Indian American Attitudes Towards Seeking Mental Health Care

By

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Table of Contents

List of Tables *3*

List of Abbreviations *4*

Abstract *5*

Chapter 1: Introduction *6*

Chapter 2: Literature Review *8*

Challenges Brought by Immigration 8

Acculturation Stress 9

Model Minority Stress 11

Stigma about Mental Illness 12

Statement of the Problem and Hypotheses 15

Chapter 3: Method *18*

Participants 18

Materials/ Measures 19

Mental Help Seeking Attitude Scale (MHSAS) 19

Social, Attitudinal, Familial, and Environmental Acculturative Stress Scale (SAFE) 20

Individual and Collectivism Scale (INDCOL) 20

Demographics 21

Chapter 4: Results *22*

Descriptive Statistics 22

Tests of Hypotheses 23

Supplementary Analysis **25**

Chapter 5: Discussion ***30***

Mental Health Care Seeking Attitudes **30**

Acculturation Stress **31**

Relationship Between Mental Health Seeking Attitude and Acculturation Stress Between the Younger and Older Groups **32**

Individualistic and Collectivistic Cultures **33**

Limitations **34**

Implications for Future Research **35**

Conclusion **35**

References ***37***

List of Tables

Table 1: *State/Union of India Where the Immigrant Participants Originated From* 23

Table 2: *Correlation Between MHSAS and SAFE* 25

Table 3: *Acculturation Stress Amongst Immigrants and Non-Immigrants* 26

List of Abbreviations

Individual and Collectivism Scale **(INDCOL)**

Mental Health Care Seeking Attitude Scale **(MHSAS)**

Social, Attitudinal, Familial, Environmental Acculturation Scale **(SAFE)**

Abstract

The purpose of this study is to analyze the attitudes of mental health care of Indian Americans. Indian Americans make up 4.7 million of the United States population and the numbers have been growing exponentially ever since. The cultures of India and the United States are very different and the way the view mental health is very different as well. Although there has been a lot of growth in the field of psychology in both countries, the United States has many more resources in respect to mental health care than India does. This study looks at aspects of immigration, acculturation, individual and collectivism, model minority stress, and stigma and the effects they may have towards the attitudes towards mental health care. The measures used in this study are the Mental Help Seeking Attitude Scale, the Social, Attitudinal, Familial, and Environmental Stress scale, and the reduced version of the Individualism and Collectivism Scale.

Chapter 1: Introduction

The purpose of this study is to evaluate Indian American attitudes towards seeking mental health care. The reason for choosing this population is that Indians make up 4.2 million (1.2%) of the total United States population (Hanna & Batalova, 2020) and it has been growing exponentially.

Migration from India to the United States started in the early 19th century but there was a very small number which grew slightly more during the mid-20th century as more opportunities arose. The biggest boom was seen in the late 20th century and early 21st century. As Hanna and Batalova (2020) note, educational exchange programs, new job opportunities requiring high skills, and temporary visas allowed many Indian immigrants to migrate to the United States from 1980 to 2019 and most brought family with them. This increased the population of Indian Americans significantly. Incentives to move to the United States included better education as the universities are perceived to be more prestigious, higher paying jobs, the rupee to dollar conversion rate (1 dollar equals 73.26 rupees) which would be helpful if they were to go back to India to spend it or if they were helping out family in India while they work in the United States which is also common, and the concept of the “American dream” that is advertised to immigrants which promises a better and stable lifestyle. The majority of the Indian population in the United States are either students, medical professionals, computer engineers, or businesspeople (Hanna & Batalova, 2020). This population is known to be a “model minority” in the sense that they have a stereotype to be very successful (Harvard Law School, 2019). The average income rate of an Indian household in the United States is $100,000, which makes them the highest earning ethnicity in the country (Pew Research Center, 2020).

Because most of the people who migrated from India arrived within the past 30 years, they have had children who have been born and raised in the United States. The difference in the two generations is likely to be large because of the different cultures they have grown up in. Many families struggle to find a proper balance between the two cultures. This is something I want to analyze in my study. India and the United States are very different cultures, from food, to clothing, to traditions, holidays, religious views, etc. The culture in India is very collectivistic and the culture in the United States is very independent (Innman & Yeh, 2007). An individualistic culture focuses more on independence of oneself, and a collectivistic culture places more importance on the community or family. A prime example is that in India it is very common for someone to live in a household with three or more generations whereas in the United States, that is not common at all. Another example is that in the United States, the norm is that one generally will move out of their parents' house when they are around 18 years old, whereas in India they may typically stay with their parents until marriage. This is an example of some notable differences between the two cultures.

I begin the literature review by identifying the main reasons for the Indian American population to not seek mental health care. First, I will reflect upon the challenges brought by immigration. Then, I will examine the process of assimilation or rejection of a new culture and what that may do to future generations who are born into the new culture. Next, I will talk about the "model minority" stereotype that is associated with the Asian and Indian American populations today and how it can affect their social and academic lifestyles. Lastly, I will examine the cultural roots of India which will assist me in identifying where the stigma of mental health comes from.

Chapter 2: Literature Review

Challenges Brought by Immigration

The immigration to a new country and new culture can be a struggle for many families. Immigration changes everything from the way one might dress, the way one speaks to others, body language, and even food. Venkatesh and Weatherspoon (2018) found that in India, most people live in a very close-knit multigenerational family where one individual is in charge of deciding the food and meal preparation for the household. In the United States it is very different, with households usually made up of just the nuclear family and food choice self-determined by everyone. Along with this, more exposure to the new culture following immigration may lead to the discovery of many new foods that may not be familiar.

While some changes caused by immigration can be small and manageable, there can be bigger changes as well. In a review of the different effects or processes of immigration, Londhe (2015) noted that it can be related to “loss and uproot of meaning” (p. 529), it can force these immigrants to have new parenting roles, it can affect identity formation in children and therefore affect decisions as parents based on the new culture, and the new way of life can be unexpectedly difficult.

Indian immigrant parents seem to have specific patterns in parenting. To some immigrants, the maintenance of culture is essential in the sense that they want to keep the values and traditions of their old culture the main focus and do not want to *assimilate* or fully partake in or accept the new culture. These individuals separate themselves from the new culture that they join to keep the roots of the original culture intact. Some parents lack interest in both cultures and do not do much to preserve the original culture or assimilate to the new culture—this is called *marginalization*. For some, assimilation is the most important path and they do not wish to

maintain their original culture at all. The biggest group falls under *integration*, which is to find the right balance between both cultures to build a better social network (Londhe, 2015).

The differences between assimilating, marginalization, and integration are large. Whichever one a family chooses is key to how they live the rest of their lives in the new country to which they have migrated. Patterns of parenting styles and strategies impact who children interact with and are reflected in how one chooses to embrace their original culture or assimilate to the new culture. The children may then carry on the same patterns or grow up to choose their own. In our sample, the participants may have fall into any of these three categories. The process of deciding what works for them may cause some identity crisis and lead them to have acculturative stress (Durvasula & Mylvaganam, 1994), which I will talk about in the next section.

Acculturation Stress

A significant stressor that many people of this ethnicity face is *acculturation* and *enculturation*. Acculturation refers to the "adaptation of mainstream cultural values after cross-national transitions, which applies to immigrants or sojourners" (Wang et al., 2019, p. 23). Enculturation refers to the process "in which individuals maintain and internalize their culture of origin in addition to a second culture" (Wang et al., 2019, p. 23). In my research, I am referring to the Indian and American culture. It is evident that Indian culture and American culture are very different. The culture in the United States is more individual, does not stem from a particular religion, and is more diverse. Indian culture is a combination of Hinduism and collectivism which is defined as generational interdependence. Obedience, conformity, obligation, and shame are values that are very important by both Asian and Asian Indian families (Durvasula & Mylyaganam, 1994). Many individuals struggle trying to find the right balance

between the two cultures, and this causes *acculturative stress* which is defined as stress resulting from attempts to incorporate host country traits within one's own culture (Karasz et al., 2019). A study by DeVitre and Pan (2020) found that while enculturation significantly negatively affects one's attitudes towards seeking mental health care, acculturation has a partial positive effect on seeking mental health care.

Because Indian culture thrives on interdependency, what one person does in a family effects the other and because of this, the children of the family are expected also keep the idea of interdependency intact (Leung et al., 2012). The children that grow up in the United States may value independence and interdependency differently as they have grown up in a different culture from their parents. Although there may be a lot of expectations from children of Indian families, there seems to be a given that the family bond will not break. Leung et al. (2012) found that most Indian American adolescents in the United States report high levels of confidence that their family ties will remain intact regardless of poor communication and strict parental controls. Later findings in the same study highlight the understanding that help seeking is appropriate within the family or local community but less so from strangers. Hence it is looked down upon to seek psychological therapy as it is believed in this culture that you should look for help within your own family. Practitioners should be aware that it could have an impact and cause low utilization within this community. But low utility does not mean that the services are being met. This situation may be impeding someone's need to go to a professional because they may feel they are going against their community (Leung et al., 2012).

On the other hand, this notion that family ties can never break can be a stressor for some who may feel that they might do something to cause shame to their family and therefore break family ties. It seems as if the fear of the mental illness affecting the family unit by bringing

shame to the family is the biggest concern (Loya et al., 2010). In collectivistic cultures like the Indian culture, a lot of importance is given to connectedness and social harmony and using this as a support system when there are issues (Innman & Yeh, 2007). It is more beneficial to use this system than to face it alone. It is possible that the norms of the culture for reacting to problems have an impact in identifying the coping strategies that are predictive of psychological outcomes of treatment (Meghani & Harvey, 2016).

In summary, the stress to fit in and be a part of one's community is a struggle for most individuals. When a person must balance two cultures and also somehow fit into both, this situation can bring on a completely new struggle in itself. Acculturative stress arises from the need to fit into both cultures, while meeting social pressures and collectivistic culture expectations. This is the reality of what many Indian Americans must face.

Model Minority Stress

Having any kind of stereotype attached to your race or ethnicity can be harmful to those who do not fit into it. Many Asian Americans including Indian Americans fall into a category called the *model minority.* A model minority refers to when a "minority group is perceived as particularly successful, especially in a manner that contrasts with other minority groups" (Harvard Law School, 2019). When you are a part of a model minority group, you must strive to achieve and be better than most to fulfil your family's expectation and society's expectations (Sunmin et al., 2009). Asian Americans have this stereotype because most Asian Americans come from countries that have a large emphasis on academics and monetary success (Sunmin et al., 2009).

Because of Indian Americans' model minority status, there is a stereotype associated with the ethnicity that assumes that all people of Indian descent are successful. There is a lot of

pressure for many people of Indian descent to fit into that stereotype. As noted in Sunmin et al. (2009), the first and second generations deal with a large amount of stress due to the model minority steryotype. Their parents often put a large focus on academics and consider it to be the most important thing in their children's lives. This causes a great deal of competition within other Indian Americans who constantly feel pressure to please their parents by being successful. Children are often referred to as the "culmination of their parents' life work" (Sunmin et al., 2009) and the idea that they should always do what their parents say and be grateful for all that they have done is a very important value (Sunmin et al., 2009). This pressure causes a lot of stress on their wellbeing because they can be hesitant to speak up or feel under pressure to always be perfect to please their parents.

Many Indian families feel it is important that their children only marry someone who is from Indian descent and sometimes even in their own sub-cultures due to language (Tewary, 2005). Tewary also states that the model minority stereotype may have placed pressure on Asian Indians and given a false picture of their mental health, thus limiting prevention and treatment efforts for depression experienced by this ethnic group.

In summary, the model minority stereotype has a negative effect on the young adults in this community. A high level of stress associated with the need to fit the stereotype for their family and for society also has a negative effect on their well-being. Not fitting in may cause shame for their family and/or ostracization from their community.

Stigma about Mental Illness

A big factor that seems to be impeding the act of seeking mental health care of Indian Americans may be the stigma associated with mental illness. Stigma may be associated with

religious influences, collectivistic versus individualist cultures, a history of being taught to be inferior, and lack of awareness of mental health (Durvasula & Mylyaganam, 1994).

Ancient Indian psychiatric illnesses and chronic physical conditions were viewed similarly. If a person was mentally ill, it was considered just as big of a problem as someone who was physically ill (Durvasula & Mylyaganam, 1994). But other ancient codes of India inform us that psychiatrically ill individuals do not have the same social privileges as others, such as not being able to go to social gatherings, attending religious events, taking part in family traditions, etc. (Durvasula & Mylyaganam, 1994). Current research proves that the stigma is very present today in India. Since most Asian Indian immigrants arrived in the United States in the past 30 years, it is likely that they hold similar beliefs about mental illnesses. Therefore, that the stigma is carried on in the United States and may be passed on through generations (Durvasula & Mylyaganam, 1994). Sunmin et al. (2009) state that it is taboo in many Asian cultures to openly discuss mental illness. Most often people choose to hide or deny symptoms instead of seeking help. The social implication of shame is so great that they would rather not even get help and find out if they have a mental illness (Durvasula & Mylyaganam, 1994).

A recent cross-cultural study found that compared to European Americans, Asian American college students have greater aversion to help seeking, a higher concern of loss of face or shame, and their families have higher stigmas towards mental health (Gee et al., 2020). This shows that the difference of how cultures view mental health is still prominent today. The loss of face that is mentioned may be due to the increase of negative attitudes about seeking therapy for mental health in order to deal with emotional problems or stress (Turner & Mohan, 2016). Arora (2016) found that the higher one's personal stigma is, the more negative attitudes they can have towards seeking professional help for their mental health issues.

The stigma prevents people from seeking mental health care until absolutely needed, which can be harmful. One prime example is abuse. Indian society is patriarchal which can cause women to feel inferior and make men feel superior (Kumar & Nevid, 2010). In some conservative families, women are considered weak and their only role in the family is to be a wife and a mother. They are sometimes victims of assault by men in their own family. In some cases, medical care may be required but they do not have adequate resources or facilities to assist their needs (Kumar & Nevid, 2010). In many Indian families, these gender role stereotypes are considered the norm. This dynamic inadvertently makes the men in the family appear stronger and reinforces their role as the caretakers or protectors of the family. The encouragement for taking on the inferior role could explain why first- and second-generation immigrant women from India who are marginalized, reported the highest self-esteem—much higher than bicultural women—and they also have the lowest rates of depression—much lower than assimilated women (Joseph et al., 2020). That being said, there has a lot of progress in India and these cases of abuse are not as prominent as they were in the past (Kumar & Nevid, 2010).

In many conservative families, South Asian women are encouraged to take on an inferior role and taught to compromise their wants and needs to keep the marriage intact. They may also feel like they fit in more in society because they always expected life to be this way. But if physical or emotional abuse is present, psychotherapy is often sought. And in some cases, it can be too late. It has been found that suicide rates and self-harm prevalence are much higher among South Asian women than among South Asian men whereas in the Western hemisphere, the suicide rate is much higher among men (Karasz et al., 2019). Additionally, Tabassum (2017) notes that in different districts of India, women have a higher prevalence for psychiatric illness than men. Overall, it has been found that the inequalities related to gender in forms of marriage,

workplace discrimination, and poor mental health have impeded Indian women from getting the psychological help they might need (Tabassum, 2017).

In summary, the stigma associated with mental health in the Indian American community stems from the ideologies of ancient Indian culture which used to ostracize people with mental illnesses due to the lack of awareness. Although there is more awareness today than there was in the past, there is still a long way to go. The stigma continues to be prominent today in India and in the Indian American community as well.

Statement of the Problem and Hypotheses

The Indian American population is known to not seek help for mental health because of collectivistic cultural values, the lack of awareness, and the stigma associated with mental health in Asian cultures. This research study will look at these aspects and examine the difference between generations.

Since there are many factors that impede the steps to get psychological help in this community, the current study will investigate how this thought has changed over time. The field of psychology has grown enormously in the past 30 years and mental health awareness has grown along with it. Therefore, I want to create a generational study that examines the differences of perceptions of mental health care between the old and new generations. The cutoff age I have chosen is 35, because most Indian Americans have immigrated in the last 30 years. Since my research talks about how the generations are very different, I wanted to separate these groups by generation. Most parents and grandparents would fall in the older group whereas the children of said parents would fall in the younger group. The younger group will include adults aged 18-35.

Hypothesis 1: The younger group (18-35) of Indian Americans is more likely to value mental health care than the older group (36+).

Since the younger group would have grown up with more awareness and more access to mental health care than the older group, I predict that they would also be more likely to seek mental health care.

Hypothesis 2: The younger group, (18-35) of Indian Americans will have more positive attitudes towards mental health care than the older group (36+).

Because of the same reasons stated above, the younger generation would have more positive attitudes towards mental health care as they would have grown up with more awareness and more access to mental health care as well as other medical professionals such as physicians, school counselors, etc.

Hypothesis 3: The younger group (18-35) of Indian Americans is more likely to have more acculturative stress than the older group (36-70).

Previous research suggests that the 1st and 2nd generation of Indian Americans have more pressure to assimilate than immigrant Indian Americans. Since most of the immigrants moved here in the last 30 years, the older group (36-70) should be mostly comprised of immigrants and the younger group (18-35) should be mostly comprised of 1st and 2nd generation Indian Americans. Therefore, I predict that the younger group will have more acculturative stress and therefore have higher scores on a measure of acculturative stress than the older group.

Hypothesis 4: Acculturative stress and mental health seeking attitude will be positively correlated among both age groups.

This hypothesis is the combination of Hypothesis 1 and Hypothesis 3. The younger group is predicted to be more likely to seek mental health care and have more acculturative stress than

the older group. Therefore, mental health seeking attitude and acculturative stress should have a positive correlation among the younger but not the older group.

Chapter 3: Method

Participants

Participants were from a metropolitan city in the southern United States. They were also recruited online from a closed Facebook group for Indians residing in the United States. The recruitment email included the name of the study and a statement explaining that this survey asks questions about their perception of mental health and mental health care seeking attitudes. The inclusion of social media as a form of delivery allowed a wider range of people and can reduce potential setting biases. The cut off age has been chosen to be 35 because individuals younger than 35 are more likely to be more independent and individuals over 35 are more likely to have families of their own, additionally, there has been an exponential growth of Indians in the United States in the last 30 years so this number will account for that as well. There were 145 participants that took the survey, but 37 responses had to be deleted due to missing items. There were no specific patterns for items skipped but most of the responses that were deleted tended to just fill out the consent question and leave the rest of the survey blank When deciding which responses to delete, I analyzed what percent of the survey was completed by each participant. The ones that we consequently deleted had similar features such as entirely skipping some questionnaires, and most participants had just checked the consent box and left the rest of the survey blank. Therefore, a total of 108 participants successfully completed the survey. Out of the 108 participants, there were 51 men, 56 women and 1 non-binary individual. The mean age was 35.22 with a standard deviation of 11.74. The observed age range was from 18 to 60. Most (53) of the immigrants were part of the older group whereas the first, second or third generations were part of the younger group. The participants were not given compensation for participating.

Materials/ Measures

This study was a self-survey. The first page of the survey included informed consent and information regarding Internal Review Board (IRB) approval. The survey then asked questions regarding ethnicity and age demographics used to categorize in the two groups. It also included questions from the Mental Help Seeking Attitudes Scale (MHSAS) and the Social, Attitudinal, Familial, and Environmental Acculturative Stress Scale (SAFE). The Mental Help Seeking Attitudes Scale (MHSAS) was chosen because the goal of the scale is to measure how willing one is to seek mental health care. The Acculturative Stress Scale was chosen because previous research indicates that acculturative stress is a big factor as to what could be added stressors in the lives of Indian Americans. This survey tested the correlation between mental health help seeking and acculturative stress, as well as conducting group comparisons. These two scales have been used with this population separately before, but not comparatively in a single research study.

Mental Help Seeking Attitude Scale (MHSAS)

The Mental Help Seeking Attitude Scale (MHSAS, Hammer, 2018) is a 9-item self-report questionnaire that measures potential mental help seeking from a professional. The scale asks readers to respond to the following prompt: "If I had a mental health concern, seeking help from a mental health professional would be..." Responders answer on a 7-point semantic differential scale, shown to them as (3, 2, 1, 0, 1, 2, 3). They are to choose the number corresponding to how they feel about seeking mental healthcare on a spectrum of opposite adjectives. The items assessed include useless/useful, important/unimportant, unhealthy/healthy, ineffective/effective, good/bad, healing/hurting, disempowering/empowering, satisfying/unsatisfying, and

desirable/undesirable. The MHSAS has strong reliability and validity (Hammer, 2018). The Cronbach's alpha reliability of the MHSAS with the current sample was acceptable ($\alpha = .94$).

Social, Attitudinal, Familial, and Environmental Acculturative Stress Scale (SAFE)

The Social, Attitudinal, Familial, and Environmental Acculturative Stress Scale (SAFE, Mena et al., 1987) is a 24-item self-report questionnaire which measures acculturative stress stemming from social, attitudinal, familial, and environmental factors. *Social acculturative stress* is the stress experienced in social settings. *Attitudinal acculturative stress* is the stress related to culture that is experienced within oneself. *Familial acculturative stress* is the stress related to culture that is experienced in the presence of one's family or in conversations related to one's family. *Environmental acculturative stress* is the stress related to culture that is experienced in any kind of setting in which the subject is in (Mena et al., 1987). These also happen to be the subscales of this measure. Higher scores on this measure indicate someone who may feel a lot of stress to adapt to or accept a new country/culture. Respondents rate items on a 5-point scale (1 = *Not Stressful*, 5 = *Extremely Stressful*). Internal consistency for the SAFE is around .89 to .93 (Suh et al., 2016). It has previously been used for international students who come to the United States for higher education. With the present sample, internal consistencies were at or near acceptable levels for the total score ($\alpha = .89$), the social acculturative stress subscale ($\alpha = .73$), the attitudinal acculturative stress subscale ($\alpha = .67$), the familial acculturative stress subscale ($\alpha = .56$), and the environmental acculturative stress subscale ($\alpha = .69$).

Individual and Collectivism Scale (INDCOL)

Another factor that seemed to be highlighted in my research is the difference between individual and collectivistic cultures. I used a reduced version of the Individual and Collectivistic Scale (INDCOL) that consists of 14 items that tests whether one has a more individual or

collectivistic view on different aspects of their life (Sivadas et al., 2008). The individualism scale had 6 questions and the collectivism scale had 8 questions. An example of an item on the collectivism scale is “my happiness depends very much on the happiness of those around me” and an example of an item on the individual scale is “I'm not especially sensitive to other people's feelings.” The reliability for this measure should be around .85 to .94 (Sivadas et al., 2008). With the current sample, the internal consistencies for the individualism subscale (α = .42), and the collectivism subscale (α = .40) failed to reach acceptable levels. The reasoning for this may be that this specific measure may not work well with this sample. I noticed that all of the individualism items were related to competition and that may be confusing as competition is a big part of Indian culture as we know from our research that the model minority stress leads to competition between individuals (Sunmin et al., 2009).

Demographics

In order to further the research, I asked additional questions about my participants and their life outside of this study to understand more about the data I collected. Since I am looking at aspects of acculturation and enculturation, I asked the participants the degree to which they spend their time with their ethnic group or with other groups and the nature of activities spent in different contexts. I also asked them questions surrounding previous involvement/engagement with mental health services and if they know anyone that might have sought treatment for mental health concerns as this would tell us how much awareness they have about mental health care. It was decided that the measures MHSAS, SAFE, and INDCOL would be listed before the demographics eliminate biases and make sure that participants do not answer the scales with any inkling to what the scales may ask for.

Chapter 4: Results

Descriptive Statistics

To test the hypotheses, the sample was split into two age groups, 18-35 (the younger group) and 36+ (the older group). Fifty-three participants fell in the younger group category and 55 participants fell in the older group category. Eighty-three participants (76.9%) who were immigrants and 25 participants (23.1%) who were born and raised in the United States. Based on the individuals that were personally given the survey, this is what was expected. There are 54 immigrants and 1 non-immigrant in the older group and 29 immigrants and 24 non-immigrants in the younger group. When asked about their engagement with other individuals of Indian descent, 56.5% of individuals reported engagement all the time, 34.3% reported often, 8.3% reported rarely and 0.9% reported never. In addition, 17.6% of the population reported having a history of mental illness and 66.1% reported knowing someone with a mental health illness. Additionally, the older group ($M = 1.58$, $SD = .69$) engaged slightly more with other people of Indian descent that the younger group ($M = 1.49$, $SD = .69$), $t(106) = -0.69$, $p = 0.257$, but this was not statistically significant. Regarding having a history with mental illness, the younger group ($M = 1.70$, $SD = .46$) had more people report that they have a history with mental illness than the older group ($M = 1.95$, $SD = .23$), $t(106) = -3.54$, $p < 0.001$. When asked whether they know someone with a mental health disorder, the younger group ($M = 1.25$, $SD = .44$) reported knowing more people with mental health disorders than the older group ($M = 1.53$, $SD = .50$), $t(106) = -3.11$, $p < 0.001$. I also asked the immigrated participants what state of territory they came from in India. Out of the 83 immigrants, only 34 answered this item. The results are displayed in Table 1.

Table 1: *State/Union of India Where the Immigrant Participants Originated From*

State/Union of India	Number of Participants	Percent of Sample
Andhra Pradesh	5	4.6
Bihar	2	1.9
Gujarat	10	9.3
Karnataka	6	5.6
Madhya Pradesh	1	0.9
Maharashtra	23	21.3
Odisha	3	2.8
Punjab	2	1.9
Rajasthan	1	0.9
Tamil Nadu	2	1.9
Telangana	2	1.9
Uttar Pradesh	15	13.9
West Bengal	2	1.9
Total	34	31.5

Tests of Hypotheses

The first hypothesis that was that the younger group (18-35) of Indian Americans is more likely to value mental health care than the older group (36+). To test this hypothesis, there was an item in the questionnaire that asked participants on a Likert scale how much they value mental health care, this question and the age split was analyzed using a *t*-test. The younger group (M = 4.15, SD = 1.09) reported valuing mental health care non-significantly less than the older group (M = 4.40, SD = .76), $t(106) = -1.37$, $p = 0.086$.

The second hypothesis was that the younger group of Indian Americans would have more positive attitudes towards mental health care than the older group. To test this hypothesis, I compared the two groups on the MHSAS total score. The results of this test were also opposite of the expected results, with the older group (M = 53.89, SD = 10.29) reporting non-significantly

more positive attitudes than the younger group (M = 51.09, SD = 12.22), $t(106) = -1.37$, p = 0.100.

The third hypothesis was that the younger group would be more likely to have more acculturative stress than the older group. To test this hypothesis, I compared the two groups on the SAFE total as well as all the SAFE subscales. The results show that for the SAFE total, the older group (M = 62.87, SD = 17.70) had a higher level of acculturative stress than the younger group (M = 59.38, SD = 16.09), $t(106) = -1.07$, $p = 0.143$, although it was statistically non-significant.

For the social acculturation subscale, the older group (M = 14.47, SD = 5.56) reported a slightly higher level of social acculturative stress than the younger group (M = 12.66, SD = 5.11), $t(106) = -1.76$, $p = 0.041$ although it was statistically non-significant. For the attitudinal acculturative stress subscale, results were again opposite to what I predicted although they were statistically non-significant, with the older group (M = 15.84, SD = 5.16) having more attitudinal acculturative stress than the younger group (M = 15.45, SD = 5.02), $t(106) = -0.39$, $p = 0.348$. For the familial acculturative stress subscale, the younger group (M = 13.57, SD = 4.24) reported a tendency for more familial acculturative stress than the older group (M = 13.31, SD = 4.02), $t(106) = 0.32$, $p = 0.373$, but it was statistically non-significant. Lastly, for the environmental acculturative stress subscale, the results were opposite to what I predicted, with the older group (M = 19.25, SD = 5.74) reporting non-significantly more attitudinal acculturative stress than the younger group (M = 17.70, SD = 5.31), $t(106) = -1.46$, $p = 0.074$. Thus, the familial acculturative stress subscale was the only subscale that trended toward supporting the hypothesis but overall, since the results were non-significant, this hypothesis was not supported.

The final hypothesis was that acculturative stress and mental health seeking attitude would be positively correlated among both age groups. To test this hypothesis, a correlation was tested between the MHSAS and the SAFE subscales. The younger group has a significant negative correlation between acculturation stress and mental health care seeking attitudes and the older group has a significant positive correlation between acculturation stress and mental health seeking attitudes. In other words, for the younger group, the more acculturation stress one has the less likely they are to seek out mental health care and for the older group, the more acculturation stress they have, the more likely they are to seek mental health care. While the older groups results support the hypothesis, the younger groups results do not.

Table 2: *Correlation Between MHSAS and SAFE*

MHSAS	Acculturation Total	Social Acculturation	Attitudinal Acculturation	Familial Acculturation	Environmental Acculturation
Younger Group	-.523**	-.497**	-.485**	-.350*	-.368**
Older Group	.334*	.281*	.307*	.292*	.277*

Supplementary Analysis

Immigrant Status. To further examine my research questions, I tested a few additional measures and comparisons. The first thing I wanted to see was whether immigration status was in any way related to mental health seeking attitude. To do this, I first separated the sample into two groups, an immigrant group, and a non-immigrant group. To get these data, I used the question that asked what percent of your life you have lived in the United States. I placed anyone

who said 100% into the non-immigrant group and anyone who said anything else into the immigrant group. I then compared the two groups using an independent-samples *t*-test with the MHSAS. The results show that non-immigrants ($M = 53.84$, $SD = 10.07$) had a somewhat more positive mental health seeking attitude than immigrants ($M = 52.12$, $SD = 11.69$), although this difference was not significant, $t(106) = 0.66$, $p = 0.254$. I also compared the two groups on how much they valued mental health. The results of this comparison showed that non-immigrants ($M = 4.56$, $SD = 0.65$) valued mental health care significantly more than immigrants ($M = 4.19$, $SD = 1.01$), $t(106) = 1.72$, $p = 0.044$.

I next compared the immigrant and non-immigrant groups on their scores on the acculturative stress measure (SAFE). I did this using an independent sample *t*-test. These results can be found in Table 3. The results showed that immigrants had more total acculturative stress than non-immigrants. Also, the immigrants had more social acculturative stress than non-immigrants Additionally, the immigrants had more attitudinal acculturative stress than non-immigrants. The immigrants also had more familial acculturative stress than the non-immigrants. Lastly, the immigrants had more environmental acculturative stress than non-immigrants. All the results suggest that immigrants have more acculturative stress than non-immigrants but this cannot be assumed as the results are not statistically significant.

I also asked participants whether their views had changed since they had moved to the United States. I compared the younger and older groups on this item with an independent-samples *t*-test (using only the immigrant participants). There were 54 immigrants in the older group and 29 immigrants in the younger group. The results show that the older group's ($M = 4.09$, $SD = 0.830$) views had changed significantly more than the younger group's views ($M = 3.44$, $SD = 1.39$), $t(105) = -2.62$, $p = 0.005$. This question was asked on a Likert scale and 3 was

labeled as “neither agree nor disagree”, 4 was labeled as “agree”, and 5 was labeled as “strongly agree”. The younger groups mean was almost halfway between “neither agree not disagree” and “agree” and the older groups mean was much closer to “agree”. Therefore, this change was in a positive direction overall.

Table 3: *Acculturation Stress Amongst Immigrants and Non-Immigrants*

Acculturation	Non-Immigrants	Immigrants	Cohen’s d
Total	56.40 (14.96)	62.59 (17.32)	0.02
Social	12.04 (4.50)	14.05 (5.58)	0.08
Attitudinal	14.08 (4.56)	16.12 (5.15)	0.09
Familial	13.24 (3.76)	13.49 (4.23)	0.02
Environmental	17.04 (5.60)	18.93 (5.51)	0.06

Note. Standard deviations are in parentheses. * $p < 0.05$; ** $p < 0.01$.

Individualism/Collectivism. Next, I wanted to see whether individualism/collectivism scores were related to mental health seeking attitudes. For this analysis, I examined the bivariate correlation comparing the MHSAS to the two subscales of the INDCOL (individualism and collectivism). The results show that the correlations between mental health seeking attitude and these dimensions were positive but weak and non-significant—individualistic scores: $r = 0.087$, $p = 0.370$, and collectivism scores: $r = 0.101$, $p = 0.299$.

Another interesting question was whether immigration status was related to individualistic or collectivistic views. In order to test this question, I conducted an independent-samples *t*-test using immigration status and the INDCOL subscales. The results show that the non-immigrants ($M = 31.64$, $SD = 8.64$) had significantly more individualistic views than the immigrants ($M = 25.30$, $SD = 6.93$), $t(106) = 3.78$, $p < 0.001$. Alternatively, the immigrants ($M =$

51.70, *SD* = 7.55) had significantly more collectivistic views than non-immigrants (*M* = 48.48, *SD* = 7.54), *t*(106) = -1.87, *p* = 0.032. I also ran a correlation of age with all the major measures and there were no significant effects. This shows that non-immigrants relate to a more individualistic culture and immigrants relate to a more collectivistic culture.

Gender Comparisons. I also evaluated whether gender was related to mental health seeking attitudes in my sample. For this, I first used an independent-samples *t*-test with gender and MHSAS scores. The results show that women (*M* = 54.05, *SD* = 9.52) tended to report more positive mental health seeking attitudes than men (*M* = 51.08, *SD* = 12.89), though this difference was not statistically significant, *t*(106) = -1.37, *p* = 0.087.

I next examined gender differences in acculturative stress using the SAFE scales. There were no significant differences in total acculturation stress between men (*M* = 62.45, *SD* = 18.45) and women (*M* = 63.76, *SD* = 17.29; *t*(106) = -0.26, *p* = 0.934.), in social acculturation stress between men (*M* = 14.48, *SD* = 5.56) and women (*M* = 14.52, *SD* = 5.84; *t*(106) = -0.03, *p* = 0.656), in attitudinal acculturation stress between men (*M* = 15.97, *SD* = 5.71) and women (*M* = 15.71, *SD* = ; *t*(106) = 0.17, *p* = 0.256), or in environmental acculturation stress between men (M = 18.94, SD = 6.00) and women (M = 19.52, SD = 5.49; *t*(106) = -0.36, *p* = 0.675). However, there was a significant difference in familial acculturative stress between men and women. Women (*M* = 14.34, *SD* = 3.73) reported significantly more familial acculturative stress than the men (*M* = 12.57, *SD* = 4.27), *t*(105) = -2.29, *p* = 0.012.

Lastly, I examined how gender related to individualism and collectivism (INDCOL) scores. The results show that women (*M* = 28.29, *SD* = 8.02) scored higher on individualism than men (*M* = 25.24, *SD* = 7.30), *t*(105) = -2.05, *p* = 0.021. The male participants (*M* = 51.55., *SD* = 7.73) tended to score higher on collectivism than the female participants (*M* = 50.20, *SD* = 7.45),

$t(105) = 0.92$, $p = 0.179$. These results suggest that the women in this sample relate more to an individualistic culture and the men relate more to a collectivistic culture but this cannot be assumed as the results were not statistically significant.

Chapter 5: Discussion

The purpose of the research was to see whether there is a difference in the way younger Indian Americans and older Indian Americans perceive mental health. I also wanted to analyze if younger Indian Americans have more acculturative stress than older Indian Americans. I also examined whether perception of mental health and acculturative stress was related to immigration status and gender. Lastly, I examined whether older and younger Indian Americans related more to individualistic or collectivistic cultures and whether immigration status related to such views.

Mental Health Care Seeking Attitudes

According to previous research, there is more awareness now about mental health than there was in the past (Durvasula & Mylyaganam, 1994). From this trend, I assumed that the younger people value mental health more than older individuals. But when testing the first hypothesis (that the younger group would value mental health more than the older group), I found the results were non-significant and therefore cannot support the hypothesis. Additionally, when I tested the second hypothesis (that the younger group would have more positive attitudes towards mental health care than the older group), I again found the results to be non-significant and therefore cannot support the hypothesis.

However, my supplementary analyses showed that non-immigrants value mental health care more than immigrants. My results also showed that immigrants have more collectivistic views than non-immigrants which supports previous research (Innman & Yeh, 2007).

Another interesting finding was that both age groups saw a positive change in views but there was a significant difference between the groups. The older group reported significantly more change in their views about mental health care than the younger group. A possible

reasoning for this finding is that the times have changed, and we know that there is more awareness in the world about mental health today. Therefore, younger population may have been brought up in a more accepting society in both countries and therefore the level of change is different. Lastly, I wanted to see if gender related to the perception of mental health. I found that overall, both men and women in this sample have positive views on mental health care.

Acculturation Stress

According to the research, first and second-generation Indian Americans have more stress when trying to find the proper balance between their cultures (Sunmin et al., 2009). So, the hypothesis that I tested was that the younger group would have more acculturative stress than the older group. Yet again, my findings were non-significant and cannot support the hypothesis.

Although the supplementary analysis shows us that immigrants reported more acculturative stress than non-immigrants. A possible reason for this result is that acculturative stress may be more immediate now than it was in the past. The study that I had used to make this prediction was published in 2009, and in the intervening years, there has been even more growth of the Indian American population in the United States and more growth of immigrants in the United States in general (Pew Research Center, 2020), which leads to more diversity overall. More diversity may lead to more comfort in being different and diverse. The first and second generations may not feel the need to find the balance between the cultures and may feel more accepted in social settings. But we do know that immigrants do struggle initially when moving to a new country (Londhe, 2015). This may be the difference in the acculturative stress between the two groups.

Relationship Between Mental Health Seeking Attitude and Acculturation Stress Between the Younger and Older Groups

The most interesting finding of this study was the correlation of the MHSAS and SAFE for both the younger and older groups that can be found in Table 2. My hypothesis was that the mental health seeking attitude and acculturation stress will be positively correlated for both groups, but this was only true for the older group. For the younger group, the more acculturation stress they have, the more negative attitudes they have towards seeking mental health care. For the older group, the more acculturation stress they have, the more positive attitudes they have towards seeking mental health care. This was very surprising as previous research indicated that the older group should have more hesitation seeking mental health care (Durvasula & Mylvaganam, 1994). But in this case, it is the younger group that has the hesitation regarding acculturation stress.

Regarding the younger group, some possible explanations may be that acculturation stress essentially means the stress to “fit in”. Going to seek mental health care may make individuals feel more out of place than before as they must acknowledge the problem, and then solve the problem by talking to someone else about their issues. This may highlight their issues more and make them feel insecure about their feelings. Additionally, younger individuals may be more reckless or may not understand their feelings and may not seek the proper care that they need due to the lack of maturity (Duangpatra et. al., 2009). Lasty, the younger group may not feel that acculturation stress is a big enough stressor to seek mental health care for.

For the older group, some possible explanations may be that the new culture that they are in (United States) teaches them to go and seek mental health care when you are worried or stressed about anything. Additionally, older individuals are more likely to have a family and

children and their mental health indirectly affects their family, so they may be more willing to seek mental health care as they are responsible to be healthy for their family. Lasty, older individuals are less reckless than younger individuals (Duangpatra et. al., 2009) and therefore may take care of themselves more than the younger group which would lead them to seek mental health care.

Individualistic and Collectivistic Cultures

The differences between individualism and collectivism were a reoccurring theme in my results. India is a collectivistic culture whereas the United States is an individualistic culture (Yeh & Inman, 2007). Although it was not a part of the main hypotheses, it was important to do supplementary analyses since this subject may have been one of the contributing factors to mental health care seeking attitudes and acculturative stress.

I also found that although both immigrants and non-immigrants in my sample relate to the collectivistic culture more than the individualistic culture, immigrants relate more to the collectivistic culture than non-immigrants and non-immigrants relate more to an individualistic culture than immigrants. This is understandable as immigrants from India would have grown up in a more collectivistic culture and non-immigrants in the United States would have grown up in a more individualistic culture. It also makes sense that the overall sample reported higher collectivism scores, since the Indian culture itself is more collectivistic and since everyone is of Indian descent.

Additionally, when analyzing gender differences, I found that overall, both genders relate more to the collectivistic culture than the individualistic culture. But surprisingly, women have a higher score on the individualism scale than men and men have a higher score on collectivism than women. According to my research, women in the Indian culture are taught to be inferior and

have a more compromising role in the family than men (Kumar & Nevid, 2010). But this finding does not support that statement. A possible explanation is that moving to the United States has invoked more individualistic values in females. Another possibility is that in recent years there has been more awareness about feminism and the feminist movement through social media and other internet resources (Jain, 2020). It is possible that the idea of feminism as it is related to independence and self-dependency has evoked a change.

Limitations

There were many limitations to the present research, the first being the sample size. If there had been double or more participants instead of 108, I might have had more accurate data and maybe more significant results as more participants will make the data more reliable. Also, many friends and family members of the researcher were contacted to participate in this study and therefore may have views on these topics that are similar to the researchers. Also, most of the immigrants came from the state of Gujarat or the state of Maharashtra in India, meaning that the results might be reflective of people from these areas of India. For further research, it would be beneficial to include a larger population.

Additionally, there is a lack of studies discussing mental health and Indian Americans specifically. My study was an initial foray into this research area. Additionally, there is not much research regarding Indian Americans and acculturative stress. If there was more research, there could have more factors to analyze that I may be missing regarding acculturative stress and mental health seeking attitudes of Indian-Americans, such as more information on immigrants and how they have overcome change in a new country, what immigrants' perceptions are of the new country and the older country, and maybe more additional challenges that they may have faced that were not indicated in these findings.

The MHSAS scale and the SAFE Acculturative scale had good internal reliability, but the INDCOL scale did not. When reflecting back onto the questions of the INDCOL, it may have not been the best scale for this population. The reason for this is that many of the individualistic questions pertain to being competitive (Sunmin et al., 2009). As we know from my research, Indian culture is very competitive due to the pressure of being the model minority. But as we also know from my research, Indian culture is collectivistic. This could explain why the responders may have related to both the individualistic and collectivist questions.

Implications for Future Research

To address the question of whether there is a difference of views of mental health in India and the United States, it would be best to conduct a longitudinal study. First have a new set of immigrants take the MHSAS survey when they first arrive in the United States, and then periodically, maybe every 2-3 years have them take it again and see if there are changes to their responses as they adjust to the new culture. It would be interesting to also give the SAFE to these individuals to see if their acculturation stress changes from when they first arrive. Additionally, it may be interesting to conduct this study in India for people who have immigrated to India from the United States and non-immigrants of India and see if they have a different perspective. Since there has already been so much advancement in the field of mental health, it might be interesting to see how the responses would be different a decade from now.

Conclusion

This study was conducted to analyze the difference of opinions about mental health care and acculturation between the younger and older populations as well as immigrants and non-immigrants of the United States. My findings show that overall, the participants value mental health and they also have positive attitudes about mental health. Additionally, the sample overall

has moderate levels of acculturation stress. However, there were not many significant differences between the groups. Some significant findings between the groups are that non-immigrants value mental health care more than immigrants and non-immigrants also related more to the individualistic culture and the immigrants related more to the collectivistic culture. Immigrants also have seen a much bigger change in their views about mental health care than non-immigrants. Also, the older group's perception about mental health care had changed more significantly than the younger groups. Lastly, women related more to the individualistic culture and men relate more to the collectivist culture.

The results tell us that although previous research has observed that Indian Americans do not have positive views about mental health care, this research tells me that is not the case. The reasoning for this may be that the previous results are outdated and there has been a difference of opinion in the last decade. More awareness about mental health, more resources for mental illnesses and more understanding about the science of mental health may have contributed to this change. Additionally, one key difference between the older immigrants and younger immigrants was that the older group saw more change in their views when they moved to the United States. Lastly, the biggest revelation of this study was that for younger individuals, the more acculturative stress they have, the less likely they are to seek mental health care and for older individuals, the more acculturation stress they have, the more likely they are to seek mental health care. This could also be due to more resources in the United States than India and more awareness about the topic. The development of technology has significantly aided in spreading the importance of mental health care and mental illnesses in India and around the world and we hope that this continues to be the case for the years coming.

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