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Introduction: South Asian Americans (from Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka) were one of the fastest growing ethnic groups in the United States in the last two decades. According to the United States Census 2010, over 3.4 million South Asians live in the United States; however, this group has been largely understudied in the field of mental health. Cultural expression of symptoms of mental illness in South Asian immigrants may vary significantly from those in westernized culture, or symptoms may cluster in different ways in various ethnic groups. Acculturation also plays a significant role in health seeking behavior. Recent immigrants may be less acculturated, which may contribute to additional stress and mental health problems that go unnoticed under the “model minority myth”. Acquiring more information about the mental health-seeking behaviors of South Asians may help to promote culturally appropriate care, health education, and improve health outcomes of South Asians.

Objective: The purpose of this secondary analysis was to determine the relationships between acculturation, medical mistrust, family resources, demographics and anxiety and depression in South Asians immigrants.

Methods: The parent study employed a cross-sectional, descriptive design with 330 South Asians immigrants recruited in community settings and interviewed in English, Hindi, and Gujarati based on the respondents’ preference.

Results: The mean age of the participants was 58.9 years, the majority were married, and from India. Depression was related to the acculturation subscale of language; medical mistrust; the money, basic needs, and time subscales of family resources; and quantity and quality of social support, and being Hindu. Higher mean anxiety was significantly related to age, medical mistrust, money, basic needs, and time, quantity and quality of social support. In the final regression analyses, depression was predicted by gender, medical mistrust and having a regular physician, while anxiety was predicted only by having a regular physician.

Discussion: Overall, South Asian immigrants reported low levels of depression and anxiety but these mental health problems were associated with less support and resources. Clinicians may want to not only assess for the presence of anxiety and depression but also identify the resources and support available to patients.

Key words: South Asian, anxiety, depression, mental health, acculturation.

INTRODUCTION

South Asian Americans (SAA) (from Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka) were the fastest growing ethnic group in Asian Americans between 2000 and 2010, according to the United States Census 2010. Over 3.4 million South Asians live in the United States; the SAA community as a whole grew 81% over the decade (saalt.org, 2012).

Mental health is closely connected with physical well-being, but it often may be overlooked or neglected because of stigma, cultural beliefs and medical mistrust. Study findings suggest that SAA tend to display emotional pain in physical terms or through physical complaints (Raguram, Weiss, Channabasavanna, & Devins, 1996; Rao, Young, & Raguram, 2007). Additionally, family and religion play a big role in mental health seeking behavior among SAA, who traditionally tend to rely on family for emotional support; seeking outside help may be considered as self-serving (Sayegh, Kellough, Otilingam, & Poon, 2013). Cultural expression of symptoms of mental illness in SAA may also vary significantly from westernized cultural expressions, or symptoms may cluster in different ways in different ethnic groups (Fenton & Sadiq-Sangster, 1996). Changes to current healthcare practice are needed to adequately address the needs of the SAA community to reduce health disparities. Acquiring more information about the health-seeking behavior of SAA may help to promote culturally appropriate care, health education, alleviate barriers, and improve health outcomes for this community.

PURPOSE

The purpose of this study was to determine the relationships between acculturation, medical mistrust, and family resources on anxiety and depression in South Asian immigrants in the United States.

RESEARCH HYPOTHESES/ QUESTIONS

The specific research questions were posed:

- 1) What is the relationship of predisposing factors (acculturation, medical mistrust, cultural beliefs and stigma about mental illness) with anxiety and depression in SAA?
- 2) What is the relationship of enabling factors (access to care, family resources and social support) with anxiety and depression in SAA?

- 3) How do sociodemographic factors explain anxiety and depression?
- 4) Do predisposing and enabling factors vary across sociodemographics?
- 5) What is the combined effect of predisposing and enabling factors on anxiety and depression in SAA?

LITERATURE REVIEW

In United States there are over 3.4 million South Asians and they present the largest growing minority population among Asian Americans with a growth rate of 81% over the last decade and 106% in the previous decade 1990-2000 (US Census 2010). However, this group has been seriously understudied in the field of mental health. One of the primary limitations is the clustering of South Asians in a broad Asian or Asian American and Pacific Islander (AAPI) group. Question number 6 of the US Census pertains to a person's race as White, African American/ Black, American Indian or Native Alaskan, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Samoan, Guamanian, Other Pacific Islander, or Other Asian, where smaller minority groups would have to type in their ethnicity (Pakistani, Laotian, Hmong, etc.). Health information on SAA is unclear and incomplete because of such grouping. SAA remain largely understudied (Roa, Akram, Levy, & Bhattacharya, 2002). More research is necessary to be able to adequately address the health needs of this underserved population and provide a culturally sensitive approach to diagnosis, treatment and health-seeking behavior.

Approximately two-thirds of SAA are foreign born; the majority (87%) of SAA are of Indian origin (Barnes & Bennett, 2002). The "model minority myth" as an idealized representation of the SAA minority group; the myth has resulted in many positive and negative outcomes for both the affluent and low-income segments of the community (Chaudhary, Vyas, & Parrish, 2010; Kanukollu & Mahalingam, 2011). Among the general population, SAA are seen widely as an upwardly mobile, high achieving group, defined by the successes of science professionals who comprised a large group of post-1965 immigration from South Asia (Masood, Okazaki, & Takeuchi, 2009). Indeed, some South Indian Americans are very successful and different from other Asian groups. Asian Indians report the highest annual income among all Asian immigrants, and 25% above the national average (Barnes & Bennett, 2002) and higher rates of college education. This largely positive portrayal of SAA as healthy, wealthy and invincible works against many members of the community and overshadows the problems

experienced by many recent immigrants from South Asia who may lack education, resources and access to care. The rates of uninsured SAA (21%) are higher than that of general population (Menon, Szalacha, & Prabhughate, 2012).

Besides public perception, Kanukollu and Mahalingam (2011) suggested that internalization of the idealized identity is one of many negative consequences of the model minority myth, and has contributed to masking the circumstances that are seen as shaming the community or one's family. Positive idealized identities can be a motivating factor for one's success and ethnic pride, it can also be a significant factor for distress as immigrants feel pressured to live up to the explicit and implicit expectations of one's ethnic group (Kanukollu & Mahalingam, 2011). Among other things, we can speculate that the model minority myth significantly affects SAA health seeking behavior, including seeking professional health for anxiety and depression.

For recent immigrants, being less westernized may contribute to additional stress, and affect mental health. Certain mental health issues may go unnoticed under the “model minority myth”. In addition, acculturation plays a significant role in health seeking behavior. Knowing how levels of acculturation correlate with levels of anxiety and depression in this sample of SAA living in Chicago could help target certain groups that are more susceptible to mental health problems and lead to a change in nursing practice.

Sayegh et al. (2013) also noted gaps in research and have conducted studies on older SAA and Middle Easterners in regards to dementia, mood disorders, and anxiety disorders. Cultural consideration of barriers to assessment and diagnosis in SAA is important. These barriers include health beliefs, role of family, and generational status in the United States, educational level, social class, and acculturation experiences (Sayegh et al., 2013).

Multiple studies highlighted that mental illness in South Asians specifically tends to be expressed first through somatic symptoms, with psychological symptoms revealed only after specific query (Raguram et al., 1996; Rao et al., 2007; Sayegh et al., 2013). One of the reasons leading to somatization of mental illness was perceived stigma attached to psychological problems. However, Rao et al. (2007) proposed that degree of Westernization was associated with the presentation of more psychological symptoms. No studies reported on correlations between acculturation and anxiety and depression, and acculturation and medical mistrust in SAA.

THEORETICAL FRAMEWORK

The Precede-Proceed Model (Glanz, Rimer, & Viswanath, 2003) was used to assess variables associated with mental health outcomes. Predisposing variables are antecedents that provide rationale for behavior changes, such as acculturation, medical mistrust, cultural beliefs, and stigma about mental illness. Enabling variables are external resources that facilitate behavior change, such as access to care, family resources, and social support. Reinforcing factors were not considered because they provide information about health behavior change in the long-term and their use would not be appropriate in a cross-sectional study.

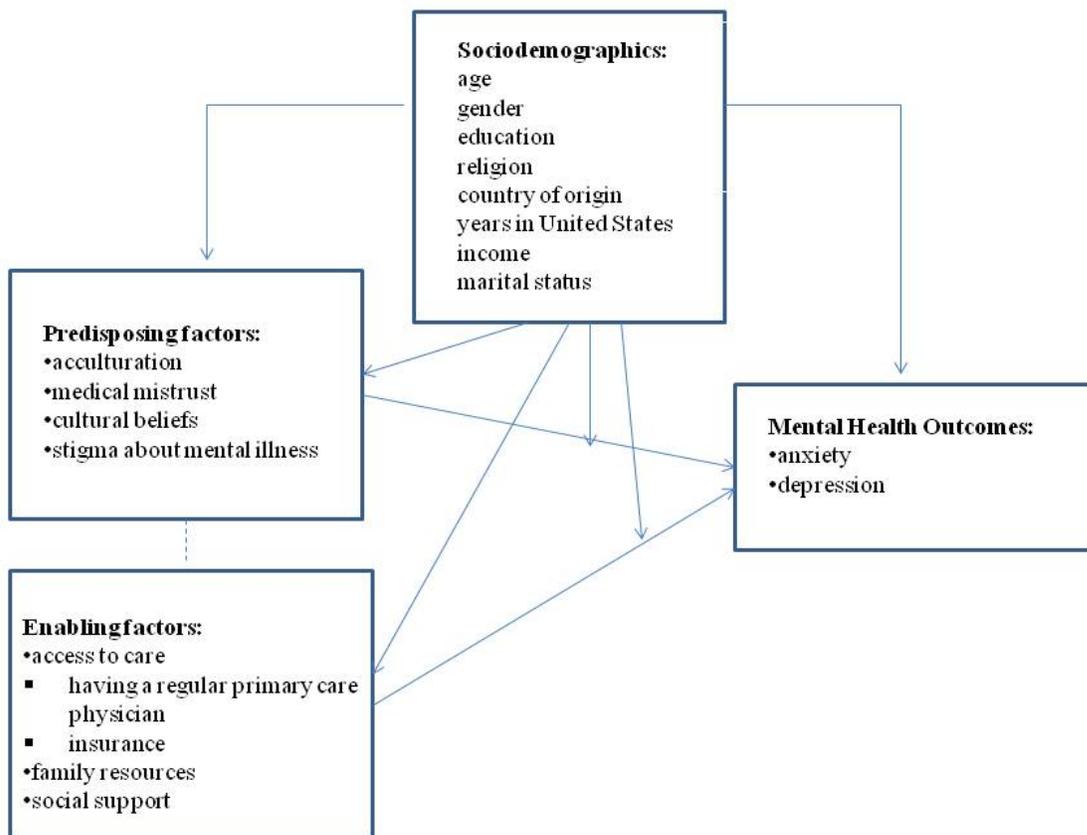


Figure 1. Conceptual framework of the study

CONCEPTUAL AND OPERATIONAL DEFINITION OF VARIABLES:

Predisposing factors are antecedents that provide a rationale for behavior change (Glanz et al., 2003; Menon et al., 2011). Predisposing factors such as acculturation, beliefs about mental illness, medical mistrust, and mental health stigma are discussed below.

A. Acculturation**Conceptual definition:**

Acculturation is a process that occurs when two or more cultures interact with each other. Merriam-Webster dictionary (2014) defines acculturation as cultural modification of an individual, group, or people by adapting to or borrowing traits of another culture; or a process by which a person acquires the culture of a particular society from infancy. The possible outcomes of acculturation process are assimilation - when a host culture absorbs the immigrant culture, and multiculturalism, when the two cultures can exist side by side (Suinn, Ahuna, & Khoo, 1992). On an individual level, a person either resists the change in his/her values and behavioral skills or adopts the host culture's values and behavioral skills to a certain degree. Identity involves individuals' self-perception or subjective statement of his/her character.

Operational definition:

The Suinn-Lew Acculturation scale (SL-ASIA scale) was used to measure the degree of acculturation of Asian American participants, it originally consisted of 21 items; later the authors added 5 additional items. The original version of SL-ASIA acculturation scale was used. The scale consists of three identity subscales based on language (reading/writing/cultural preference), culture (ethnic interactions, food preference, entertainment preference), and parents (generation identity) (Suinn et al., 1992). The scale included 21 items, the 5-points scales are offered ranging from "only South Asian" (1) to "only English" (5); answers to each question are added up and then divided by total value of 21. The score can range from 1.00 (low acculturation) to 5.00 (high acculturation). SL-ASIA scale has been successfully used with participants across a wide range of ages (Suinn et al., 1992).

B. Beliefs about Mental Illness**Conceptual definition:**

Beliefs about mental illness are negative stereotypical beliefs (Sayegh et al., 2013). Cultural beliefs are rooted in religion and culture about etiology and treatment of mental illness. Prior research examined normalization of mental illness and conceptualized it as a normal component of aging presenting a barrier to assessment and treatment among SAs (Sayegh et al., 2013).

Operational definition:

In this study, beliefs of two types were examined: the belief of incurability of mental illness and belief that people with mental illness have poor interpersonal skills. Therefore, two subscales of the Beliefs Toward Mental Illness (BTMI) scale will be used: “poor interpersonal and social skills” subscale and “incurability” subscale (Hirai & Clum, 2000). The BTMI scale has 16 questions, which are divided into three categories measuring perceived danger of people with mental illness, belief of incurability of mental illness and beliefs about people with mental illness having poor social skills. Each question is measured on 6-point scale from “1 - completely disagree” to “6 - completely agree”.

C. Medical Mistrust

Conceptual definition:

Medical mistrust is defined as perception of how much an individual trusts their health care provider.

Operational definition:

The Group-based Medical Mistrust Scale (GBMMS; Shelton et al., 2010) was used to assess the level of medical mistrust in SAAs. There is a growing evidence of higher rates of medical mistrust among minority groups, acting as a barrier to health care participation and adherence to recommended health behavior (Shelton et al., 2010). The scale consists of 12 items, with answers ranging from “strongly agree” (5) to “strongly disagree” (1).

D. Mental Health Stigma

Conceptual definition:

Stigma about mental health can be conceptually defined as an individual’s perceptions of the stigma associated with seeking professional counseling for mental health problems (Komiya, Good & Sherrod, 2000).

Operational definition:

Stigma about mental health was measured using the Stigma Scale for Receiving Psychological Help (SSRPH), and adapted for cultural relevance (Komiya et al, 2000). SSRPH is a five item scale with answers ranging from “completely disagree” (1) to “completely agree” (4) and is aimed at understanding respondents’ opinion about how stigmatizing it is to seek help from a mental health practitioner.

Enabling factors are external resources that facilitate behavior change (Glanz et al., 2003).

Based on extant literature, specific variables were identified from past research; they include access to care, family resources, and sense of social support.

A. Access to care

Conceptual definition:

Access to care is defined as the ability to get healthcare as well as pay for it.

Operational definition:

Access to care is measured by two questions about having a regular primary care physician (PCP) and health insurance.

B. Family Resources

Conceptual definition:

Family resources are defined by adequacy of family resources.

Operational definition:

This variable was measured using Family Resources Scale (FRS; Dunst & Leet, 1987). FRS uses three subscales: (1) basic needs, (2) money, and (3) time. Items are arranged hierarchically, from the least basic resource that can affect an individual’s well-being (Menon et al., 2011). The FRS consists of 30 questions total, with 4-point scales, ranging from “not at all adequate” (1) to “almost always adequate” (4). The scale also allows participants not to respond if the item is not applicable to their family “does not apply” (0).

C. Social Support

Conceptual definition:

Social support is an individual’s perception of the amount of available social support and the quality of social support.

Operational definition:

Sense of social support was measured using Sense of Support Scale (SSS; Dolbier & Steinhardt, 2000). SSS measures both qualitative and quantitative aspects of social support perceived by respondents. The scale includes 20 items with answers ranging from “not at all true” (1) to “completely true” (4).

Outcomes include: levels of anxiety and depression measured with the Patient Health Questions on anxiety and depression.

Sociodemographic characteristics are defined as the general social and demographic characteristics of a population. In the current study these include age, gender, education, marital status, country of origin, years in the United States, employment status, income, and religion.

METHODS

STUDY DESIGN AND SAMPLE

We performed a secondary analysis on data collected from 330 SAA in Chicago, IL. The parent study used a cross-sectional, descriptive design. Interviews were conducted in-person with SAA in three community-based agencies that provide health and immigration services (Menon et al., 2011), in English, Hindi, or Gujarati based on the respondents’ preference. The parent study was approved by the University of Chicago Institutional Review Board (IRB). The current analysis was approved by the Ohio State University IRB.

The eligibility criteria for the parent study were: 1) being South Asian by country of birth (India, Pakistan, Bangladesh, Bhutan, Burma, and Sri Lanka), 2) age 40 or older, and 3) ability to speak and understand English, Hindi or Gujarati.

RECRUITMENT AND DATA COLLECTION

Recruitment and data collection procedures have been previously described (Menon et al., 2011). Informed consent was obtained prior to survey implementation.

DATA ANALYSIS

Data were analyzed using the IBM SPSS statistical package. Results from this secondary analysis will be disseminated via scientific presentations/posters and a publication in a relevant journal.

Descriptive statistics (mean, standard deviation, median, range for continuous variables, and frequency for categorical variables) were used to describe the participant population. Multiple regression analysis was used to determine the effect of multiple variables on each outcome.

Bivariate analyses were conducted on all sociodemographics, predisposing and enabling factors and the outcome variables of anxiety and depression using t-tests, Pearson r correlations, chi square or analyses of variance (ANOVA) as appropriate to the level of data. All variables significant at $p \leq .10$ were included in multivariable linear and logistic regression model for each outcome.

RESULTS

Mean age of the sample of 330 was 58.9 years (SD 10.49 years). The majority of participants were married, or had a partner; and most (89%) had emigrated from India.

Anxiety and depression were strongly correlated ($r=0.783$; $p \leq .001$). Most significant correlations were weak to moderate. Lower language acculturation, higher medical mistrust, lower family resource scale (FRS) money, lower basic needs, and less time were significantly related to higher depression ($r = -0.151$; $p \leq .01$; $r=0.155$; $p=0.005$; $r=-0.325$; $p \leq .01$; $r=-0.252$; $p < .001$; $r = -0.206$; $p \leq .01$, respectively). There was a weak negative correlation between higher depression scores and lower quantity of social support ($r = -0.227$; $p \leq .01$), and lower quality of social support ($r = -0.252$; $p < .001$).

Mean scores for medical mistrust ($F=3.20$, $p \leq .05$), mental health stigma $F=2.01$, $p \leq .05$), basic needs subscales of family resource scale (FRS) ($t=2.52$, $p \leq .05$), money and time subscales of FRS ($t=6.77$, $p \leq .01$, & $t=2.32$, $p \leq .05$), and quality ($t=3.47$, $p \leq .01$) and quantity of social support ($tF=2.16$, $p \leq .05$) were significantly different by low or high anxiety (Table 1).

No statistically significant differences were found in mean anxiety and depression scores by gender, marital status or education level. Among religious groups, being Hindu ($N=146$) was associated with higher levels of depression ($F=3.25$, $p \leq .001$). However, for anxiety scores there was no significant difference by religious group (See Table 2).

Linear regression models were run for depression with variables significant at $p \leq 0.10$. Four models were fit; the referent is the category against which other groups were compared (Table 3). Model 4 represents the full model. Of the sociodemographic variables, only

gender, and of the enabling variables, only medical mistrust and having a physician were significant predictors of depression (Table 3). Gender was a mild predictor with men having higher depression compared to women. Medical mistrust and having a physician were slightly stronger predictors of depression and more so for men than women.

Anxiety was divided into two groups of high and low because of the skewed distribution (majority reporting lower levels of anxiety). In the final model, only having a physician was significant (Table 4). That is, those that reported having a regular physician were .23 times less likely to report higher anxiety.

DISCUSSION

The SAA population in the United States has been largely understudied for several reasons. One of the reasons is clustering of SAA under the AAPI group for US Census purposes and ambiguous answer options to question number 6 about person's race on US Census questionnaire, such as "Other Asian", "South Asian", or "Other Pacific Islander". The need to disaggregate the data is necessary in order to provide sensitive care to one of the largest growing immigrant population in the United States. The rapid growth of the SAA population began relatively recently, after 1965 (Roa et al., 2014); and healthcare system needs time to better understand and provide appropriate care to South Asians. While SAA have been stereotyped as a "model minority", due to the success stories of science and health professionals who emigrated after 1965, it does not always match reality. The "model minority myth" does not account for recent SAA immigrants, some of whom lack education, resources and access to care (Roa et al., 2014). The results of this study closely matched the SAA population distribution in the U.S., with Asian Indian Americans comprising 89% of population (vs. 84% in this study). The rates of uninsured in SAA (21%) are higher than that of general population. More than a half of SAA population in this study (55%) immigrated after 1990, and in the current sample about 56.8% of SAA reported living in the U.S. for more than 10 years by 2008 (Menon et al., 2012).

The majority of the sample reported lower levels of anxiety. Neither anxiety nor depression was very high in this sample, which may be a function of that fact that we recruited the sample from those attending social agency groups. No predisposing factors were significantly related to either anxiety or depression. Several enabling factors were related to anxiety and

depression in bivariate analyses but in the combined effect of the regression models, only gender, medical mistrust and having a regular physician predicted higher depression, and having a regular physician predicted lower anxiety. Not surprisingly, anxiety and depression were strongly and positively correlated.

These exploratory findings speak to the importance of regular health care for SAA. In clinical practice, particularly in primary care, it is important to understand there may be subgroup differences in the occurrence of anxiety and depression. More research is warranted with larger samples of SAA from different cities in the U.S. as the current study has limited generalizability. Although we attempted robust, committee-based translation (Menon et al., 2011), some findings in the parent study may have been influenced by the translated questions.

Lastly, the secondary analyses were driven in part by the data already collected in the parent study. There may be additional predictors of anxiety and/or depression not included in this model. In general however, the findings add to the knowledge base in an area that is understudied and underreported in the literature. These results may have implications for public health nursing, because people of with limited family resources and less social support should be screened and educated about mental health. Knowing more about South Asians may help to promote culturally appropriate care, health education, screening, and improve health outcomes of SAA population.

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TABLES

Table 1: Relationships among continuous predisposing factors, enabling factors depression and anxiety.

Measure	Depression r	Anxiety		t-test Statistic
		No M (SD)	Yes M (SD)	
Acculturation: Culture	-0.069	1.88 (.62)	1.79 (.64)	ns
Acculturation: Language	-0.151**	2.35 (.73)	2.23 (.85)	ns
Acculturation: Parents	-0.006	1.21 (.63)	1.18 (.48)	ns
Medical mistrust	0.155**	1.69 (.50)	1.86 (.44)	3.20*
Mental illness stigma	0.099	1.89 (.73)	2.04 (.65)	2.01*
FRS: Basic needs	-.0252**	3.91 (.27)	3.80 (.44)	2.52*
FRS: Money	-0.325**	3.16 (.86)	2.51 (.86)	6.77**
FRS: Time	-0.206**	3.58 (.58)	3.42 (.66)	2.32*
Social support: Quality	-0.252**	3.20 (.62)	2.95 (.65)	3.47**
Social support: Quantity	-0.227**	3.40 (.72)	3.24 (.67)	2.16*
Respondent's age	0.069	60.7 (10.7)	62.96 (10.3)	ns

*p ≤ .05 **p ≤ .01 ***p < .001

ns – not statistically significant.

Table 2: Differences in anxiety and depression scores across sociodemographic factors.

Measure	Depression			Anxiety		Chi-Square Test
	Mean	SD	T-test	Yes N (%)	No N (%)	
Gender:						
Male	.32	.54	ns	88 (26.6%)	84 (25.4%)	ns
Female	.35	.49		44 (13.3%)	115 (34.7%)	
Education:						
<High School Graduate	.40	.57	F-test =	70 (21.5%)	90 (27.7%)	ns
High School Graduate	.20	.37	ns	6 (1.8%)	23 (7.1%)	
>High School Graduate	.30	.46		56 (17.2%)	80 (24.6%)	
Marital Status:						
Married/partner	.33	.50	ns	94 (28.4%)	148 (44.7%)	ns
Single/divorced	.35	.52		38 (11.5%)	51 (15.4%)	
Income						
A: Less than \$15,000	.391	.5	F-test = 3.49*	68 (20.7)	81 (24.6)	9.95*
B: \$15,001 - \$50,000	.365	.55		40 (12.2)	68 (20.7)	
C: \$50,001 and above	.212	.30		22 (6.7)	34 (10.3)	
D: Income not reported	.056	.09		1 (.030)	15 (4.6)	
Religion						
Hindu	.413	.58	3.25***	95 (28.7%)	51 (15.4%)	ns
Muslim/Others	.241	.37		81 (24.5%)	104 (31.4%)	

*p≤.05 **p≤.01 ***p≤.001

ns – not statistically significant.

Table 3: Predicting depression as a function of sociodemographic characteristics, predisposing and enabling factors in multiple regression models.

Sociodemographic Characteristics	Model 1 Std. β (SE)	Model 2 Std. β (SE)	Model 3 Std. β (SE)	Model 4 Std. β (SE)
Age	.023 (.003)			
Male (vs. Female)	-.049 (.065)			.019 (.04)*
Education				
<High School Graduate	.080 (.062)			
High School Graduate	-.063 (.103)			
>High School Graduate	Referent	Referent	Referent	Referent
Religion: Hindu (vs. other)	-.177 (.059)**			-.074 (.089)
Country of Origin (India)	-.037 (.045)			
Income				
Less than \$15,000	-.013 (.063)			
\$15,001 - \$50,000	-.077 (.082)			
\$50,001 and above	-.093 (.066)			
Income not reported	Referent	Referent	Referent	Referent
Partnered (vs. Not)	.039 (.066)			
In US 5 years or more (vs. Less)	.071 (.068)			
Predisposing Factors				
Acculturation				
Culture		.023 (.051)		
Language		-.187 (.042)**		.034 (.065)

Parents	-0.541 (.048)	
Medical Mistrust	2.40 (.060)**	.204 (.086)*
Mental Illness Stigma	.072 (.041)	
Enabling Factors		
Insurance (vs. None)	.094 (.113)	
Regular Physician (vs. Not)	.163 (.088)~	.181 (.084)*
Family Resources		
Basic Needs	-0.013 (.146)	
Money	.030 (.062)	
Time	.075 (.095)	
Social Support		
Quality	-0.168 (.077)	
Quantity	-.193 (.063)~	-.258 (.061)**

~p≤.10 *p<.05 **p<.01 ***p<.001

Table 4: Predicting anxiety as a function of sociodemographic characteristics, predisposing and enabling factors in logistic regression models.

Sociodemographic Characteristics	Model 1 AOR (95% CI)	Model 2 AOR (95% CI)	Model 3 AOR (95% CI)	Model 4 AOR (95% CI)
Age	1.03 (1.00-1.05)*			1.01 (.949-1.06)
Male (vs. Female)	2.00 (1.14-3.51)*			1.48 (.506-4.32)
Education				
<High School Graduate	Referent	Referent	Referent	Referent
High School Graduate	.790 (.462-1.35)			.657 (.227-1.20)
>High School Graduate	.275 (.097-.777)*			.369 (.058-2.36)
Religion				
Hindu (vs Muslim/Others)	1.55 (.925-2.61)			
Country of Origin				
(India)	1.67 (.806-3.49)			
Income				
Less than \$15,000	Referent	Referent	Referent	Referent
\$15,001 - \$50,000	10.62 (1.31-85.87)*			5.31 (.98-42.1)
\$50,001 and above	7.17 (.87-58.9)			3.13 (.87-36.1)
Income not reported	9.42 (1.13-78.5)*			6.42 (1.13-32.1)
Partnered (vs. Not)	.78 (.451-1.36)			
In US 5 years or more				
(vs. Less)	.627 (.341-1.15)			

Predisposing Factors		
Acculturation	.923 (.605-1.41)	
Culture	.790 (.559-1.12)	
Language	.827 (.550-1.24)	
Parents		
Medical Mistrust	2.02 (1.22-3.32)**	4.15 (1.40-12.3)**
Mental Illness Stigma	1.29 (9.13-1.81)	
Enabling Factors		
Insurance (vs. None)		.369 (.117-1.17)
Regular Physician (vs. Not)	.257 (.099-.668)**	.235 (.085-6.52)**
Family Resources		
Basic Needs		-.931 (.220-3.93)
Money	.483 (.250-.993)*	.610 (.348-1.07)
Time	2.13 (.764-5.95)	
Social Support		
Quality	.494 (.219-1.11)	
Quantity	.727 (.390-1.43)	

*p<.05 **p<.01 ***p<.001.