial benefit to you, you may find the interview a very positive experience. Your participation will help us to understand possibilities for women's welfare and better health. It may also direct further research in this area and benefit other women in future.

**The use of this study**

The findings and reflections from the study will be shared in the form of thesis report, submitted to HIOA. It may also be published in international research journals. However, your confidentiality and anonymity will be retained. The research team will utilize the information provided by you and will assign a code number instead of a name to it. Only the research team would know your name and associated responses. All identifying information will be removed in the write up of the findings.

**Please note**: You are free to ask questions before agreeing to this study and to keep a copy of this letter and consent form, if you wish.

**Persons to Contact**

If you want to talk to anyone about the study in general or you have any other questions about the study in future, you may speak with:

| ***Contact person 1*** | |
|---|---|
| Name | Sanjana Arora |
| Organization | Oslo and Akershus university college of applied sciences |
| Contact Number | +47 97392331 |
| Contact email | S237103@stud.hioa.no |

| ***Contact person 2*** | |
|---|---|
| Name | Melanie Straiton |
| Organization | Norwegian Institute of Public Health |
| Contact Number | Melanie.Straiton@fhi.no |
| Contact email | +47 46689524 |

Thank you for your time,

Yours sincerely,

Sanjana Arora, Post graduate student, Hogskolen I Oslo Akershus

## 5.3 Consent form

I……………………………………… agree to participate in the research study *Mental health and coping among immigrant Indian women in Norway and local Indian women in India*

The purpose and nature of the study has been explained to me in writing and I am participating voluntarily.

I give permission for my interview to be tape-recorded.

I understand that I can withdraw from the study, without repercussions, at any time.

I also understand that I can withdraw permission to use my data at any time, in which case the material will be deleted (with the exception of when the data has already been published).

I understand that short extracts from my interview may be quoted in publications but that my identity will be disguised to ensure anonymity.

Signed……………………………………. Date……………….

## 5.4 Interview Guide for Local Indian participants

| Sr.No | Questions/Points for discussion | Themes |
|---|---|---|
| 1. | Can you tell me about yourself<br>Probes: where were you born<br>Situation now- Marriage/family/children<br>Who took decisions regarding your marriage?<br>Employment history<br>Decisions regarding your employment?<br><br>Who takes major household decisions in your family?<br>About your health/child's, purchase of assets/expensive things, utilization of income, child care and rearing? | Background information, autonomy over life's decisions-influence of patriarchy |
| 2. | Do you feel you have freedom here? Probe: in visiting places, social networking, taking career decisions, spending money | Autonomy/control over one's life |
| 3. | Do you ever find yourself in conflicting cultural situations, if yes then can you give an example? Do you have any responsibilities in your family? If yes, what type of responsibilities? How do you balance your different responsibilities? Can you think of a time when it was difficult to manage? Why? Did/how it affect you health (physically/mentally?) Did you find it stressful? How did you cope? Did you ask someone for practical help? | Relationship with family and responsibilities |
| 4. | Have you ever felt sad or low ?<br>What helped you get through it? Did contact with family members/friends/social network help? Work,time? Hobbies or other activities? Did you talk to anyone about the way you felt? Friends, family, husband, professional help? Did you look for practical help? What changed about the situation? | Self reported mental health status |

| | | |
|---|---|---|
| 5. | Now I would like to talk about a specific aspect of health – mental health.<br>What are the first thoughts that come to your mind when you think about mental health?<br>Probes: What does depression mean to you?<br>How might with someone with depression and /or anxiety act? What sort of symptoms might they experience? How might these symptoms be perceived in India? How do others react to someone with depression and /or? Do you think there are differences in how people view mental health in abroad compared with in India? Do you think people sympathize with someone having poor mental health? | Perception about mental health, symp-toms<br><br>Perception of mental health in India and abroad |
| 6. | (If indications of stress or feeling low) Do you think you have ever experienced a mental health problem (or that you could have had you continued in the same situation you were in)? Or have you ever had a diagnosed mental health problem?<br>Probes: If so, when was it? Can you tell me a little more about it..when did it start. How did you feel, what symptoms did you have? (e.g. sleep,apetite,tiredness,headaches,pain, concentration, mood – irritable, tearful, socially withdrawn, fearful, excessive worrying, restlessness etc?) Did it affect your daily life? For how long? | More on self – reported mental health status, self-coping strategy<br><br>Views on stigma towards poor mental health |
| 7. | How did you deal/cope with it?<br><br>Probes: Self blame, Active coping (Efforts to change situa-tion, advice seeking, venting/sharing problems, seeking sup-port-informal or professional, adjusting expectations), Passive strategies (eating/sleeping, engaging in risky behaviour, self – harm, hobbies, relaxation, exercise) What kind of help did you get if any ?Did your family know about it? How did you family/friends react when they heard? | Help seeking and coping<br><br>Gender and social context based per-spective on treat- |

| | | |
|---|---|---|
| 8. | Where else people might look for help if you having emotional problems , or were feeling stressed or depressed?<br>Probes: Discuss with your spouse?Family or friends? Others in social network-school/work, other social groups? Seeking help from A religious leader or group? Pundit/Shaman / spiritual healers)? A mental health professional? In what ways do you think these people might be able to help /offer support? How relevant would you say such strategies are for you?<br><br>Do you think treatment can make lead their lives in a normal way? What might prevent mental health problems?<br>Do you think it (stigma, treatment, coping strategies) is differently in the society here? In what ways and why do you think it's different?<br><br>Do you think these (stigma/treatment/concern etc.) and coping strategies differ for men? In what ways and why? | ment, coping strategies |
| 9. | Ask If respondent doesn't indicate experience of mental health problem:<br>Have you ever had physical symptoms such as headaches , stomach ulcers , muscular pain, pain in the heart that have not had a physical explanation? Have you ever experienced palpitations, sweating, shortness of breath, dizziness?<br>Probes: Can you tell me more about it? Did you experience changes in sleep patterns, appetite, tiredness levels too? Could these be signs of emotional problems too? | If any unrecognized symptoms of poor mental health |
| 10. | Have you or do you think you could visit your doctor here , if you were having emotional problems, or were feeling stressed or depressed?<br>Probe: Why/Why not? (issues in taking appointment? Com- | Experiences of health care at home |

| | | |
|---|---|---|
| | munication and/or gender differences)<br>How do you think the doctor might be able to help?/What did the doctor do to help? Prescription medicine, sickness absence, conversational therapy, referrals to psychologist, telephone contact. | |
| 11. | What do you think are the measures that can be taken in order to ensure better mental health of women?<br>Probes: better self care (time off for hobbies/interests, exercising, nutrition etc. ) participation in community activities, education, economic empowerment, gender sensitive health personnel and care, legal or political mechanisms | Suggestions for improvement of mental health |
| 12. | As you know, we have conducted this study with immigrant women in Norway and similar questions were being asked to them. I would like to know what do you think about mental health of immigrant Indian women, say who live in Norway? Do you think the mental health of local Indian women like you is different to the mental health of immigrant women in a country say Norway? And if yes, why do you think so?<br><br>What would you say about mental health of Norwegian women as compared with immigrant Indian women? | Perception about mental health status of women living in different societal contexts |
| 13. | In what aspects do you think life of a Indian woman changes after moving to a foreign country?)<br>Probe: in areas of education, employment, child care, household work responsibilities, relationship with spouse/family / social network/friends/ etc.<br><br>How do you compare the impact of migration on lives of Indian women to that of Indian men? What changes do you think men go through and how it affects their life? How does | Perception about impact of migration from a gender perspective |

| | | |
|---|---|---|
| | it compare to that for women? | |
| 14. | Is there anything else you want to add about mental health or health care that you've not had a chance to say yet? | Closure |
| 15. | Can I ask how you felt about being interviewed today? | |

## 5.5 Interview guide for Indian immigrant participants

| 7. Sr.No | Points for discussion | Themes |
|---|---|---|
| 1. | Can you tell me about yourself and how you came to live in Norway?<br>Probes: where were you born, when did you move, why? Have you lived in other countries?<br>Situation now- Marriage/family/children-in Norway and at home.<br>Who took decisions regarding your marriage?<br>Employment history-before and after moving<br>Decisions regarding your employment?<br>Long term plans staying in Norway? why? why not?<br><br>Who takes major household decisions in your family? About your health/child's, purchase of assets/expensive things, utilization of income, child care and rearing? | Background information, autonomy over life's decisions-influence of patriarchy |
| 2. | How do you feel about living in Norway?<br>Probes : How well do you feel adjusted? Role of husband and other family members/friends/social network/work Good/bad aspects of living in Norway ..How have you overcome these problems? What helped? | Adjustment |
| 3. | Before migration, what kind of changes did you expect in your life to take place? And In what aspects has your life changed because of/after moving to Norway?( or in what aspects do you think life of a woman like you changes after moving to a foreign country?)<br>Probe: in areas of education, employment, child care, | Expectations vis. a vis reality after migration<br><br>Autonomy/control over one's life after |

| | | |
|---|---|---|
| | household work responsibilities, relationship with spouse/family / social network/friends/ etc. –<br>Do you feel you have more freedom here than at home? Probe: in visting places, social networking, taking career decisions, spending money<br>How do you compare the impact of migration on lives of women to that of men? What changes do you think men go through and how it affects their life? How does it compare to that for women? | migration<br><br>Impact of migration from a gender perspective |
| 4 | How do you feel about visting back home?<br>Probe: To what extent are you able to stay in touch (phone/letters/internet)with your family and friends back home?Do you think you are able to visit home often? How often do they visit you? Decision making process of visting home? How does the distance affect your relationship with your closed ones back home? Do you ever find youself in conflicting cultural situations, if yes then can you give an example? Do you have any responsibilities in your family? If yes, what type of responsibilities? How do you balance your responsibilities back home and in Norway? Can you think of a time when it was difficult to manage? Why? Did/how it affect you health (physically/mentally?)<br>Did you find it stressful? How did you cope? Did you ask someone for practical help? | Relationship with family back home |
| 5. | Have you ever felt sad or low while in Norway?<br>What helped you get through it? Did contact with family members/friends/social network back home or/and here help? Work, understanding the culture/language/time? Hobbies or other activities? Did you talk to anyone about the way you felt? Friends, | Self reported mental health status |

| | | |
|---|---|---|
| | family, husband, professional help? Did you look for practical help? What changed about the situation?<br><br>Do you think your response could have differed if you were living in your home country? Or a woman like you could have responded differently if still living in India? | |
| 6. | Now I would like to talk about a specific aspect of health – mental health.<br>What are the first thoughts that come to your mind when you think about mental health?<br>Probes: What does depression mean to you?<br>How might with someone with depression and /or anxiety act? What sort of symptoms might they experience? How might these symptoms be perceived in India? How do others react to someone with depression and /or? Do you think there are differences in how people view mental health in Norway compared with in India? Do you think people sympathize with someone having poor mental health? | Perception about mental health, symptoms<br><br>Perception of mental health in India and Norway |
| 7. | (If indications of stress or feeling low) Do you think you have ever experienced a mental health problem (or that you could have had you continued in the same situation you were in)? Or have you ever had a diagnosed mental health problem?<br>Probes: If so, was this while in Norway? Can you tell me a little more about it..when did it start. How did you feel, what symptoms did you have? (e.g. sleep,apetite,tiredness,headaches,pain, concentration, mood – irritable, tearful, socially withdrawn, fearful, | More on self – reported mental health status, self-coping strategy<br><br>Views on stigma towards poor mental health |

|  |  |  |
|---|---|---|
|  | excessive worrying, restlessness etc?) Did it affect your daily life? For how long? |  |
| 8. | How did you deal/cope with it?<br><br>Probes: Self blame, Active coping (Efforts to change situation, advice seeking, venting/sharing problems, seeking support-informal or professional, adjusting expectations), Passive strategies (eating/sleeping, engaging in risky behaviour, self –harm, hobbies, relaxation, exercise) What kind of help did you get if any ?Did your family know about it? How did you family/friends react when they heard? | Help seeking and coping<br><br>Gender and social context based perspective on treatment, coping strategies |
| 9. | Where else people might look for help if you having emotional problems , or were feeling stressed or depressed?<br>Probes: Discuss with your spouse?Family or friends in Norway? Family/friends at home? Others in social network-school/work, other social groups? Seeking help from A religious leader or group? Pundit/Shaman / spiritual healers)? A mental health professional? In what ways do you think these people might be able to help /offer support? How relevant would you say such strategies are for you?<br><br>Do you think treatment can make lead their lives in a normal way? What might prevent mental health problems?<br>Do you think it (stigma, treatment, coping strategies) is differently in the society here? In what ways and why do you think it's different?<br><br>Do you think these (stigma/treatment/concern etc.) and |  |

| | | |
|---|---|---|
| | coping strategies differ for men? In what ways and why? | |
| 10. | Do you think the mental health of women belonging to Norwegian society is different to the mental health of Indian immigrant women? If so, why do you think so? Do you think the mental health of local Indian women like you is different to the mental health of immigrant women in Norway ? And if yes, why do you think so? | Perception about mental health status of women living in different societal contexts |
| 11. | Ask If respondent doesn't indicate experience of mental health problem:<br>Have you ever had physical symptoms such as headaches , stomach ulcers , muscular pain, pain in the heart that have not had a physical explanation? Have you ever experienced palpitations, sweating, shortness of breath, dizziness?<br>Probes: Can you tell me more about it? Did you experience changes in sleep patterns, appetite, tiredness levels too? Could these be signs of emotional problems too? | If any unrecognized symptoms of poor mental health |
| 12. | Have you or do you think you could visit your doctor here in Norway, if you were having emotional problems, or were feeling stressed or depressed?<br>Probe: Why/Why not? (issues in taking appointment? Communication, cultural and/or gender differences)<br>How do you think the doctor might be able to help?/What did the doctor do to help? Prescription medicine, sickness absence, conversational therapy, referrals to psychologist, telephone contact. | Experiences of health care at home and in Norway |

| | | |
|---|---|---|
| 13. | What do you think are the measures that can be taken in order to ensure better mental health of women?<br>Probes: better self care (time off for hobbies/interests, exercising, nutrition etc. ) participation in community activities, education, economic empowerment, gender sensitive health personnel and care, legal or political mechanisms | Suggestions for improvement of mental health |
| 14. | Is there anything else you want to add about mental health or health care that you've not had a chance to say yet? | Closure |
| 15. | Can I ask how you felt about being interviewed today? | |

***