ASIAN INDIAN AMERICAN STUDENTS: ATTITUDINAL MOTIVATION TO SEEK MENTAL HEALTH SERVICES

By

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ABSTRACT

Help seeking attitudes and acculturation of Asian Indian Americans were examined in this study by taking a sample consisting of 69 Asian Indian American students. Participants completed a demographic questionnaire, the Suinn-Lew Asian Self-Identity Acculturation Scale and the Attitudes toward Seeking Professional Psychological Help Scale. There were no significant relationships between levels of acculturation and motivation or attitudes toward seeking help. Reasons why professional help would not be sought included alternative sources of support and prohibitive cost. In seeking assistance, the participants preferred family first, followed by mental health professionals and then religious persons. Religion also played a major role in deciding the tolerance and help seeking behaviour of the people. Specifically, results demonstrated no significant difference between the low acculturated and bicultural groups for attitudes toward seeking psychological help.

INTRODUCTION

Colleges and universities, by their very nature, are investing in promoting academic success for students. One factor of particular interest is motivation, a characteristic viewed as crucial for academic success and attrition reduction (Dembo, 2004; Dennis, Phinney, & Chuateco, 2005; Ridgell & Lounsbury, 2004). Motivation in higher education is critical across cultures and has been studied in Kuwaiti students (Alkhadher, 2007), Egyptian students (Abdel-Khalek & Throson, 2006), Chinese students (Dai, 2007), Japanese students (Saint Arnault, Sakamoto, & Moriwaki, 2005), and Asian Indian students (Reece & Palmgreen, 2000). Studies of Asian Indians have included motivation to engage in physical activity for older participants (Kalavar, Kolt, Giles, & Driver, 2004; Kolt, Giles, Driver, & Chadha, 2002), the role of knowledge for empowerment of patients with diabetes (Stone, Pound, Pancholi, Farooqi, & Khunti (2005), and an examination of role identity for Indian-born women living in the United States (Ramaswamy, 2002). However, some of the studies related to Asian Indians have been dissertation studies that have not yet published in peer reviewed journals. Thus, there is a paucity of research on motivational factors in Asian Indians, in general, and in higher education particularly. One would not be surprised, then, that there is a dearth of literature concerning the mental health needs of Asian Indians, the third largest Asian subgroup in the United States. Little is known about the help-seeking attitudes of Asian immigrants to the U.S., despite the possibility that psychological distress levels for these groups may be higher, often due to the immigration experience and the difficulties associated with adjustment to a new culture (Sharma, 1994). There has been an influx of Asian immigrants into the country, and the number continues to increase substantially.

In the 2000 US census, there were 10,019,405 Asian Americans residing in the United States and of that number, 1,678,765 are Asian Indians (US Bureau of the Census, 2000). According to the Overseas Indian online magazine (2007), the Asian Indian populations today is over 2.3 million with a growth rate of about 41% over the period 2000 to 2005. Despite this high number, Asian Indians have been greatly ignored in the sphere of psychology, and most of the research conducted on this subgroup has been anthropological or sociological in nature (Mehta, 1998). A possible reason that Asian Indians have been largely neglected in research within the United States may be that they are seen as a relatively well adjusted community because of their educational and financial advancement (Nagra, 2005).

An important factor to consider in the utilization of mental health services is the need for services. Even though only

minimal research has been conducted in the United States regarding the mental health status of Asian Americans, studies from the rest of the world report substantial mental health problems. Studies done in Singapore, Taiwan, Korea, and China indicate a high prevalence of mental disorders in Asian countries (Nagra, 2005). Based on this evidence, the assumption that Asian American immigrants are a model minority, free of psychological symptoms, is not accurate. Research has revealed that Asian Americans display higher levels of depression than European Americans (Aldwin & Greenberger, 1987; Kuo, 1984; Kuo & Tsai, 1986; Loo, Tong & True, 1989; Nagra, 2005;). Verghese and Beig (1974) has shown that there is a high prevalence of depressive disorders in India. Social conditions, interpersonal problems, and cultural meanings play a significant role in the experience and interpretation of the Indian depressive symptomatology, according to Raguram, Weiss, Keval, & Channabasavanna (2001). A study in Great Britain examined the suicide levels and patterns among Asian Indian immigrants; it was reported that the highest suicide rates were among women, the young, and especially the young married women (Nagra, 2005; Raleigh, Bulusu, & Balarajan, 1990). In addition, Iwamasa (1997) reported that the experiences of immigration, such as leaving behind family members and poor living conditions on arrival in the U.S., may create stress for this population, possibly making them likely candidates for the development of anxious symptomatology (Nagra, 2005).

Fernandez (1998) reported that Asian Indians in the San Francisco area were less likely to receive promotions than their European American counterparts or were not equally financially compensated for similar jobs. Even though Asian Indians are considered to be advanced educationally and occupationally, most reported experiencing stress due to racial discrimination based on their skin color, physical appearance and foreign accent (Buchignani, 1980; Cochrane, Hashmi, & Stopes-Roe, 1977; Nagra, 2005). According to Jones and Korchin (1982), the small number of Asian Americans who utilize mental health services indicate underutilization of the such facilities rather than lack of problems. It can be inferred from this finding that it is not a lack of need that results in underutilization of mental health services by Asian Indians but, rather, the attitudes toward counseling which impact their motivation toward help-seeking behaviors. In order to better understand these attitudes, one must consider the cultural system of Asian Indians and the possible reasons for them to underutilize mental health services.

An important aspect to keep in mind is that a significant diversity exists even in the subgroup of Asian Indians. India is a nation with twenty-eight states and most of them have their own languages, festivals, religions, traditions, and sub-cultures making it a heterogenous country. Many religions are practiced in the country, Hinduism being the most predominant, followed by Christianity, Islam, Sikhism, Buddhism, and Jainism. As a result of this diversity, there is a great difference between the northern, southern, eastern and western parts of the country (Nagra, 2005). Flaskerud (1986) reported that the underutilization of mental health services can be connected to the stigma and shame that is associated with mental illness in the culture, an unresponsive and inaccessible mental health service system, inconvenient location and lack of knowledge of services, and beliefs about mental illness and its treatment.

The common factor and the most integral unit of the Asian Indian culture is family. Everything in an individual's life centers around the family and, as in most collectivistic cultures, the decisions one makes impact every other member in the family. The Asian Indian population has been characterized as being highly educated professionals who are strongly committed to maintaining family connections, both in America and in India (Solmayor, 2001). Asian Indians value family relationships above everything else, and anything that brings shame and dishonor to the family name must be avoided at all costs.

According to Janzen and Harris (1997), Asian Indians are hesitant to use services that are likely to expose the family in a negative manner. They further note that shame and fear of losing face is an adverse experience in the Asian

Indian culture that can serve to motivate conformance to community and family expectations. Sue and Sue (2003) noted that the public discussion of family problems is seen as a source of embarrassment and as an indication of the family's failure. Asian Indians would rather seek help from family or community members in assuaging their problems and in finding solutions.

Expression of problems by Asian Indians is limited to the family system and stays within its boundaries. This deficit of outwardly expressing problems, mental or otherwise, is associated with the concept of stigma to the family (Solmayor, 2001). There is also a social stigma associated with seeking help for psychological services since it is a foreign concept to many Asian Indians. Individuals might fear that they will be labeled "crazy" if they are to seek psychological help since it is a common notion in the culture that only severely distressed people use mental health services. Psychological services are seen as a last resort only if familial and community help were not effective or available. In a 1985 survey conducted by Saran, some respondents indicated that they believed time would cure psychological problems. For those respondents who reported somewhat favorable attitudes toward psychiatry, many of them were highly aware of the strong stigma associated with seeking help for mental health problems (Sharma, 1994).

Similar to people in India, it seems that Indians in the United States are also hesitant to seek professional help when they experience psychological problems. Due to the social stigma that exists in the culture, Asian Indians may turn to resources such as the extended family, friends, elders, indigenous healers, religious rituals, meditation, or yoga to manage psychological distress (Desai & Coelho, 1980).

Another factor that impacts the utilization of mental health services is the expectation that the Asian Indian client has towards counseling or therapy. According to Berg & Jaya (1993), service providers hardly know or understand the long-standing tradition of solving problems through meditation and negotiation rather than head-on-confrontation.

According to Steiner & Bansil (1989), somatization is frequent among Indian patients as well. In a study of Indian students in the United States, researchers found that students rarely used the services of the student counseling center; however, these same students utilized the health center extensively and had higher rates of complaint in areas usually related to the physical expression of stress such as psychosomatic or pain complaints, gastrointestinal problems, and generalized vague symptoms (Klein, Alexander, Miller, Haack, & Bushnell, 1986; Sharma, 1994). The researchers concluded that the interplay between somatic complaints and psychological distress may be an effort by the client to disacknowledge psychological difficulties. In short an Asian Indian individual is hesitant in admitting to psychological distress because of the familial and social stigmatization of psychological disorders.

A consideration in the utilization of mental health services by Indian Americans are the sources of support among them. As mentioned before, family is the main source of support when confronted with problems, either physical or mental. Apart from family, religion is also an important source of support because Asian Indians are characterized as being strongly rooted in religion (Solmayor, 2001). Religious practices and rituals are held and observed in a social context that draws together individuals with common beliefs, thereby creating a context for social interaction, a sense of belonging and intimacy (Tarakeshwar, Stanton & Pargament, 2003). In order to maintain a sense of cultural identity and the transmission of religious tradition to the next generation, Asian Indian families socialize not only exclusively with their own ethnic group but also within their religious groups (Solmayor, 2001).

Eck (2000) reported that Hindus in the United States celebrate annual religious festivals, regularly attend services at temples, and honor multiple deities, serving to strengthen the bond between one's native culture and one's current identity. Therefore, seeking help outside of the family is contained within the cultural community. If the family needs outside help, priests will be approached

first, then public sources, such as their personal physicians, and lastly psychiatrists (Root, 1985). Laungani (1994) reported that, when compared to individuals in Great Britain, those in India did not perceive stress as requiring the expertise of psychologists or psychiatrists; instead, they used indigenous forms of medicine and healing, yoga, and religion to cope with their situations. This perception of stress is likely to affect the motivation to seek help in individuals who immigrate to America and, also, impact their utilization of mental health services.

Asian Indians who come to the United States face the challenge of choosing the culture of origin to release or retain at one time or another. It has been reported that Indian immigrants have assimilated quite easily at a structural level, but cultural assimilation has been minimal and the desire to maintain cultural heritage is strong within the Indian community in America (Saran, 1987). Sodowsky & Carey (1988) identified three distinct groups among Asian Indian immigrants varying on level of acculturation. Sixty-five percent of the respondents fell into a category that was designated "mostly or very Asian Indian." Members of this group preferred to wear Indian clothing, eat Indian food, and think and speak mostly in an Indian language. They had a strong belief that Indians should adhere closely to their traditional values, customs, religious practices, and cultural rituals. Twenty-one percent of respondents categorized themselves as "bicultural" and had a preference for both Indian and American clothing styles, ate both Indian and American food, thought and read in both English and an Indian language, and tended not to be extreme with cultural attitudes. The smallest group of seven percent labeled themselves as "mostly or very American," and typical of this group is a preference for American food, Western styles of dress, and use the English language. Saran (1987) offered evidence to the existence of these three different groups, of which the largest group is highly characterized by its Indian heritage, resistant to new values and life in a marginal status in American society. The majority of the people in this category were recent immigrants from India.

Generation is an important variable with relation to acculturation. Asian Indian immigrant parents and their children may experience more extensive value conflicts than parents and children reared in the same culture (Sharma, 1994). The conflict is created by the notion that children with parents of Asian origin have to conform to a set of cultural expectations that differ from those of the culture in which the child is being raised. Indian immigrant parents want to maintain their traditional values by transmitting them to their children. However, children while demanding more freedom and equality, most of the Indian parents generally allow because of the influence of peer groups and their extensive exposure to American society. As a result, tension and conflict rise within the family. Most Indian parents have a traditional background that has made it difficult for them to accept the more Westernized ideas and practices of their children. Children of immigrants tend to be more assimilated into American cultural values than their parents (Sodowsky & Carey, 1987). The issue of being different than their peers and being considered "too Americanized" by their parents is common among second-generation Indian Americans (Sue & Sue, 2003). In one study, an Asian Indian daughter described her parents as displaying a "museumization of practices." On a trip to India, she discovered that there was a wide difference between her parents' version of "Indian" and what Indians in India actually did; her parents' version was much more restrictive (Das Gupta, 1997). Saran and Leonhard-Spark (1980) believed that the matter of parent-child relationships is the most pressing issue the Indian community is facing.

Asian Indians in the United States, especially male college students, may have a considerable level of stress as a population (Nagra, 2005). Indian American college students might experience more stress because they fear academic failure since academic achievement is valued highly in Indian culture. The higher amount of stress in males is due to the fact that they carry the financial burden of the family, and they are pressured to obtain employment soon after receiving their graduation to care for their family. Another reason is that since family is the greatest source of emotional and social support, leaving

them to come to America would mean that they are not readily accessible anymore, which can cause psychological distress especially for international students from India who might not know anyone in the United States.

To summarize, research with Asian Indians suggests that there is an underutilization of mental health services by this population. It has also been reported that it is not the lack of problems that stops Asian Indians from seeking help for psychological problems but rather it is the attitudes toward mental health services that affect motivation. General cultural factors would include reliance on family for emotional support similar to other collectivistic cultures, fear of bringing shame and disgrace to one's family, stigmatization of seeking help for mental health issues in the culture, and lack of ethnically inappropriate mental health services. The attitudes of Asian Indians living in the United States toward mental health services are most likely to depend upon the factor of acculturation. It has been noted in studies that highly acculturated individuals hold more positive attitudes toward mental health than those individuals who maintain traditional values and are more likely to be motivated to seek help for psychological problems. Therefore, investigations into the relationship between acculturation and attitudes towards mental health services will be particularly useful in offering psychological help for this particular population.

This study examined attitudinal motivation factors of Indian Americans towards utilization of mental health services, reasons for underutilization that have been reported among this particular population, and the effect acculturation has on these attitudes. The study differs from previous researchers as it attempts to investigate the impact of acculturation on help seeking attitudes and motivation for this particular population. It adds to the literature on utilization by providing a better understanding of reasons ethnic minorities, such as Asian Indians, underutilize mental health services and the role that assimilation into the American culture plays in utilization.

Three particular research questions were explored in this study:

1) Are the reasons for the underutilization of mental health services reported by Asian Indians consistent with previous research and minority attitudes toward seeking psychological help?

2) To what extent do factors such as the number of years participants have been living in the U.S., age upon arriving in the U.S., fluency in the English language indicate acculturation in Indian Americans?

3) Does acculturation affect attitudes toward seeking help for mental health issues? In particular, are highly acculturated individuals more likely to seek psychological help than those less acculturated individuals?

Methodology

The sample consisted of college students who were born in the United States as well as those who were born in India. The inclusion criterion for students who were born in the United States was that both parents must be from India. There were 155 participants initially; however, only 69 completed the questionnaires. The rest of the participants failed to complete the lengthy questionnaires. There were no significant differences for the demographic variables between those who completed and did not complete the questionnaires (age and gender). The final sample consisted of 69 participants who were students of Sam Houston State University, a rural regional institution, and University of Houston, an urban institution, and were recruited from various Asian Indian organizations. Overall, the sample included 40 males (58%) and 29 females (42%) between the ages of 18-32 with the majority being between the ages of 21-26 (83.9%). Approximately one-third (30.9%) reported being engineering majors; additional fields were indicated as well, such as nursing, information technology, business, and medicine. The majority of participants classified themselves as graduate students (37.7%), 18.8% as juniors, 17.4% as seniors, 5.8% as sophomores, and 20.3% as other.

The majority of the respondents were single (89.9%). One-half (52.2%) of the participants reported that they were Hindus and 22.1% indicated that they were Christians. Out

of the 67 participants who reported annual household income, 49 indicated income between $40,000 and above $100,000 which demonstrates that they belong to the middle and upper class sector. A little more than half (58%) indicated that they were financially independent. Thirty-one (40.6%) participants reported being US citizens. More than two-thirds (69.6%) indicated that they were born in India; and 17.4% reported the US as their country of birth. Most of the participants (40) came to the United States after the age of 15 years with 25 of them indicating that they arrived in the US after the age of 20. Almost half of the participants (44%) indicated that they had been in the US for five years or less, and 18.8% reported that they had lived in the US for more than 20 years. A majority of the respondents (65.2%) reported that they had been exposed to the Western or American culture before arriving in the United States. Only 18 of the participants (26.1%) were educated in the US during the primary grades, 36.5% during high school, and 55.1% during college. Frequency analysis revealed that 43% planned to live in the US permanently, 20.3% indicated that they were not so inclined, and 36.2% reported that they were unsure. A large majority of the participants (94.2%) indicated that they had never previously sought help from a mental health professional.

The *Demographic Questionnaire* was developed for the present study. *It* consisted of 20 items that requested information reported in the previous section.

The Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA).

Level of acculturation for Asian Indian participants was assessed by the SL-ASIA. This particular scale was selected because of its psychometric validity and its wide use among cross- cultural studies including research with Asian Indian participants (Menon, 1994; Shah, 2000). The SL-ASIA was modeled after the Acculturation Rating Scale for Mexican Americans to be an objective measure of acculturation (Cuellar, Harris, & Jasso, 1980). It consists of 26 items which assess the multidimensionality of bicultural development by addressing values, attitudes, behaviors, language, identity, friendships, and generational / geographic background. The SL-ASIA has been shown to have strong content validity as reported by Suinn and colleagues (1992, 1995). Participants are asked to choose one response for each item that best described them using a 5-point scale, where responses on the low end would reflect highly Asian-identified characteristics and responses on the high end of the scale would indicate highly Western-identified characteristics.

An acculturation score was obtained by summing across the answers for the first 21 items and then dividing the total score by 21, yielding scores ranging from 1 to 5 (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). Mean scores range from 1 (low acculturation) to 5 (high acculturation), and a score of 3 indicated a bicultural individual. Originally, the SL-ASIA was a 21 item scale that operationalized the Sue and Sue (1973) model of Asian American ethnic identity (Chou, 1999). Five more questions were added (Nos. 22 through 26) to account for research which indicated that acculturation is a multidimensional and orthogonal construct in that individuals can, for example, believe strongly in both Asian and Western values rather than it being a linear and unidimensional construct (Suinn, Khoo, & Ahuna, 1995). Two questions measure values (Nos. 22 and 23), two measure behavioral competencies (Nos. 24 and 25) and one question measures self-identity (No. 26). Suinn suggests that scoring of items 22-26 be done separately from scoring of the first 21 items in order to obtain additional classification of data from a categorical viewpoint, as opposed to the continuum scoring for the first 21 items.

Reliability, concurrent validity, and factorial validity were reported for the SL-ASIA using a sample of Asian American university students (n = 284). Consistent with alphas reported in other studies, Cronbach's alpha was found to be .91 (Suinn, Ahuna, & Khoo, 1992; .88 by Suinn, et al., 1987; .89 by Atkinson & Gim, 1989; .87 by Tata & Leong, 1994). Cronbach's alpha for the current study was .85.

Attitudes Toward Seeking Professional Psychological Help Scale

It was developed by Fischer and Turner (1970) and consists of 29 items representing four subscales that underlie the following help seeking attitudes:

1) Need - the recognition of need for professional psychological help; low scores on this subscale would indicate that an individual sees little need for professional help for emotional difficulties and believes that such problems will resolve themselves,

2) Stigma - or the tolerance of stigma associated with seeking psychological help; low scores indicate a sensitivity to other's opinions if the individual were to seek help from a mental health professional,

3) Openness - or interpersonal openness regarding one's problems which refers to an individual's willingness to reveal problems to a mental health professional and,

4) Confidence - in the mental health profession and the individuals who work in that field. Participants are asked to rate the items on a scale of disagree strongly (1) to agree strongly (6). In this study, a modified version of the scale (Sharma, 1994) was used in which the participants were asked to rate the items on a scale of disagree (1) to agree (4). Out of the 29 items, eleven are stated positively and the remaining eighteen are negatively stated.

A test-retest reliability of .83 was reported by Fischer and Turner (1970) and subscale alpha coefficients of .67 (need), .70 (stigma), .62 (openness), and .74 (confidence). Cronbach's alpha for the current study was .67. This instrument was used to assess the attitudes of Asian Indians toward the utilization of mental health services in this study.

Participants were asked to complete the three instruments online and did not have to provide any identifying information. A page break was inserted before the questionnaires and by clicking the *continue* button, participants gave their informed consent.

Results

Data analyses were performed using SPSS 15.0 computer program (2006). Descriptive statistics and ANOVAs with Scheffe Post Hoc comparisons, alpha = .05, were used in the analysis of the data. Although a number of analyses were performed, alpha level was set at .05 to provide a more liberal interpretation since the present study was exploratory in nature.

Analysis of reasons that might influence participants' motivations to forego consulting a mental health professional indicated the following: 39.1% reported alternative sources of support, 26.1% indicated cost, 15.9% said that they did not believe in it, 15.9% believed that the Western therapist might not understand their problems, 11.6% reported stigma/shame, 8.7% reported difficulty finding an Indian therapist, 5.8% indicated family disapproval, and 1.4% reported religious beliefs. When given choices, over half (55.1%) reported that the person they would consider most reliable to consult about emotional problems was a senior relative or family member, 30.4% indicated a mental health professional or physician, and 14.5% reported a religious authority or community elder. When asked if they would prefer a counselor from the same ethnic group; 20.3% said yes, and 29% said no, and 49.3% indicated that they were not sure.

A majority of the participants reported slightly positive attitudes toward seeking psychological help. On the ATSPPHS scale, more than half of the participants (63.9%) indicated that they would obtain professional psychological help no matter who knew about it, and the majority of participants (70.8%) reported that they would want to obtain professional help if they experienced emotional problems for a long period of time.

The items on the SL-ASIA were summed and averaged to produce a score from 1 to 5. Recall that 1's indicated low acculturation, 3's bicultural, and 5's high acculturation. The individuals who had scores between 1.51 and 2.50 were classified as less acculturated, between 2.51 and 3.50 as bicultural, and between 3.51 and 4.50 as more acculturated. There were no scores less than 1.5 or higher than 4.51. Thirty individuals fell into the low acculturation group, 39 were in the bicultural group and the remaining three individuals belonged to the high acculturation group. Since there were only three individuals in the high acculturation group, only two groups (low acculturation and bicultural) were used for the one way ANOVA.

A one-way ANOVA was performed with the ATSPPHS total score as the dependent variable and the acculturation scores (low acculturation and bicultural groups) as the independent variable. The results did not reveal a

significant difference ($F_{1,67}$ = 2.26, ns) between the low acculturated group (M = 72.00, SD = 10.24) and the bicultural group (M = 75.59, SD = 9.50) on the attitudes toward mental health scale. There were significant differences for some of the factors that might affect acculturation such as religion, place of birth, US citizenship and plan to live permanently in the United States. There was a significant difference for religion between those who reported Christianity and Hinduism in that more Hindus were in the low acculturated group and the bicultural group included more Christians ($X^2_{(3)}$ = 11.213, p <.011). A significant difference was also found for place of birth; individuals who were born in the USA tended to be more bicultural than those who were born in India ($X^2_{(2)}$ = 16.003, p <.000). Citizenship was also found to be a significant factor in that US citizens tended to be more bicultural than no- citizens ($X^2_{(1)}$ = 12.59, p <.000). On the question, "Are you planning to live permanently in the U.S.?" the low acculturation group (Yes, 7; No, 11; Undecided, 12) differed significantly ($X^2_{(2)}$ = 12.18, p <.002) from the bicultural group (Yes, 23; No, 3, Undecided 13). This indicates that people who were less acculturated apparently did not plan to live in the US permanently compared to the bicultural individuals.

Additional ANOVAs were performed with various variables as the independent variables and the five scales of the ATTSPPHS as the dependent variables. A sex difference appeared on the Recognition of Need for Psychotherapeutic help subscale, the recognition of need for professional psychological help; low scores on this subscale would indicate that an individual sees little need for professional help for emotional difficulties and believes that such problems will resolve themselves ($F_{(1, 67)}$ = 6.66, p = .01). Females (M = 20.07, SD = 3.51) recognized more need than males (M = 17.75, SD = 3.80). Stigma Tolerance was the dependent variable that displayed several instances of significance. Recall that Stigma Tolerance is the tolerance of stigma associated with seeking psychological help; low scores indicate sensitivity to others' opinions if the individual were to seek help from a mental health professional. There was a marginal difference ($F_{(2, 66)}$ = 3.73, p = .04) between those who were undecided about permanently living in the US (M = 14.52, SD = 2.49), those definitely not planning to live in the US (M = 13.29, SD = 3.05), and those planning to live in the US (M = 12.67, SD = 2.59). There was also a significant difference ($F_{(1, 52)}$ = 6.73, p = .01) for reported religion and Stigma Tolerance with Christians being more sensitive to the stigma (M = 12.33, SD = 2.33) and Hindus reporting less sensitivity to the stigma (M = 14.14, SD = 2.45). When asked the question, "Were you exposed to Western culture before coming to the US," there was a significant difference ($F_{(1, 57)}$ = 6.12, p = .02) between those who were (M = 14.09, SD = 2.76) and those who were not (M = 12.00, SD = 2.75). Interpersonal Openness regarding, an individual's willingness to reveal problems to a mental health professional, was significant when the independent variable was Language ($F_{(2,66)}$ = 4.90, p = .01) with those preferring to speaking only English (M = 18.25, SD = 1.67) significantly different from those who prefer to spoke an Indian language and English about equally (M = 15.66, SD = 2.24) and those who prefer to spoke mostly English and some Indian (M = 15.70, SD = 2.25). Finally, there were significant differences for the dependent measures of Total Mental Health Attitude Scale ($F_{(3, 64)}$ = 4.123, p = .01), Stigma Tolerance ($F_{(3, 64)}$ = 3.12, p = .03), and Interpersonal Openness ($F_{(3, 64)}$ = 3.77, p = .02). The reported academic majors were assigned to four categories: Bio/Medicine, Engineering, Business, or Other. Post hoc analysis indicated Bio/Medicine Total Scores (M = 78.00, SD = 11.80) were significantly higher than Other Total Scores (M = 66.50, SD = 10.69), indicating that the Bio/Medicine group had more positive attitudes toward seeking mental health assistance. Likewise, Bio/Medicine Stigma Tolerance (M = 14.20, SD = 2.83) was significantly higher than Other Stigma Tolerance (M = 11.57, SD = 3.06), indicating that the Bio/Medicine majors reported less sensitivity regarding any stigma attached to seeking help. When Interpersonal Openness was the dependent variable, Business majors (M = 17.28, SD = 1.78) reported more openness than Other majors (M = 14.93, SD = 2.27).

Discussion

Little is known about the help seeking attitudes of Asian

Indian Americans; however, it has been reported that their cultural background leads toward negative attitudes (e.g., Sue & Sue, 2003). Therefore, it was expected that our sample of Asian Indian Americans would have negative attitudes toward seeking psychological help. The role acculturation plays in determining attitudes toward seeking professional help is also examined in this study. It is expected by the researcher that the more acculturated individuals were, the more positive were their attitudes. The results demonstrated that, despite of previous assumptions, Asian Indians hold positive attitudes toward seeking psychological help. It was also found that acculturation levels do not significantly influence help seeking attitudes. A significant difference was not found between low acculturated and bicultural individuals for attitudes toward mental health.

The results further revealed that participants' reasons for not seeking professional help, consistent with previous research, were due to the availability of alternative sources of support, which is related to the collectivistic nature of the Asian culture. Participants also indicated cost, the lack of belief in psychological help, and the Western therapist's inability to understand their problems as major reasons. Contrary to previous notions, however, stigma/shame and family disapproval were not principal reasons for the motivation to seek or not to seek professional help. This was a surprising result since psychological problems in previous research were usually considered a stigma in the Indian culture (see Janzen & Harris, 1997). As the sample consisted of second generation college students, it is possible that they do not consider family disapproval or the risk of shame in the society as hindrances to seeking psychological help. This also indicated the fact that even though most participants would prefer to talk to a senior relative or family member, they would consult a mental health professional if it was necessary.

We also found that years of living in the USA, age upon arriving in the USA, and fluency in the English language influenced acculturation scores. Low acculturation scores were found among those having been in the U.S five years or less and among those who came at an older age. Asian Indian individuals born in the United States tended to be more acculturated into the mainstream American culture according to their music, movie, and food preferences. The low acculturated individuals considered themselves basically Indian, whereas more acculturated individuals considered themselves either basically American or a blend of both cultures. We also found that factors such as place of birth, religion, citizenship, and plans to live permanently in the United States had an effect on acculturation. According to the results, Christian citizens who were born in the United States and had plans to live permanently in the US tended to be more assimilated into the mainstream American culture than Hindu non citizens who were born in India and did not have plans to live permanently in the USA.

The sample taken for the study suffered from a lack of highly acculturated persons which made it difficult to draw conclusions in regard to that group. A significant relationship did not emerge between low acculturated and bicultural individuals for attitudes towards mental health. Most of the participants of the sample had some previous exposure to Western culture prior to arriving in the USA; this may have served as a shaping influence on their help seeking attitudes. Another possibility may have been that attitudes toward mental health are changing in the Indian culture, especially in the younger generation, and it is reflected in our results. Since many participants reported no stigma or shame related to help-seeking behavior from a mental health professional, any negativity toward mental health services is possibly due to personal choices and not cultural influences. Only five of the participants reported having used mental health services previously, and they were in the bicultural group. The lack of highly acculturated individuals in the present study is possibly due to social desirability for the sake of not being too "Americanized" which caused participants to rate themselves more Indian than American or as bicultural.

Conclusion

In considering the results of our report, one should keep in mind that the sample consisted of only college students or recent graduates who were second generation Asian

Indian Americans. Additionally, the modified scale used for the Attitudes Toward Seeking Psychological Help Scale represented a change, as noted above; the Sharma (1994) instrument with a four-point rating scale rather than the Fischer and Turner (1970) six-point scale could have affected the results. Most of the participants were born in India; thus, the sample was not evenly distributed. Finally, another point to ponder is that the nation of India as a diverse country with many subcultures. For example, someone migrating to the USA from a metropolitan city may have an entirely different view about psychological help than someone hailing from a remote village.

Hopefully, this study is a small step toward increasing our understanding of the help seeking attitudes of Asian Indian Americans. As our world becomes increasingly diverse it is imperative that greater effort be aimed at understanding varying cultures, and, thus, assisting those in professional service to render aid. By better understanding individuals' help seeking attitudes and motivations; it becomes increasingly possible to provide people with the assistance they need.

References

[1]. Abdel-Khalek, A. M., & Thorson, J. A. (2006). Religiosity and death anxiety in American and Egyptian college students. In M. V. Landow (Ed.) *College Students: Mental health and coping strategies*. Pp. 167-185). Hauppauge, NY, US: Nova.

[2]. Aldwin, C. & Greenberger, E. (1987). Cultural differences in the predictors of depression. *American Journal of Community Psychology, 15(6),* 789-813.

[3]. Alkhadher, O. (2007). Emotional intelligence and psychological health in a sample of Kuwaiti college students. *Perceptual and Motor Skills, 104*, 923-936.

[4]. Atkinson, D.R. & Gim, R.H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 36(2),* 209-212.

[5]. Berg, I.K. & Jaya, A. (1993). Different and same: Family therapy with Asian American families. *Journal of Marital and Family Therapy, 19(1),* 31-38.

[6]. Buchignani, N. (1980). Accommodation, adaptation, and policy: Dimensions of South Asian experience in Canada. In V. Ujimoto & G. Hirabayashi (Eds.), *Visible minorities and multiculturalism: Asians in Canada.* Toronto: Butterworths.

[7]. Chou, E.L. (1999). Predictors of treatment acceptability, willingness to see a counselor, and counselor preferences for Asian-Americans and Whites: Acculturation, loss of face, self-construals, and collective self-esteem. *Dissertations and Theses Proquest, 60(8).* 4209B. (UMI No. AAT9941303).

[8]. Cochrane, R., Hashmi, F., Stopes-Roe, M. (1977). Measuring psychological disturbance in Asian Immigrants to Britain. *Social Science and Medicine, 11,* 157-164.

[9]. Cuellar, I., Harris, L.C., & Jasso, R. (1980). An acculturation scale for Mexican-American normal and clinical populations. *Hispanic Journal of Behavioral Sciences, 2,* 199-217.

[10]. Dai, G. (2007). Functional universal of goal orientation: A cross-cultural study (China, United States). *Dissertation Abstracts International: Section B: The Sciences and Engineering, 67(12-B.* 7412. (UMI No. AAI 34246916).

[11]. Das Gupta, M. (1997). "What is Indian about you?" A gendered, transnational approach to ethnicity. *Gender and Society, 11,* 572-596.

[12]. Dembo, M. H. (2004). *Motivation and learning strategies for college success: A self-management approach* (2nd ed.). Mahwah, NJ, US: Lawrence Erlbaum Associations.

[13]. Dennis, J. M., Phinney, J. S., & Chuateco, L. I. (2005). The role of motivation, parental support, and peer support in the academic success of ethnic minority first-generation college students. *Journal of College Student Development, 46*, 223-236.

[14]. Desai, P.N., & Coelho, G. (1980). Indian immigrants in America: Some cultural aspects of psychological adaptation. In P. Saran, & E. Eames (Eds), *The new ethnics: Asian Indians in the United States (pp.363-386).* New York, NY: Praeger.

[15]. Eck, D.L. (2000). Negotiating Hindu identities in

America. In H. Coward, J.R. Hinnells, & R.B. Williams (Eds.), *The South Asian diaspora in Britain, Canada, and the United States* (pp. 219-237). New York, NY: State University of New York Press.

[16]. Fernandez, M. (1998). Asian Indian Americans in the Bay area and the glass ceiling. *Sociological Perspectives, 41(1),* 119-149.

[17]. Fischer, E.H. & Turner, J.L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*, 79-90.

[18]. Flaskerud, J.H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal, 22,* 127-141.

[19]. Iwamasa, G.Y. (1997). Asian Americans. In S. Friedman (Ed.), *Cultural issues in the treatment of anxiety* (pp. 99-129). New York, NY: Guilford Press.

[20]. Janzen, C., & Harris, O. (1997). *Family treatment in social work practice.* Itasca, IL: F.E. Peacock.

[21]. Jones, E.E., & Korchin, S.J. (1982). *Minority mental health*. New York: Praeger.

[22]. Kalavar, J. M., Kolt, G. S., Giles, L. C., & Driver, R. (2004). Physical Activity in older Asian Indians living in the United States: Barriers and motives. *Activities, Adaptation & Aging, 29*, 47-62.

[23]. Klein, M.H., Alexander, A.A., Miller, M.H., Haack, L.J., & Bushnell, N.J. (1986). Indian students in the United States: Personal and professional issues in cross-cultural education. *Studies in Third World Societies, 38,* 115-132.

[24]. Kolt, G. S., Giles, L. C., Driver, R., & Chadha, N. K. (2002). Exercise participation motives in older Asian Indians. *Psychological Studies, 47(1-3)*, pp. 139-147

[25]. Kuo, W.H. (1984). Prevalence of depression among Asian-Americans. *Journal of Nervous & Mental Disease, 172*(8), 449-457.

[26]. Kuo, W.H. & Tsai, Y.M. (1986). Social networking, hardiness and immigrant's mental health. *Journal of Health & Social Behavior, 27(2),* 133-149.

[27]. Laungani, P. (1994) Cultural differences in stress: India and England. Counseling *Psychology Review, 9*(4), 25-37.

[28]. Loo, C., Tong, B., & True, R. (1989). A bitter bean: Mental health status and attitudes in Chinatown. *Journal of Clinical Child & Adolescent Psychology, 17(4),* 283-296.

[29]. Mehta, S. (1998). Relationship between acculturation and mental health for Asian Indian immigrants in the United States. *Genetic, Social & General Psychology monographs, 124*(1), 61-78.

[30]. Menon, M. (1994). Ascertaining the relationship of acculturation and the perception of in psychological stress, self-concept, and locus-of-control, among Asian Indian immigrants the United States of America. *Dissertations and Theses Proquest, 55(6).* 2388B. (UMI No. AAT 9428892)

[31]. Ministry of Overseas Indian Affairs (Ct). Overseas Indian: Connecting India with its Diaspora. Retrieved October 7, 2007, from http://www.overseasindian.in /2006/aug/news/23n1.shtml

[32]. Nagra, A. (2005). Psychological health and mental health services utilization in Asian Indians in the United States. *Dissertations and Theses Proquest, 66 (5).* 2834B. (UMI No. AAT 3176267)

[33]. Raleigh, V.S., Bulusu, L., & Balarajan, R. (1990). Suicides among immigrants from the Indian subcontinent. *British Journal of Psychiatry, 156,* 46-50.

[34]. Raguram, R., Weiss, M.G., Keval, H., & Channabasavanna, S.M. (2001). Cultural dimensions of clinical depression in Bangalore, India. *Anthropology & Medicine, 8,* 31-46.

[35]. Ramaswamy, M. G. (2002). An exploration of role-related identity in India-born Indian women living in the United States and Anglo-American women. *Dissertation Abstracts International: Section B; The Sciences and Engineering, 63(6-B)*, 3070. (AAI 3056110)

[36]. Reece, D., & Palmgreen, P. (2000). Coming to America: Need for acculturation and media use motives among Indian sojourners in the US. *International Journal of Intercultural Relations, 24*, 807-824.

[37]. Ridgell, S. D., & Lounsbury, J. W. (2004). Predicting academic success: General intelligence, "big five" personality traits, and work drive. *College Student Journal, 38*, 607-619.

[38]. Root, M.P.P. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy, 22,* 349-356.

[39]. Saint Arnault, D., Sakamoto, S., & Moriwaki, Aiko. (2005). A cross-cultural study of the experiential structure of emotions of distress: Preliminary findings in a sample of female Japanese and American college students. *Psychologia: An International Journal of Psychology in the Orient, 48*, 254-267.

[40]. Saran, P. (1985). *The Asian Indian experience in the United States*. New Delhi: Vikas.

[41]. Saran, P. (1987). Pains and pleasures: Consequences of migration for Asian Indians in the United States. *The Journal of Ethnic Studies*, *15*, 23-46.

[42]. Saran, P., & Leonhard-Spark, P.J. (1980). Attitudinal and behavioral profile. In P.Saran & E. Eames (Eds.), *The new ethnics: Asian Indians in the United States (pp. 163-176).* New York, NY: Praeger.

[43]. Shah, S. (2000). The composition of self-esteem in second generation Asian Indian and mainstream European American college women: A comparative study. *Dissertations and Theses Proquest, 61(4).* 2221B. (UMI No. AAT 9972242)

[44]. Sharma, P. (1994). Asian Indian attitudes toward seeking professional psychological help. *Dissertations and Theses Proquest, 55*(10). 4614B. (UMI No. AAT 9506090)

[45]. Sodowsky, G.R., & Carey, J.C. (1987). Asian Indian immigrants in America: Factors related to adjustment. *Journal of Multicultural Counseling and Development, 15,* 129-141.

[46]. Sodowsky, G.R., & Carey, J.C. (1988). Relationships between acculturation-related demographics and cultural attitudes of an Asian Indian immigrant group. *Journal of Multicultural Counseling and Development, 16,* 117-135.

[47]. Solmayor, P. (2001). Underutilization of mental health services by Asian Americans. *Dissertations and Theses Proquest, 39(6).* 1517MAI. (UMI No. AAT 1404493) SPSS, Inc. (2006). SPSS 15.0 for Windows. Chicago: Author

[48]. Steiner, G.L., & Bansil, R.K. (1989). Cultural patterns and the family system in Asian Indians: Implications for psychotherapy. *Journal of Comparative Family Studies, 20,* 371-375.

[49]. Stone, M., Pound, E., Pancholi, A., Farooqi, A., & Khunti, K. (2005). Empowerinig patients with diabetes: A qualitative primary care study focusing on South Asians in Leicester, UK. *Family Practice, 22*, 647-652.

[50]. Sue, S. & Sue, D.W. (1973). Chinese American personality and mental health. In S. Sue & N. Wagner (Eds.), *Asian Americans: Psychological perspectives* (pp.111-124). Palo Alto, CA: Science and Behavior Books, Inc.

[51]. Sue, D.W. & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice*. New York: John Wiley & Sons.

[52]. Suinn, R.M., Ahuna, C., & Khoo, G. (1992). The Suinn-Lew Asian Self-Identity Acculturation Scale: Concurrent and factorial validation. *Educational and Psychological Measurement, 52*(4), 1041-1046.

[53]. Suinn, R.M., Khoo, G. & Ahuna, C. (1995). The Suinn-Lew Asian Self-Identity Acculturation Scale: Cross-cultural information. *Journal of Multicultural Counseling and Development, 23*(3), 139-148.

[54]. Suinn, R.M., Rickard-Figueroa, K., Lew, S., & Vigil, P. (1987). The Suinn-Lew Asian self-identity acculturation scale: An initial report. *Educational and Psychological Measurement, 47*(2), 401-407.

[55]. Tarakeshwar, N., Stanton, J., & Pargament, K.I. (2003). Religion: An overlooked dimension in cross-cultural psychology. *Journal of Cross-Cultural Psychology, 34*(4), 377-394.

[56]. Tata, S.P. & Leong, F.T.L. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. *Journal of Counseling Psychology, 41(3),* 280-287.

[57]. US Bureau of the Census (2002). Profiles of General Demographic Characteristics 2002. _Retrieved October 5, 2006, from http://www.census.gov/population/www/socdemo/race/api.html

[58]. Verghese, A. & Beig, A. (1974). Neuroses in Vellore town. *Indian Journal of Psychiatry, 16*, 1-6.

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