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SOUTH ASIAN AMERICAN COLLEGE STUDENTS' MENTAL HEALTH HELP-SEEKING ATTITUDES AND PREFERENCES

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BY

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ABSTRACT

Previous research has established that Asian Americans are less likely than other racial and ethnic groups to utilize mental health services. This has given rise to a multitude of studies examining Asian Americans' attitudes towards seeking professional psychological help. However, given the immense diversity of the Asian American population, there exists a need for additional studies exploring the needs of specific subsets of the Asian American population. The present study explored the mental health help-seeking preferences and attitudes of South Asian Americans in particular. Participants were 131 South Asian American undergraduate and graduate students from universities across the United States. The influence of acculturation and enculturation on these students' mental health help-seeking attitudes was examined. Additionally, this study investigated students' preferences for sources of support (such as friends, family, therapists, or campus faculty) when struggling with a mental health problem, as well as their preferences for different types of mental health treatments (such as group counseling, individual therapy, or medication) and different types of therapy (virtual or in-person).

Results indicated that levels of acculturation and enculturation did not impact participants' help-seeking attitudes. Participants reported that they were most willing to seek help for a mental health concern by talking with the following people: a close friend or significant other, a sibling or cousin, and a psychiatrist. They were least willing to seeking help from the following people: an extended family member (like an aunt, uncle, or grandparent), a religious or spiritual leader, or a family friend. Additionally, when asked about their preferences regarding types of mental health treatments, participants

expressed that they were most willing to utilize individual therapy or counseling. Lastly, the vast majority of participants indicated that they would prefer in-person counseling over virtual counseling. Implications for practice, intervention, and future research are discussed.

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PREFACE

The following dissertation was prepared using the Manuscript Format, as the author intends to submit this piece to the *Asian American Journal of Psychology* to be considered for publication.

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This manuscript is prepared for submission to the *Asian American Journal of Psychology.*

CHAPTER 1
INTRODUCTION

Many studies have found that Asian Americans are less likely than other racial and ethnic groups to seek help for mental health concerns. Data from the National Latino and Asian American Study (NLAAS) show that Asian Americans have a 17.3% overall lifetime rate of any psychiatric disorder and a 9.19% 12-month rate (Takeuchi et al., 2007). Despite the significant prevalence of mental illness within this population, Abe-Kim et al. (2007) found that only 8.6% of Asian Americans sought any mental health services, in comparison to 17.9% of the general population. Additionally, a study focusing specifically on the mental health needs of Asian American youth found that they used outpatient services, informal services (self-help, peer counseling, or religious counseling), and any mental health services less often than other racial ethnic groups (Garland et al., 2005).

The underutilization of mental health services by Asian Americans has given rise to a multitude of studies centered around Asian American mental health and attitudes towards mental health service utilization. However, although there exists a plethora of mental health studies exploring the experiences of Asian Americans as a broad group, relatively fewer studies have explored the unique mental health needs of the various Asian American subgroups. The description of Asian Americans as a monolithic group may be problematic as Asian Americans are an incredibly diverse group, with 20 million Asian Americans tracing their ancestry to more than 19 countries in East and Southeast Asia and the Indian subcontinent (Budiman et al., 2021). Each of

these groups has their own unique culture, traditions, histories, political structures, experiences of colonization, religious movements, and other characteristics. Moreover, Asian American subgroups have differed greatly in terms of their histories of immigration to the United States. In fact, the term "Asian American" was not established until the 1960s, when student activists, inspired by protests against the Vietnam War and the Black power movement, developed the term as a pan-ethnic political identity that united students from different ethnic backgrounds (Maeda, 2005). Given the vast heterogeneity of this group, it is possible that there are important within group differences in the mental health and service utilization experiences of Asian Americans, and further research focused on specific Asian American subgroups is needed.

In particular, the South Asian American subgroup has been especially understudied. In fact, in a content analysis of the psychological research on South Asian Americans published between 1980 and 2012, Inman and colleagues (2014) found fewer than 40 articles pertaining to South Asian American mental health and psychotherapy experiences had been published. This dearth of research is troubling as this is a rapidly growing population with unmet mental health needs (Arora et al., 2016).

South Asian Americans

South Asian Americans are the third largest and fastest growing Asian American ethnic group in the United States (U.S. American Community Survey, 2005), with more than 5.6 million individuals residing in the United States (Budiman et al., 2021). South Asian Americans are individuals who trace their ancestry to countries which were formerly part of the Indian subcontinent. These countries include India, Pakistan, Bangladesh, Sri Lanka, Nepal, Maldives, Burma, and Bhutan (Asia-Pacific Population

Information Network, 1995; Central Intelligence Agency, 2014; Inman & Tummala-Narra, 2010). Although each of these countries possesses its own unique cultural and religious traditions, these nations do share a history of European colonization and some common cultural values (Tummala-Narra et al., 2016). Moreover, individuals from these countries are often perceived as racially similar by non–South Asians because of visible physical features (Bhattacharya & Schoppelrey, 2004; Inman & Tummala-Narra, 2010).

While the majority of South Asian Americans are of Asian Indian descent, immigration from Pakistan, Bangladesh, Sri Lanka, Burma, Bhutan, and Nepal to the United States has increased rapidly over the past two decades (Budiman et al., 2021). For example, recent data from the Pew Research Center indicates that from 2000-2019, there was a 171% increase in the Pakistani American population, a 263% increase in the Bangladeshi American population, and 127% increase in the Sri Lankan American population (Budiman et al., 2021). Additionally, between 2000 and 2019, the Nepalese American population grew from 9,000 to 198,000 (a 2000% increase), the Burmese American population grew from 17,000 to 189,000 (a 1000%), and the Bhutanese American population grew from less than 1,000 to 24,000 (an 11,000% increase; Budiman et al., 2021).

The initial wave of South Asian immigration to the United States began in 1898 and consisted of individuals from India, present-day Pakistan, and present-day Bangladesh (Ibrahim et al., 1997). The majority of these immigrants were laborers and often worked in the agricultural sector (Ibrahim et al., 1997). However, in 1921, the

United States government established national origin immigration quotas, limiting immigration from Arab and South Asian countries for several years (Zong & Batalova, 2016). Then, in 1965, South Asian immigration to the United States increased rapidly after the passage of the Immigration and Nationality Act, which marked the end of many exclusionary immigration laws (Bhatia & Ram, 2018). At this time, large numbers of South Asian immigrants entered the United States for a variety of reasons, including the pursuit of better educational and employment opportunities, reunifying with family members, and fleeing natural disasters, civil wars, and political persecution (Tummala-Narra et al., 2016). The majority of South Asian immigrants at this time were professionals such as doctors, academics, engineers, scientists, and students seeking professional degrees from American universities (Shah & Tewari, 2019). In fact, Doshi (1975) collected data from a sample of 46,000 Asian Indian immigrants and found that at least 50% of them were working as medical doctors, scientists, and engineers. These South Asian immigrants were often able to succeed financially and obtain American citizenship, and they were allowed to bring their children and spouses with them (Sandhu & Madathil, 2007).

Then, in the 1980s, the Family Reunification Act allowed many second wave South Asian American immigrants to sponsor their family members. This brought a new wave of immigrants who were often less educated and less fluent in English. Many of these immigrants worked as taxi drivers, convenience store owners, and motel clerks (Sandhu & Madathil, 2007), and some owned small businesses (McMahon, 1995). Although it was predicted that discrimination against South Asians following

the terrorist attacks of September 11, 2001 would reduce South Asian immigration to the U.S, South Asian immigration has continued to increase since 2003 (Yang, 2011).

South Asian Americans' Mental Health

As a broadly construed group, Asian Americans have been found to hold a considerable burden of mental illness (Spencer et al., 2010). However, when compared to the broader Asian American population, South Asian Americans have been found to have lower rates of mental illness diagnoses (Masood et al., 2009). For example, Masood and colleagues (2009) found that South Asian Americans had lower lifetime rates of major depressive disorder and dysthymia (2.7% for South Asian Americans and 9.1% for Asian Americans), as well as lower lifetime rates of anxiety disorders, including panic disorder, generalized anxiety disorder, and posttraumatic stress disorder (5.3% for South Asian Americans and 9.8% for Asian Americans).

Masood and colleagues (2009) note that the lower rates of psychiatric disorders among South Asian Americans may be due to the fact that throughout history, the majority of South Asians who have been able to immigrate to the United States have been highly educated health and science professionals. Research has found that immigrants who held higher socioeconomic statuses in their countries of origin and who reside in the United States as documented immigrants report fewer mental health concerns than immigrants who are undocumented or hold less social capital (Portes & Rumbaut, 2006). Thus, selection bias in South Asian immigration to the United States may explain this population's lower rates of mental illness. However, Masood and colleagues (2009) also note that another explanation for these lower rates may be that cultural factors such as shame or greater attention to somatic symptoms cause South Asian

Americans to under-endorse mental health symptoms (Conrad & Pacquiao, 2005; Karasz et al., 2007).

Acculturative Stress and Psychological Functioning in South Asian Americans

One factor that has been found to impact South Asian Americans' mental health is acculturative stress. Acculturation refers to the process by which an individual's practices, values, and identities change when experiencing intercultural contact (Ward & Geeraert, 2016). This process typically involves the integration of behaviors and beliefs from a new dominant cultural context into a heritage culture (Tummala-Narra et al., 2016), and has been found to impact an individual's social functioning and psychological well-being (Berry et al., 2006). Early conceptualizations of acculturation described the process as unilinear, meaning that as an individual adopted the dominant culture, the individual rejected his or her culture of origin (Yoon et al., 2013). However, later conceptualizations of acculturation view the process as bilinear, meaning that an individual's retention of his or her culture of origin and adoption of the dominant culture are two independent processes (Kim & Omizo, 2006).

Thus, an individual experiencing acculturation is thought to hold two orientations (Berry, 1980; Sue & Sue, 1971). The first is the dominant cultural orientation (also known as the acculturation outcome), which reflects the extent to which one is involved with the mainstream culture, and the second is the heritage cultural orientation (also known as the enculturation outcome), which is the extent to which one is involved in their own culture of origin (Miller, 2007). These orientations apply to many different domains or dimensions (Nguyen & Benet-Martínez, 2013), including cultural

traditions, cultural identity, family socialization, language use or preference, communication style, social affiliation, daily living habits, perceived discrimination/prejudice, generational status, and cultural knowledge, beliefs, or values (Zane & Mak, 2003). Individuals undergoing acculturation may be involved in both, either, or neither cultures in regard to their identity, beliefs, or behaviors (Berry, 2003; Miller, 2007). The interaction of these orientations results in four different acculturation strategies (Nguyen & Benet-Martínez, 2013). These include assimilation (orientation to only the dominant culture), separation (orientation to the heritage culture only), marginalization (orientation to neither cultures), and integration (orientation to both cultures; Berry et al., 2006.) Individuals undergoing acculturation may experience reductions in physical and psychological health. This phenomenon is referred to as acculturative stress (Berry et al., 1987).

Several studies have explored the impact of acculturation and acculturative stress on South Asian Americans' mental health. In one such study, Mehta (1998) investigated the experiences of 195 Indian immigrants in the United States and found that greater perceptions of acceptance, being oriented towards American culture, and greater English usage were related to better mental health outcomes, while feelings of not being accepted were related to poorer mental health outcomes. Importantly, this relationship between acculturation and mental health was independent of age, sex, skin color, education level, family income, years in the United States, and years of education within the United States (Mehta, 1998). This finding underscores the important role of acceptance and acculturation in mental health outcomes.

Moreover, in another investigation of South Asian American acculturation, Krishnan and Berry (1992) explored the relationship between acculturation attitudes (assimilation, integration, separation, and marginalization) and stress in a sample of 76 Indian immigrants living in the Midwestern United States. They found that participants with attitudes of separation from American culture or attitudes of rejection of both cultures experienced greater acculturative stress. Conversely, participants with stronger integration attitudes (integrating both cultures) experienced less stress (Krishnan and Berry, 1992). The results of this study suggest that the type of acculturation strategy utilized impacts South Asian Americans' psychological well-being, with the integration strategy predicting the best mental health outcomes.

The idea that certain acculturation strategies predict better adjustment outcomes for South Asian Americans is also supported by Farver and colleagues' (2002a) study on acculturation strategies within Asian Indian American families. Here, the researchers explored acculturation preferences for 85 U.S.-born Asian Indian adolescents and one of their immigrant parents and found that parents and adolescents typically adopted similar acculturation strategies (Farver et al., 2002a). Moreover, adolescents who had utilized the integration strategy had higher school achievement and higher scores on the self-perception profile than did adolescents who used separation or marginalization strategies (Farver et al., 2002a). In a subsequent study (Farver et al., 2002b), the researchers found that parents who utilized marginalization or separation strategies reported greater family conflict than those who utilized integrated or assimilated strategies. Additionally, they found that adolescents reported less anxiety,

less family conflict, and greater self-esteem when there was no acculturation gap between them and their parents (Farver et al., 2002b). Ultimately, these findings not lend support to the idea that integration and assimilation strategies can lead to more positive psychological outcomes, but also support the notion that psychological adjustment and outcomes can be a result of acculturation gaps between South Asian American parents and children.

Tummala-Narra and colleagues (2016) also explored the influence of acculturation gaps between parents and their children by interviewing sixteen South Asian American adolescents. They found that one common source of stress among the adolescents was bearing the responsibility of serving as cultural and linguistic translators for their parents and other family members who were less proficient in English. They also found that another significant source of stress for these adolescents was being seen as "too Americanized" by their parents and family members when their acculturation strategies differed from their parents (Tummala-Narra et al., 2016). Thus, cultural conflicts between South Asian American adolescents, who may have greater exposure to mainstream American culture, and their parents, who may adhere to more traditional South Asian values, may impact South Asian American adolescents' psychological well-being.

South Asian Americans' Attitudes Towards Utilizing Mental Health Services

The utilization of mental health services has been found to be associated with attitudes towards seeking professional help (Mackenzie et al., 2006). Thus, in trying to understand Asian Americans' underutilization of mental health services, researchers have often examined Asian American's attitudes towards seeking professional help for

mental health issues (Kim & Lee, 2014; Loya et al., 2010; Luu et al., 2009; Ting & Hwang, 2009). While numerous studies have examined help-seeking attitudes of Asian Americans as a group (Gloria et al., 2008; Kim & Omizo, 2010; Kim & Lee, 2014; Kim & Kendall, 2015; Masuda & Boone, 2011; Miller et al., 2011; Ting & Hwang, 2009), fewer studies have focused specifically on the attitudes of South Asian Americans. Most of the studies that have examined South Asian Americans' attitudes towards seeking help for mental health concerns have found that this group generally does not hold favorable attitudes about seeking help from a mental health professional.

For example, two studies (Loya et al., 2010; Mokkarala et al., 2016) found that South Asian American college students held less positive help-seeking attitudes than Caucasian college students. Moreover, Leung, and colleagues (2011) found that Asian Indian Americans with depressive symptoms rarely sought help from mental health professionals, instead preferring to seek help from friends or relatives. Similarly, Rao and colleagues (2011) conducted an online survey of 267 South Asian American participants and found that while participants typically perceived mental illness as a medical problem, they expressed a preference for seeking help from friends or family members rather than mental health professionals. These findings suggest that South Asian Americans may have less favorable help-seeking attitudes than some other groups, such as Caucasians. However, in contrast to these findings Panganamala and Plummer (1998) found that Asian Indians in the United States held primarily neutral or positive attitudes towards seeking professional psychological help. Given the small number of studies examining South Asian American help-seeking attitudes, more

research is needed to gain a better understanding of this group's attitudes towards mental health service utilization.

Interestingly, research suggests that while South Asian Americans may have less favorable help-seeking attitudes than Caucasians (Loya et al., 2010), they may have more favorable help-seeking attitudes than other Asian American subgroups. For example, Lee and colleagues (2015) found that despite having lower rates of mental illness diagnosis than East Asian Americans, South Asian Americans are more likely than East Asian Americans to utilize mental health services for all mental disorders. In addition, Lee and colleagues (2015) found that while South Asians had lower rates of substance abuse disorders than South East Asians, they were more likely than South East Asians to seek treatment for substance abuse disorders. This suggests that South Asian Americans may hold more positive views of mental health service utilization than East Asian Americans and South East Asian Americans. This conceptualization is supported by a study by Frey and Roysircar (2006), who found that South Asian international students at a midwestern university were more likely than East Asian international students to seek help for mental health concerns. Together these findings suggest that there may be important differences in South Asian and East Asian cultures that impact help-seeking attitudes. Further research is needed to understand the unique aspects of South Asian American culture and experience that lead this group to be more likely than other Asian subgroups to seek help from a mental health professional.

The Impact of Acculturation on Help-Seeking Attitudes of South Asian Americans

Researchers have studied Asian American's attitudes towards seeking help for mental health difficulties in relation to a variety of factors, including stigma (Masuda & Boone, 2011), stigma tolerance (Ting & Hwang, 2009), acculturation and enculturation (Kim & Omizo, 2010; Miller et al., 2011; Ruzek et al., 2009), beliefs about the etiology of mental illness (Kim & Kendall, 2015), and the internalized model minority myth (Kim & Lee, 2014). Research focused specifically on the help-seeking attitudes of South Asian Americans has examined help-seeking in relation to factors such as stigma (Chaudhry and Chen, 2019) and beliefs about the etiology of mental illness (Karasz, 2005). Furthermore, some research on South Asian Americans' attitudes towards mental health help-seeking has focused on the impact of the acculturation process on help-seeking.

As previously noted, acculturation refers to the process by which an individual's practices, values, and identities change when experiencing intercultural contact (Ward & Geeraert, 2016). As Asians have been found to have less positive help-seeking attitudes than Whites, many researchers have hypothesized that acculturating to American culture would lead one to hold more positive help-seeking attitudes. Thus, a great deal of research has examined the effects of acculturation on the help-seeking attitudes of Asian Americans (Atkinson & Gim, 1989; Han & Pong, 2015).

In studies completed with Asian Americans as an entire group, findings on the effect of acculturation on help-seeking attitude have been mixed. While several studies (Atkinson & Gim, 1989; Han & Pong, 2015; Leong, Kim, & Gupta, 2011; Miller et al., 2011; Tata & Leong, 1994; Zhang & Dixon, 2003) have found that greater acculturation predicted more positive attitudes towards seeking professional psychological

help, other studies (Atkinson et al., 1995; Kim & Omizo, 2010) found no association between acculturation and help-seeking attitudes.

While many studies have examined this topic utilizing samples of Asian American participants, only two studies have explored the effects of acculturation on help-seeking specifically in South Asian American populations. In one study, Kim (2015) found that higher levels of acculturation were associated with Asian Indian women's attitudes towards seeking psychological counseling after experiencing sexual and verbal intimate partner violence. In another study, Frey and Roysircar (2006) found that South Asian international students, but not East Asian American international students, were more likely to utilize help resources, including psychiatric and psychological resources, when the students were more acculturated to American culture. The finding that acculturation influenced the help-seeking attitudes of South Asians but not East Asians suggests that there might be important cultural differences in these subgroups that make South Asians more open to help-seeking. Future research is needed to explore these differences and to understand how acculturation impacts South Asian Americans' attitudes about reaching out to a mental health provider for help.

South Asian Americans' Preferences Regarding Types of Treatment

While research on South Asian Americans' attitudes towards seeking mental health treatment is limited, research regarding their preferences for the modality, or type, of treatment they receive is even more so limited. Various modalities of mental health treatment may include individual psychotherapy, family therapy, group counseling, and medication. Unfortunately, little is known about South Asian Americans' preferences regarding these types of treatment. However, in Rao and colleagues'

(2011) study, participants cited a dislike of medication as one of the barriers to seeking mental health treatment, thus suggesting that South Asian American clients may prefer psychotherapy over use of medications to treat mental health disorders. This finding is consistent with Givens and colleagues' (2009), whose work concluded that people from ethnic minority backgrounds were less likely than Caucasian Americans to believe that medications were effective in treating depression and were more likely to believe that antidepressants were addictive and dangerous. However, as only one studied has examined South Asian Americans' attitudes towards medication use, more research is needed in this area.

Moreover, in writing about treatment modalities that may be effective with Asian Indian Americans, Chandra and colleagues (2016) have argued that family therapy may be a preferred treatment modality for South Asian Americans because of the collectivist nature of Asian Indian culture. South Asian Americans may be open to family therapy because family is an incredibly important value in South Asian culture, and because in this community, an individual's mental health concerns may be viewed as an entire family's concern. However, it is important to note that the opposite may also be true regarding preferences for family therapy. In a study with Asian American college students, Ruzek and colleagues (2009) found that participants' least preferred mode of help-seeking was family therapy. The authors note that this may have been the case because in many Asian cultures, an individual who discloses their own problems to another person may be seen as exposing disharmony in the family, which could bring shame to the entire family (Ruzek et al., 2009). While this study (Ruzek, 2009) was conducted with Asian Americans as a group, this finding may also apply

specifically to South Asians as well. At the same time, it is also possible that this belief is more representative of East Asian culture than South Asian culture. Therefore, further research is needed to understand if South Asians differ from other Asian American subgroups in this regard. Ultimately, further research is needed to explore how South Asian Americans differ in their attitudes towards different types of treatment, such as medication, family therapy, group counseling, and individual therapy. Such information could help inform the identification and selection of interventions aimed at increasing rates of service use among South Asian Americans.

South Asian Americans' Preferences for Sources of Support

While some studies have explored South Asian Americans' attitudes towards seeking help, no studies have explored their preferences regarding treatment providers when struggling with a mental health concern. To address this gap in the knowledge base, the present study will explore which supports South Asian American college students prefer to utilize when seeking help for a mental health concern. This information will be crucial in informing intervention and support efforts aimed at increasing help-seeking in this population. For example, if it is revealed that South Asian American college students would prefer to seek help from a friend rather than a therapist, interventions may need to focus on teaching South Asian American students how to support their peers when they are struggling with a mental health concern.

Present Study

To date, many studies have investigated the help-seeking attitudes of Asian Americans. However, few studies have explored the unique needs of the South Asian American subgroup. The present study had three aims. The first was to explore how

acculturation impacts South Asian American college students' attitudes towards seeking professional psychological help. Second, the present study aimed to explore South Asian American college students' help-seeking preferences regarding sources of support and types of mental health treatment. Lastly, this study explored how preferences regarding sources of support and types of mental health treatment are influenced by acculturation.

Research Hypotheses

As previous research has found that acculturation predicts help-seeking attitudes in South Asian Americans (Frey & Roysircar, 2006; Kim, 2015), it is hypothesized that participants with greater levels of acculturation to Western culture will be more likely to hold positive help-seeking attitudes. Furthermore, given the lack of previous research addressing South Asian Americans' preferences for sources of support and types of mental health treatment, no a priori hypotheses regarding these variables will be established.

CHAPTER 2
METHODS

Participants and Procedures

The present study utilized a sample of South Asian American undergraduate and graduate students attending universities across the United States. Participants were recruited through the Qualtrics Panel System. The Qualtrics Panel System is an online survey platform that offers access to a large, diverse sample of participants across the United States (Soucy & Hadjistavropoulos, 2017). Qualtrics recruits respondents through channels such as social media, targeted email lists, and member referrals (Soucy & Hadjistavropoulos, 2017) and has become a popular recruitment method for researchers interested in studying perceptions and attitudes (Lou & Kim, 2019; Minton et al., 2018). Registration with Qualtrics as a potential research participant involves individuals completing background questionnaires and agreeing to complete online surveys for an incentive. Incentives are based on factors such as the length of the survey and may include cash or gift cards. For any given study, Qualtrics uses demographic information provided by registrants to randomly select potential participants who are likely to meet the study's eligibility criteria.

For the present study, Qualtrics Panel Systems recruited participants who were a) age 18 or older b) currently enrolled in college c) of South Asian American descent and d) currently living in the United States. Qualtrics reached out to eligible participants via email and informed them of the length of the survey and the potential compensation amount. Interested individuals were then asked to complete a survey designed to be completed in approximately 10 minutes. The first portion of the survey

included brief measures of acculturation and help-seeking. In the second portion of the survey, participants were asked to read a vignette about a mental health problem and answer questions about their help-seeking preferences in relation to the vignette.

The final sample consisted of 131 South Asian American college students. Participants ranged in age from 18 to 33 years, with the mean age of participants being 21 years. Of these participants, 42% identified as men (*n*= 55) and 56% identified as women (*n* = 74). Additionally, 1 participant (1%) identified as non-binary, and 1 participant (1%) did not report their gender. Furthermore, in regard to generational status, 20% of the participants were first generation South Asian American (*n* = 26), 16% were 1.5 generation (*n* = 21), 57% were second generation (*n* = 75), 4% were third generation (*n* = 5), and 1% were fourth generation or beyond (*n* = 1). Additionally, 2% of participants (*n* = 3) indicated that their parents held different generational statuses. Table 1 provides demographic information about all participants.

Table 1

Participant Demographics

Ethnicity

	N	**%**
Bangladeshi	15	11.5
Bhutanese	1	0.8
Indian	79	60.3
Nepali	5	3.8
Pakistani	22	16.8
Sri Lankan	2	1.5
Other ethnic group	2	1.5

Multiple ethnicities	5	3.8

Gender

	N	**%**
Men	55	42
Women	74	56.5
Non-Binary/Third Gender	1	0.8
Prefer not to say	1	0.8

Previous Counseling Experience

	N	**%**
Yes	32	24.4
No	99	75.6

Year in College

	N	**%**
Freshman	52	39.7
Sophomore	19	14.5
Junior	19	14.5
Senior	22	16.8
Graduate Student	19	14.5

Yearly Family Income

	N	**%**

Less than $20,000	18	13.7
$20,000 - $39,000	22	16.8
$40,000 - $59,000	12	9.2
$60,000 - $79,000	23	17.6
$80,000 - $99,000	17	13.0
$100,000 - $119,00	15	11.5
$120,000 - $139,000	11	8.4
$140,000 - $159,000	3	2.3
Over $160,000	10	7.6

Generational Status

	N	**%**
1st	26	19.8
1.5	21	16.0
2nd	75	57.3
3rd	5	3.8
4th and beyond	1	.8
Two or more statuses	3	2.3

Religious or Philosophical Identification

	N	**%**
Atheism	13	9.9
Agnosticism	4	3.1
Buddhism	3	2.3
Christianity	11	8.4
Hinduism	42	32.1

Jainism	1	.8
Judaism	1	.8
Islam	44	33.6
Sikhism	8	6.1
Another Religion	4	3.1

Living Arrangement

	N	**%**
Alone	8	6.1
With roommates or friends	28	21.4
With family (parents, grandparents, siblings, etc.)	87	66.4
With significant other or spouse	8	6.1

Measures

Demographic questions. Participants completed a brief demographic questionnaire regarding their age, gender, ethnicity, generational status, religious background, family income, previous counseling experience, and grade point average (see Appendix A).

Attitudes Toward Seeking Professional Psychological Help - Shortened Form (ATSPPH-SF; Fischer & Farina, 1995). The extent to which participants hold positive attitudes towards seeking professional help for psychological difficulties was measured using the Attitudes Towards Seeking Professional Psychological Help - Shortened Form (ATSPPH-SF) (Fischer & Farina, 1995). This is a 10-item unidimensional measure of help-seeking attitude. A copy of this scale is located in Appendix B.

In completing the ATSPPH-SF, participants rate each item on a 4-point scale, ranging from 1 (disagree) to 4 (agree), and after four items are reverse scored, a total scale score is obtained. Higher scores indicate a more positive attitude toward seeking professional help (Miller et al., 2011). Fischer and Farina (1995) reported that the ATSPPH-SF score yielded a coefficient alpha of .84 and a 1-month test–retest reliability coefficient of .80 with a largely European American sample. Furthermore, researchers studying South Asian American populations have noted adequate ($\alpha = .78$; Arora et al., 2016) to good ($\alpha = .80$; Kanukollu, 2010) internal consistency. In the present study, the internal consistency was adequate ($\alpha = .72$).

Abbreviated Multidimensional Acculturation Scale (AMAS-ZABB; Zea, Asner-Self, Birman, & Buki, 2003). Acculturation was measured using the Abbreviated Multidimensional Acculturation Scale (Zea et al., 2003; AMAS-ZABB), a 42-item bilinear measure of acculturation (21 items) and enculturation (21 items). The AMAS-ZABB explores three dimensions of acculturation: identity, cultural competence, and language competence. Items are rated on a 4-point Likert scale ranging from 1 (strongly disagree, or not at all) to 4 (strongly agree, or extremely well), with higher scores indicating greater levels of acculturation or enculturation. The AMAS-ZABB was developed by Zea et al. (2003) for use with diverse ethnic groups, and it has been utilized in studies exploring the experiences of Asian Americans (Yoon et al., 2012), Korean Americans, (Yoon et al., 2008), and South Asian Americans (Sandil et al., 2015). The authors of this scale reported strong construct validity (Zea et al., 2003). Moreover, these authors reported good internal consistencies ranging from .90 to .97 in their study with Latinx college students. Furthermore, Sandil

and colleagues (2015) utilized this scale in their research with a South Asian population, and they reported internal consistencies of .84 for the South Asian scale and .90 for the Western scale. In the present study, Cronbach's alphas were .94 for the South Asian enculturation scale and .86 for the Western acculturation scale. Furthermore, the internal consistencies of each of the three acculturation and each of the three enculturation scales was calculated. Internal consistencies for the three enculturation subscales were as follows: .90 for the South Asian cultural identity subscale, .96 for the South Asian language subscale, and .91 for the South Asian cultural competence subscale. Additionally, Cronbach's alphas for the acculturation subscales were .86 for US Cultural Identity subscale, .94 for the US English language subscale, and .88 for the US Cultural Competency subscale.

Help-Seeking Preferences Questionnaire. Participants' help-seeking preferences were measured using the Help-Seeking Preferences questionnaire, which was developed by the study author for use in this study. This questionnaire consisted of a vignette describing a student struggling with a mental health problem and a few questions regarding participants' preferences for different mental health supports and treatments. The vignette was reviewed by three clinical psychologists in order to ensure it accurately depicted a mental health concern.

Participants were asked to imagine that they were struggling with the mental health condition described in the vignette and then answer questions regarding their help-seeking preferences. The survey consisted of six questions. In the first question, participants were asked whether they would seek help from someone or try to solve the problem on their own. Then, in the second question, participants were asked to

rank order their preferences for sources of support (such as parents, friends, or a mental health professional at the campus counseling center). Participants were asked to rank the various sources of support from 1 to 13, with 1 being their most preferred option and 13 being their least preferred option. Furthermore, the third question asked participants to list any other supports not covered by the previous question.

In the fourth question, participants were asked to rate how likely they would be to turn to each source of support using a 5-point Likert scale. The fifth question focused on preferences regarding mental health treatments. Participants were asked to rate how open they would be to various types of mental health treatments (such as medication, group counseling, or individual therapy) using a 5-point Likert scale. Finally, the last question in this survey asked participants whether they preferred online or in-person therapy. The Help Seeking Preferences Questionnaire is provided in Appendix C.

CHAPTER 3
RESULTS

Preliminary Analyses

Data were analyzed using the statistical analysis program SPSS 25.0. Preliminary analyses were conducted for all variables to ensure that assumptions of normality, linearity, and homoscedasticity were met. All variables were normally distributed, with skewness values falling between -1 and 1, kurtosis values falling between -1 and 1.5, and all scores falling within 3 standard distributions of the mean. Furthermore, an examination of scatter plots revealed that the assumptions of linearity between variables and homoscedasticity were met. Descriptive data for the primary study variables is provided in Table 2.

Table 2

Means and Standard Deviations for Primary Study Variables

Variable	Mean	Standard Deviation
U.S. Cultural Identity	18.22	3.97
U.S. English Language	34.78	2.84
U.S. Cultural Competence	17.95	3.85
South Asian Cultural Identity	19.74	3.66
South Asian Language	23.98	8.49
South Asian Cultural Competence	13.83	4.72
Help-Seeking Attitudes	27.45	4.65

Additionally, multicollinearity between variables was assessed by examining correlations, the tolerance score, and the VIF (variance inflation factor) score. Correlations of 0.70 or higher typically indicate some level of multicollinearity (Tabachnick and Fidell, 2013), as do tolerance scores of less than .20 and VIF scores greater than 10 (Chen, Cohen, West, & Aiken, 2003). As all correlations were less than 0.70, tolerance was greater than .20, and the VIF was less than 10, it was

determined that multicollinearity was not present between predictor variables. Correlations between these variables are presented in Table 3.

Table 3

Correlations Between Primary Study Variables

Variable	1	2	3	4	5	6	7
1. Help-Seeking	1.00						
2. U.S. Cultural Competence	.17*	1.00					
3. U.S. Cultural Identity	.01	.27**	1.00				
4. U.S. English Language	.16*	.30***	-.02	1.00			
5. South Asian Cultural Compe-tence	.01	.27**	.09	-.09	1.00		
6. South Asian Language	-.12	.04	.16*	-.11	.61***	1.00	
7. South Asian Identity	-.14	.09	.19*	.11	.44***	.36***	1.00

Note. *$p < .05$ ** $p < .01$ *** $p < .001$

Analyses were conducted to examine potential covariates. Sociodemographic factors previously linked to mental health help-seeking were examined in relation to acculturation, enculturation, and help-seeking attitudes. These factors included gender, year in college, ethnicity, generational status, religious background, socioeconomic status, living arrangement, and previous counseling experience. Independent samples t-tests revealed that men and women did not differ on any of the scales or subscales of acculturation and enculturation. However, women (M = 28.49, SD = 4.46) had significantly more positive attitudes towards seeking help for mental health concerns

than did men (M =25.98, SD= 4.45); $t(126) = 3.17$, $p = .002$. Similarly, independent samples t-tests revealed that individuals who had (vs. had not) previously received counseling or therapy from a mental health professional did not differ on any of the subscales of acculturation or enculturation. However, individuals who had previously received counseling or therapy from a mental health professional (M = 29.66, SD = 5.22) were more likely than those who had no previous counseling experience (M = 26.78, SD = 4.24) to have positive attitudes towards seeking help for mental health concerns $t(128) = 3.15$, $p = .002$. Significant differences in acculturation, enculturation, and help-seeking attitudes were not detected for year in college, living arrangement, religion, generational status, socioeconomic status, or ethnicity (F_s ranged from .17 - 2.52; p_s ranged from .06 to .95). Thus, only gender and previous counseling experience were included as covariates in the main analysis.

Primary Analysis

A hierarchical multiple regression analysis was conducted to assess the contributions of gender, previous counseling experience, each of the three domains of acculturation, and each of the three domains of enculturation in South Asian American students' attitudes towards seeking help for mental health concerns (see Table 4). Gender and previous counseling experience were entered in step 1, and scores on each of the acculturation and enculturation subscales were entered in step 2. A power analysis conducted in G*power 3.1 for linear multiple regression, fixed model revealed that a sample size between 52 and 109 was needed to detect a medium (.15) to large effect (.35) in a multiple regression analysis with 8 predictor variables. Power was set at $f^2 = 0.80$, and the alpha set at .05. Therefore, given the number of

participants in the current study (N = 131), there was a high likelihood of detecting medium and large main effects should they be present.

As shown in Table 4, in step 1, the overall regression model was significant, F(2,126) = 11.44, p < .001. Gender (β = .28, p < .01) and previous counseling experience (β = - .25, p < .01) significantly predicted help-seeking attitudes. Together, these variables accounted for 15.4% of the variance in help-seeking scores. In step 2, when the scores for the dimensions of enculturation and acculturation were entered, the overall model remained significant, F(8,120) = 4.36, p < .001. Gender (β = .31, p < .001) and previous counseling experience (β = - .21, p < .05) remained significant predictors of help-seeking attitudes, and South Asian identity emerged as a negative predictor of help-seeking attitudes (β = −.23, p < .05). However, the change in R^2 was not significant, indicating that scores on the domains of acculturation and enculturation did not account for additional variance in help-seeking scores. Although South Asian identity emerged as a significant predictor of help-seeking attitudes, it did not account for additional variance in help-seeking scores above and beyond the effects of gender and previous counseling experience.

Table 4

Regression Analyses Examining Roles of Acculturation and Enculturation on Help-Seeking Attitudes

		F	*R*	R^2	ΔR^2	B	*SE*	β	*t*
Step 1		11.44	.39	.14	.15***				
	Gender					2.38	.69	.28**	3.42
	Previous Couns.					-2.65	.88	-2.48**	-3.00
Step 2		4.36	.48	.17	.07				

Gender	2.62	.71	.31***	3.70
Previous Couns.	-2.28	.89	-.21*	2.56
SA Identity	.30	.12	-.23*	-2.48
SA Language	- .09	.06	-.16	-1.46
SA Cultural	.20	.11	.20	1.76
US Identity	.06	.10	.05	.55
US English	.12	.15	.07	.78
US Cultural	.06	.11	.05	.55

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

Post Hoc Analyses

In the primary analysis, gender was found to be a significant predictor of help-seeking, and this finding was consistent with previous research (Naam et al., 2015). However, in their meta-analysis of gender differences in help-seeking attitudes, Nam and colleagues (2015) found that studies conducted with Asian participants showed relatively smaller gender differences than those conducted with Asian American or Caucasian American participants. As such, it seemed appropriate to explore whether the effect of gender on help-seeking would differ in a sample that excluded first generation immigrants.

Thus, for exploratory purposes, a multiple regression analysis was performed with a sample that excluded first and 1.5 generation participants. Gender and previous counseling experience were entered as predictors, and the dependent variable was help-seeking. The overall regression model was significant, $F(2,77) = 7.67$, $p < .01$.

Gender (β = .31, p < .01) and previous counseling experience (β = - .24, p < .01) significantly predicted help-seeking attitudes. Together, these variables accounted for 16.6% of the variance in help-seeking scores. Ultimately, the effect of gender was slightly greater in the sample that excluded first and 1.5 generation immigrants.

Preferences for Seeking Support

A one-way repeated measures ANOVA with post hoc analyses was used to examine differences in participants' preferences for mental health supports. Results indicated significant differences among the 13 choices $F(6.84, 882.04) = 42.92$, $p < .001$. The most preferred support identified by participants was a close friend or significant other, with 87% of participants reporting they would be "slightly willing" or "very willing" to talk to a close friend or significant other if struggling with a mental health problem. Post hoc analyses revealed that a close friend or significant other (M = 4.37, SD = .99) was significantly preferred over every one of the other 12 options.

The second most preferred choice was a sibling or a cousin, with 69% of participants reporting they would be "slightly willing" or "very willing" to turn to a sibling or cousin when struggling with a mental health problem. Post hoc analyses revealed that a sibling or cousin (M = 3.88, SD = 1.18) was significantly preferred over another family member (M = 2.69, SD = 1.34), a faculty member (M = 3.32, SD = 1.10), a religious leader (M = 2.38, SD = 1.36), a family friend (M = 2.19, SD = 1.24), or strangers on an online forum (M = 2.77, SD = 1.36).

The third most preferred support was a psychiatrist, with 70% of participants reporting they would be "slightly willing" or "very willing" to seek help from a

psychiatrist. A psychiatrist was significantly preferred over another family member, faculty member, an off-campus doctor, a family friend, and strangers on an online forum. However, there was no significant difference between the second most preferred support, a sibling or cousin (M = 3.88, SD = 1.18), and the third most preferred support, a psychiatrist (M = 3.85, SD = 1.16). Additionally, a psychiatrist was not significantly preferred over an on-campus psychologist (M = 3.67, SD = 1.09), off-campus psychologist (M = 3.50, SD = 1.22), or an on-campus doctor (M = 3.55, SD = 1.05).

The least preferred supports, in descending order of preference, were an extended family member (aunt, uncle, grandparent, etc.), a religious leader, and a South Asian family friend. Only 33% of participants reported they would be "slightly willing" or "very willing" to talk to another family member when struggling with a mental health problem. Nonetheless, another family member (M = 2.69, SD = 1.34) was significantly preferred over a religious leader (M= 2.38, SD = 1.36) or a family friend (M = 2.19, SD = 1.24).

Further, only 26% of participants reported that they would be "slightly willing" or "very willing" to talk to a religious leader. There was no significant difference between preferences for a seeking help from a religious leader, which was the second least preferred support, and the preferences for seeking help from a family friend, which was the least preferred support.

Preferences for on-campus versus off-campus health care providers were also explored. Post hoc analyses revealed that there was no significant difference in preference for on-campus and off-campus psychologists. Additionally, there was no

significant difference in preferences for an on-campus doctor and an off-campus doctor. Means and standard deviations for all supports are provided in Table 5.

Table 5

Means and Standard Deviations for Support Preferences

Support	***M***	***SD***
Close friends or a significant other	4.37	0.99
Sibling or cousin	3.88	1.18
Psychiatrist	3.85	1.16
On-campus psychologist, therapist, or counselor at counseling center	3.67	1.09
Parents	3.58	1.38
Doctor at campus health center	3.55	1.05
Off-campus doctor	3.51	1.07
Off-campus psychologist, therapist, or counselor	3.50	1.22
Campus faculty or staff member	3.32	1.10
Strangers on online forum	2.77	1.36
Another family member (aunt, uncle, grandparent, etc.)	2.69	1.34
Religious or spiritual leader	2.38	1.36
South Asian “Aunty” or “Uncle” (family friend)	2.19	1.24

Additionally, multiple ANOVAs were completed to examine whether willingness to seek help from various supports, including a close friend or significant other, on-campus psychologist, parent, or religious leader, differed among participants across certain demographic variables. Ultimately, willingness to seek help from a friend, an on-campus psychologist, or a parent did not differ across generational status,

gender, socioeconomic status, or religious background. However, willingness to seek help from a spiritual or religious leader was found to differ across religious groups, with those who identified as Christians (M = 3.64, SD = 1.52) being significantly more willing than Hindus (M = 2.17, SD = 1.31) or Sikhs (M = 2.00, SD = 1.31) to seek help from a religious leader.

Preferences for Types of Mental Health Treatments and Types of Therapy

Preferences for different types of mental health treatments were also explored. Individual therapy or counseling was the most preferred type of mental health treatment, with 80% of participants reporting that they would be "slightly willing" or "very willing" to utilize this type of treatment. Individual counseling (M = 4.11, SD = 1.12), was significantly more preferred than medication (M = 2.98, SD = 1.37), group counseling (M = 2.97, SD = 1.28), and family therapy (M = 2.73, SD = 1.27). Differences between medication, group counseling, and family therapy preferences were not significant. Means and standard deviations for all types of treatments are provided in Table 6.

Table 6

Means and Standard Deviations for Treatment Preferences

Treatment	***M***	***SD***
Individual counseling or therapy	4.11	1.12
Medication	2.98	1.37
Group counseling or therapy	2.97	1.28
Family therapy	2.73	1.27

Furthermore, when asked about the type of therapy they preferred, the majority of participants (79%) reported that they would prefer in-person therapy, while a minority reported a preference for virtual therapy (21%).

Impact of Acculturation on Support and Treatment Preferences

Acculturation was significantly correlated with preferences for seeking help from a close friend or significant other ($r = .19$, $p < .05$), sibling ($r = .18$, $p < .05$), religious leader ($r = .40$, $p < .001$), family friend ($r = .53$, $p < .001$), and parent ($r = .42$, $p < .001$). Additionally, acculturation was significantly negatively correlated with seeking help from strangers online ($r = -.18$, $p < .001$). Furthermore, acculturation was significantly correlated with a preference for group counseling ($r = .20$, $p < .05$).

Impact of Enculturation on Support and Treatment Preferences

Enculturation was significantly correlated with preferences for seeking help from a sibling ($r = .25$, $p < .01$), another family member ($r = .29$, $p < .01$), a psychiatrist ($r = .20$, $p < .05$), a family friend ($r = .18$, $p < .05$), and parent ($r = .27$, $p < .01$). Enculturation was negatively significantly correlated with seeking help from strangers online ($r = -.20$, $p < .05$). Moreover, enculturation was significantly correlated with a preference for family therapy ($r = .21$, $p < .05$).

CHAPTER 4

DISCUSSION

The present study examined South Asian American college students' attitudes towards seeking help for mental health concerns. Specifically, this investigation had three aims. First, this study explored the roles of acculturation and enculturation in these students' attitudes towards seeking help from a mental health professional. Second, this study explored South Asian American students' preferences for mental health supports, treatments, and types of therapy. Lastly, this study examined how these preferences are impacted by levels of acculturation and enculturation. The following section summarizes the main findings in each of these three areas. The section concludes with a discussion of study limitations and directions for future research.

Predictors of Help-Seeking Attitudes

The present study was conducted to explore the impact of acculturation and enculturation on the mental health help-seeking attitudes of South Asian American college students. The hypothesis that levels of acculturation and enculturation would predict help-seeking attitudes was not supported. The finding that there was no association between acculturation and help-seeking attitudes is consistent with some studies conducted with Asian American participants (Atkinson et al., 1995; Kim & Omizo, 2010), but is not consistent with previous studies exploring the impact of acculturation on the help-seeking attitudes of South Asian Americans in particular (Frey & Roysircar, 2006; Kim & Hogge, 2015). One possible explanation for these differing results is that the present study and the two previous works all utilized

different measures of acculturation and explored different dimensions of this construct.

For example, in the present study, acculturation and enculturation were examined using the Abbreviated Multidimensional Acculturation Scale (Zea et al., 2003; AMAS-ZABB), a bilinear measure which explores three dimensions of acculturation and enculturation: identity, cultural competence, and language competence. In contrast, Frey and Roysircar (2006) used the American-International Relations Survey (AIRS; Sodowsky & Plake, 1991), a unilinear scale that explores the dimensions of Social Customs, Language Usage, and Perceived Prejudice. Frey and Roysircar (2006) noted they were not interested in exploring the separate contributions of the language and social customs aspects of acculturation. They also noted that in their study, the Language subscale alone demonstrated no predictive value. Therefore, the authors decided to collapse these three subscales into a single scale labeled Acculturation.

Conversely, Kim and Hogge (2015) utilized the Vancouver Index of Acculturation (VIA), a bilinear measure that includes a mainstream subscale (e.g., "I often participate in mainstream American cultural traditions") and a Heritage subscale (e.g., "I believe in the values of my heritage culture"). It is likely that results of the present study and the studies conducted by Frey and Roysircar (2006) and Kim and Hogge (2015) differed because the three studies explored different dimensions of acculturation. As these studies appear to be the only extant investigations of the relationship between acculturation and help-seeking attitudes, this may be an important area for future research. In particular, the ways in which acculturation is defined and measured warrants further investigation. For example, future studies

might utilize multiple scales of acculturation to explore which of the several different dimensions of acculturation (such as language, identity, cultural competence, social customs, and perceived prejudice) impact help-seeking attitudes. Ultimately, there exists a need for further clarification regarding the definition and measurement of the construct of acculturation.

Further, while acculturation and enculturation did not significantly predict attitudes towards seeking professional psychological help, previous experience participating in counseling emerged as a significant predictor of help-seeking attitudes. Although no studies have examined the effects of previous counseling experience with South Asian American students in particular, this finding is consistent with previous research conducted with a broader sample of Asian American students (P. Y. Kim & Kendall, 2015; P. Y. Kim & Lee, 2014). It is possible that undergoing counseling improves individuals' help-seeking attitudes because having familiarity with and knowledge about the process of seeking out and working with a therapist reduces uncertainties or concerns around mental health service utilization.

In addition, gender was also found to be a significant predictor of help-seeking attitudes, with the present study finding that South Asian American women were more likely than South Asian American men to hold positive attitudes towards seeking help from a mental health professional. This finding of gender differences is consistent with several studies that have found that men are more likely to hold negative attitudes about mental health service utilization than women (Addis & Mahalik, 2003; Mackenzie, Gekoski, & Knox, 2006; Möller-Leimkühler, 2002; Nam et al, 2010; & Yousaf, Popat, & Hunter, 2015). Several researchers have argued this gender

difference in help-seeking attitudes is likely due to the fact that men in Western cultures are often socialized to be self-sufficient and independent problem-solvers (Addis & Mahalik, 2003; Wong et al., 2017). Researchers have noted that many aspects of the help-seeking process, such as asking for help, admitting the presence of a problem, and expressing emotions, may conflict with messages that men receive from Western society about the importance of self-reliance and emotional suppression (Addis & Mahalik, 2003; Cole & Ingram, 2020; Mahalik et al., 2003). Further, researchers have found that the more men adhere to traditional Western norms of masculinity, the less likely they are to have positive help-seeking attitudes (Yousaf et al., 2015).

It is interesting to note, however, that in their meta-analysis of gender differences in attitudes towards seeking professional psychological help, Nam and colleagues (2010) found that the relationship between gender and mental health help-seeking attitudes was moderated by cultural background. These researchers found that studies conducted with Asian participants showed relatively smaller gender differences than those conducted with Asian American or Caucasian American participants (Nam et al., 2010). The finding that gender differences in help-seeking may be more pronounced in Western cultures than in Asian cultures may suggest that these cultures differ both in their socialization of boys and men and in the role that masculinity plays in help-seeking.

As gender differences in help-seeking have been found to be more pronounced in Asian samples than in Asian American samples (Nam et al., 2020), it seemed reasonable in the present work to explore whether the effect of gender on help-seeking

attitudes would hold if the analysis consisted of only first generation Asian American students. Unfortunately, however, the sample in the present study did not include enough first-generation immigrant students to explore the help-seeking attitudes of this group alone. However, notably, when first and 1.5 generation participants were removed from the sample, the effect of gender on help-seeking attitudes was slightly greater than when these participants were included in the sample. Thus, it is possible that the effect of gender on help-seeking is moderated by cultural background. Ultimately, further research is needed to understand South Asian Americans' definitions and perceptions of masculinity and the impact these perceptions may have on attitudes towards mental health service utilization.

Preferences for Mental Health Supports

This study aimed to investigate South Asian American college students' preferences for different mental health supports and different types of mental health treatments. Results indicated that participants reported that they would be more willing to talk to a close friend or significant other about a mental health concern, as compared with any other source of support. The finding that South Asian Americans are more willing to talk to a friend relative to a mental health professional is consistent with previous research (Rao et al., 2011). Additionally, this finding has important implications for the development of mental health interventions for the South Asian American community. As South Asian American college students are more willing to seek help from a friend than a therapist, mental health interventions may be particularly beneficial if they focus on teaching South Asian American students how to support their peers who are struggling with a mental health concern. These peer

supported interventions might involve university personnel teaching students how to recognize symptoms of mental illness in their friends, how to support friends that reach out to them with mental health concerns, and how to direct friends to additional resources on and off-campus.

Moreover, such mental health interventions may be even more beneficial if delivered by members of student organizations on college campuses. For example, student-led mental health advocacy groups, such as Active Minds, have been found to improve students' knowledge about mental health and increase helping behaviors (Sontag-Padilla et al., 2018). It is possible that partnerships between student cultural organizations, such as South Asian American student associations, and student mental health advocacy organizations, could help increase rates of mental health help-seeking among South Asian American college students. As 87% of participants in the present study indicated that they would be "slightly willing" or "very willing" to talk to a close friend or significant other if struggling with a mental health problem, the effectiveness of peer mental health interventions may be an important avenue for future research.

Interestingly, when preferences for on-campus versus off-campus health care providers were explored, there were no significant differences in preferences for an on-campus psychologist versus an off-campus psychologists, or in preferences for an on-campus doctor versus an off-campus doctor. This finding suggests that the location of a mental health provider may not influence how willing a student is to seek help from that provider. However, it may be that preferences for on-campus and off-campus providers are influenced by living arrangements. Unfortunately, information

regarding whether students lived on or off campus was not obtained in the present study. However, future research might investigate whether preferences for on-campus and off-campus providers are impacted by where students live.

Furthermore, participants' least preferred supports were an extended family member (aunt, uncle, grandparent, etc.), a spiritual or religious leader, and a South Asian family friend. It is possible that these were the least preferred supports because participants believed their concerns were less likely to remain private if they were shared with someone in the community who was not a close friend, immediate family member, or a healthcare provider. In this vein, Ruzek and colleagues (2009) have noted that in many Asian cultures, an individual who discloses their own problems to another person may be seen as exposing disharmony in the family, which could bring shame to the entire family (Ruzek et al., 2009). While this study (Ruzek, 2009) was conducted with a broad group of Asian Americans, the findings may also apply specifically to South Asians, thus helping to explain why the current participants were less willing to share their mental health concerns with individuals outside of their immediate family or close circle of friends. This concern about maintaining a positive image of one's family within the South Asian community was expressed by one participant in particular, who wrote in their survey that they would seek help from "Someone…who is disassociated from my family and their family friend circle most importantly because there's a lot of small politics within large family friend circles in Indian families."

Moreover, it is interesting to note that preferences for seeking help from a spiritual or religious leader did vary by participants' religious backgrounds, with

Christian participants being more willing to seek help from a spiritual or religious leader than Hindu or Sikh participants. Further research is needed to understand why members of certain religious groups may be more willing than others to reach out to spiritual and religious leaders for help when dealing with a mental health concern.

Preferences for Mental Health Treatment and Types of Therapy

Individual counseling or therapy was the most preferred type of mental health treatment, and was significantly more preferred than medication, group counseling, and family therapy. It is possible that participants preferred therapy over medication because of a dislike or distrust of medications. For example, Rao et al. (2011) found that South Asian Americans reported a dislike of medication as a barrier to accessing mental healthcare, and Givens et al. (2009), found that people from ethnic minority backgrounds were less likely than Caucasian Americans to believe that medications were effective in treating depression and more likely to believe that antidepressants were addictive and dangerous. Further research is needed to understand South Asian Americans' specific beliefs around using medication to treat mental illness. Additionally, the finding that participants preferred individual therapy over group counseling or family therapy may be due to the fact individual counseling offers the most privacy and confidentiality, which may be important to students given the stigma around mental health concerns within South Asian American communities (Arora et al., 2016; Loya et al., 2010).

Additionally, when asked about the type of therapy they preferred, the majority of participants (79%) reported that they would prefer in-person therapy, while a minority reported a preference for virtual therapy (21%). It is possible this preference for in

person versus virtual therapy is impacted by the level of privacy an individual has in their home. Unfortunately, in the present study, while information regarding students' living arrangements (alone, with roommates, with family, etc.) was collected, small sample size did not allow for the detection of statistically significant differences in preferences for in-person therapy across individuals with different living arrangements. However, the data did suggest that privacy in the home could impact preferences for type of therapy. For example, among the participants who lived alone, 50% preferred virtual therapy. Meanwhile, among the participants who lived with a spouse or significant other, only 38% preferred virtual therapy. Among the participants who lived with family, 20% preferred virtual therapy. Lastly, among the participants who lived with roommates, only 14% preferred virtual therapy. These data suggest it is possible that individuals with more privacy in their homes are more likely to select virtual therapy options. Ultimately, further research is needed to understand how students' living arrangements impact their preferences for virtual versus in person therapy.

The Role of Acculturation in Help-Seeking Preferences

The present study examined how levels of acculturation and enculturation influenced students' mental health help-seeking preferences. Both acculturation and enculturation were found to be significantly correlated with seeking help from various sources of support. Of note, acculturation was found to be significantly correlated with willingness to seek help from a religious leader and family friend, which were the two least preferred sources of support overall. It is possible that these supports were least preferred by South Asian American participants due to concerns about confidentiality

and keeping personal matters private and within the family. It is also possible South Asian American individuals with higher levels of acculturation have fewer concerns about keeping personal matters within the family and are more open to talking with members of the community about their personal experiences and problems. This may also explain why acculturation was significantly correlated with a preference for group counseling.

Limitations and Directions for Future Research

Some limitations are notable in the current research. First, while this study investigated the role of various aspects of acculturation and enculturation in help-seeking attitudes, it did not consider the role of additional factors that have been found to influence help-seeking attitudes within this population, such as stigma (Arora et al., 2016; Loya et al., 2010) and beliefs about the etiology of mental illness (Karasz, 2005; Mokkarala et al., 2016). Therefore, future studies on South Asian American students' attitudes towards seeking psychological professional help might include these variables in addition to acculturation and enculturation variables.

Additionally, another limitation of the current study was that it did not account for the role of role of religiosity in help-seeking attitudes. While the present study found that a religious or spiritual leader was among the least preferred supports, it was unclear why this was the case. It is possible that a religious leader was least preferred because participants were generally not religious. Therefore, future studies might also include a measure of religiosity to explore this possibility. However, it is also possible that a religious leader was among the least preferred because the religious leaders of certain South Asian faiths (such as Hinduism or Sikhism) are less likely to be viewed

as individuals who are knowledgeable about mental health or able to offer individual counseling. For example, in the present study, participants who identified as Christians were significantly more willing than Hindus or Sikhs to seek help from a religious leader. It is possible that this difference was due to the perception that Christian religious leaders are more likely than Sikh and Hindu religious leaders to offer counseling or mental health support. Ultimately, further research is needed to understand why members of different religious backgrounds differ in their willingness to seek help from a religious or spiritual leader.

Further, while this study provided information about South Asian Americans' preferences for supports and treatments, sample size restrictions limited further in-depth analyses regarding how these preferences might differ across several cultural and demographic factors such as ethnicity, country of origin, or living arrangement. As such, future research might explore the role of these sociodemographic factors in preferences for different types of supports and treatments. For example, while the present study suggests that South Asian American students prefer individual counseling or therapy over medication, future studies might explore whether these preferences vary based on ethnicity.

Additionally, while the study provided information about students' preferred treatments and supports, it did not provide insight into why these preferences exist. In future studies, it may be beneficial for researchers to employ a qualitative methodology to gain a greater understanding of why students from this population prefer certain supports and types of treatments. Lastly, while this study found that participants' most preferred type of mental health treatment was individual therapy, it

did not yield specific information regarding participants' preferred psychotherapy modalities (such as humanistic, cognitive behavioral, or psychodynamic approaches) or preferred characteristics in a counselor or therapist (such as therapist age, ethnicity, years of experience, or cultural competency). As the majority of participants indicated they would be willing to seek individual therapy, future research on South Asian Americans' specific preferences around individualized therapy may be especially important.

Despite its limitations, the present study provides important and necessary information regarding South Asian American college students' attitudes towards seeking professional psychological help, as well as their preferences for mental health supports, treatments, and therapies. Findings suggest that while gender and participation in counseling play a role in an individual's attitudes towards mental health help-seeking, levels of acculturation and enculturation do not influence these attitudes. Further, findings suggest that South Asian American college students prefer to seek mental health support from friends as compared with family members, mental health providers, medical doctors, or other community members. Additionally, findings suggest that South Asian American students prefer to utilize individual therapy to treat mental health concerns over other treatments such as medication, group counseling, or family therapy. Ultimately, this investigation may help inform future research and the development of interventions designed to support the mental health needs of South Asian American college students.

Appendix A

Demographic Questionnaire

Please answer the following questions.

1. What is your age?

2. What is your gender? Please select one:

    - Man
    - Woman
    - Non-binary/third gender
    - Prefer not to say
    - If not listed, please describe:

3. What is your current employment status? Please select all that apply:

    - Employed full-time
    - Employed part-time
    - Active military
    - Temporarily unemployed
    - Retired
    - Student
    - Prefer not to answer

4. Please select your year in college.

    - Freshman
    - Sophomore
    - Junior
    - Senior

5. Please select your living arrangement (prior to the COVID-19 pandemic):

    - Alone
    - With roommates or friends
    - With family (parents, siblings, grandparents, etc.)
    - With significant other or spouse

- Another living arrangement. Please describe:

6. Please select your race. (Check all that apply.)

    - White
    - Black or African American
    - American Indian or Alaska Native
    - Hispanic or Latinx
    - East Asian / Pacific Islander (for example, Chinese, Korean, Japanese, etc.)
    - South Asian (for example, Bangladeshi, Indian, Pakistani, Sri Lankan, etc.,)
    - If not listed, please describe:

7. You identified as South Asian. Please identify your ethnic background. (Please select all that apply.)

    - Bangladeshi
    - Bhutanese
    - Indian
    - Maldivian
    - Nepali
    - Pakistani
    - Sri Lankan
    - If not listed, please describe:

8. Please select your generational status.

    - 1st generation – I immigrated to the United States after age 13.
    - 1.5 generation – I identify as a member of the "1.5 generation," or as someone who immigrated to the United States before age 13.
    - 2nd generation – I was born in the United States, but my parents were not.
    - 3rd generation- My parents and I were born in the United States, but my grandparents were not.
    - 4th and beyond –My grandparents, my parents, and I were born in the United States, but my great grandparents, or any generations before them, were not.
    - If your parents hold different generational statuses (for example, if one parent is an immigrant and the other is not), please explain:

9. Please select your yearly family income.

- Less than $20,000
- $20,000 to $39,000
- $40,000 to $59,000
- $60,000 to $79,000
- $80,000 to $99,000
- $100,000 to $119,000
- $120,000 to $139,000
- $140,000 to $159,000
- Over $160,000

10. Please select which religion or philosophy you identify with.

- Atheism
- Agnosticism
- Buddhism
- Christianity
- Hinduism
- Jainism
- Judaism
- Islam
- Sikhism
- Another religion. Please list:

11. What is your current overall GPA?

Appendix B

Attitudes Toward Seeking Professional Psychological Help – Shortened Form

One common problem faced by college students is struggling with mental health concerns. Please answer the following questions about mental health.

Please respond to the statements below using the following scale:

0 = Disagree 1= Partly disagree 2= Partly Agree 3= Agree

_____1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

_____2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

_____3. If I were experiencing a serious emotional crisis at any point in my life, I would be confident that I could find relief in psychotherapy.

_____4. There is something admirable in the attitude of a person willing to cope with his or her conflicts and fears without resorting to professional help.

_____5. I would want to get psychological help if I were worried or upset for a long period of time.

_____6. I might want to have psychological counseling in the future.

_____7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

_____8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

_____9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

_____10. Personal and emotional troubles, like many things, tend to work out by themselves.

11. Have you ever seen a counselor or therapist for a mental health problem?

- Yes
- No

Appendix C

Abbreviated Multidimensional Acculturation Scale

The following section contains questions about your **culture of origin** and your **native language**. By **culture of origin** we are referring to the culture of the country either you or your parents came from (e.g., Bangladesh, Pakistan, India). By **native language** we refer to the language of that country, spoken by you or your parents in that country (e.g., Bengali, Hindi, Punjabi, Urdu). If you come from a multicultural family, please choose the culture you relate to the most.

Instructions: Please circle the response from the scale that best corresponds to your answer.

	1	2	3	4
1. I think of myself as being U.S.-American.	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
2. I feel good about being U.S.-American.	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
3. Being U.S.-American plays an important part in my life.	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
4. I feel that I am part of U.S.-American culture.	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
5. I have a strong sense of being U.S.-American.	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
6. I am proud of being U.S.-American.	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree

	1	2	3	4
7. I think of myself as being _____ (a member of my culture of origin).	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
8. I feel good about being _____ (a member of my culture of origin).	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
9. Being _____ (a member of my culture of origin) plays an important part in my life.	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
10. I feel that I am part of _____ culture (culture of origin).	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
11. I have a strong sense of being _____ (culture of origin).	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree
12. I am proud of being _____ (culture of origin).	Strongly Disagree	Disagree Somewhat	Agree Somewhat	Strongly Agree

Instructions: Please circle the response from the scale that best corresponds to your answer.

	1	2	3	4
HOW WELL DO YOU SPEAK ENGLISH				
13. at school or work	Not at all	A little	Pretty Well	Extremely Well
14. with American friends	Not at all	A little	Pretty Well	Extremely Well
15. on the phone	Not at all	A little	Pretty Well	Extremely Well
16. with strangers	Not at all	A little	Pretty Well	Extremely Well
17. in general	Not at all	A little	Pretty Well	Extremely Well
HOW WELL DO YOU UNDERSTAND ENGLISH				
18. on television or in movies	Not at all	A little	Pretty Well	Extremely Well
19. in newspapers and magazines	Not at all	A little	Pretty Well	Extremely Well
20. words in songs	Not at all	A little	Pretty Well	Extremely Well
21. in general	Not at all	A little	Pretty Well	Extremely Well

	1	2	3	4
HOW WELL DO YOU SPEAK YOUR NATIVE LANGUAGE				
22. with family	Not at all	A little	Pretty Well	Extremely Well
23. with friends from the same country as you	Not at all	A little	Pretty Well	Extremely Well
24. on the phone	Not at all	A little	Pretty Well	Extremely Well
25. with strangers	Not at all	A little	Pretty Well	Extremely Well
26. in general	Not at all	A little	Pretty Well	Extremely Well
HOW WELL DO YOU UNDERSTAND YOUR NATIVE LANGUAGE				
27. on television or in movies	Not at all	A little	Pretty Well	Extremely Well
28. in newspapers and magazines	Not at all	A little	Pretty Well	Extremely Well
29. words in songs	Not at all	A little	Pretty Well	Extremely Well
30. in general	Not at all	A little	Pretty Well	Extremely Well

	1	2	3	4
HOW WELL DO YOU KNOW:				
31. American national heroes	Not at all	A little	Pretty Well	Extremely Well
32. popular American television shows	Not at all	A little	Pretty Well	Extremely Well
33. popular American newspapers and magazines	Not at all	A little	Pretty Well	Extremely Well
34. popular American actors and actresses	Not at all	A little	Pretty Well	Extremely Well
35. American history	Not at all	A little	Pretty Well	Extremely Well
36. American political leaders	Not at all	A little	Pretty Well	Extremely Well

HOW WELL DO YOU KNOW:				
37. national heroes from your native culture	Not at all	A little	Pretty Well	Extremely Well
38. popular television shows in your native language	Not at all	A little	Pretty Well	Extremely Well
39. popular newspapers and magazines in your native language	Not at all	A little	Pretty Well	Extremely Well
40. popular actors and actresses from your native culture	Not at all	A little	Pretty Well	Extremely Well
41. history of your native culture	Not at all	A little	Pretty Well	Extremely Well
42. political leaders from your native culture	Not at all	A little	Pretty Well	Extremely Well

Appendix D

Help Seeking Preferences Questionnaire

For this last section, please read the following description of a college student struggling with a mental health problem and answer the questions that follow.

Samir is a third year Biology major at a large college in the Northeastern United States. For the past 6 months, Samir has been experiencing constant and excessive worrying. He constantly finds himself worrying about his grades, his friendships, and his family. He finds it difficult to control his worrying in these areas.

Although Samir is a good student and has excelled in college thus far, he has found himself constantly worrying about his grades. At night, he has trouble falling asleep. Lying awake in his dorm room, he imagines what might happen if he fails a test or assignment. He imagines all the worst-case scenarios. He imagines himself failing a course and bringing shame upon his family, being put on academic probation, not being able to graduate on time, and not getting into medical school. He pictures himself after graduation, unable to find a job and living at home with his disappointed parents for the rest of his life. His mind fills with one worried thought after another, and no matter how hard he tries, he finds himself being unable to "shut off" his brain and go to sleep.

Additionally, although Samir is part of a close group of friends on campus, he finds himself frequently worrying about his relationships with his friends. He constantly worries that he will make a mistake and do something to disappoint or upset them. He fears that one day his friends will decide they no longer want to associate with him, and that he will be shunned by them.

Furthermore, Samir often finds himself worried about his parents' health, despite the fact that they are in their forties and healthy. He has begun calling his mother more and more frequently, constantly asking how she and his father are doing. Although Samir's mother assures him that they are fine, Samir cannot seem to shake the feeling that something bad will happen to them while he is away at college. Recently, he's begun taking trips home every weekend to check on his parents.

In his classes, Samir is unable to concentrate on the material being taught. He also feels constantly exhausted. Additionally, his friends have noticed a change in his behavior, noticing that Samir now often appears distracted.

Samir does some research on the internet and realizes he may have an anxiety disorder.

Please answer the following questions about what you would do if you were Samir. When answering, please imagine that Samir is experiencing his problem prior to the COVID-19 pandemic.

Preference Questions

Please answer the following questions about what you would do if you were Samir. When answering, please imagine that Samir is experiencing her problem prior to the COVID-19 pandemic.

1. If you were Samir, and you thought you might have an anxiety disorder, would you talk to another person about this problem?

    - Yes, I would talk to someone.
    - No, I would not to talk to anybody about this problem.

2. Samir decides he needs to talk to someone and get help. If you were Samir, who would you talk to? Please rank these people in the order in which you would turn to them, with 1 being the person you would turn to first and 12 being the person you would turn to last.

    To rank the listed items, drag and drop each item.

    - One of my close friends or a significant other
    - One of my siblings or cousins
    - Another family member, like an aunt, uncle, or grandparent
    - An on-campus psychologist, therapist, or counselor at my college's counseling center
    - An off-campus psychologist, therapist, or counselor
    - A faculty or staff member on my campus (a professor, academic adviser, coach, resident advisor, etc.)
    - A psychiatrist
    - One or both of your parents
    - My doctor or primary care physician
    - A doctor at my campus health center
    - A religious leader in my community
    - A family friend (including South Asian "aunties" and "uncles")
    - Strangers on an online forum about mental health

3. If you were Samir, are there any other people you would turn to who were not mentioned in the previous question?

    - No, there is no other person I would turn to.
    - Yes, there are other people I would turn to. Please list these people and your relationship to them below.

4. For this next question, please rate how willing you would be to turn to each of the following people or groups for support using the following scale:

1= very willing **2** = slightly willing **3** = indifferent **4** = slightly unwilling **5** = very unwilling

a) One of my close friends or a significant other
b) One of my siblings or cousins
c) Another family member, like an aunt, uncle, or grandparent
d) An on-campus psychologist, therapist, or counselor at my college's counseling center
e) An off-campus psychologist, therapist, or counselor
f) A faculty or staff member on my campus (a professor, academic adviser, coach, resident advisor, etc.)
g) A psychiatrist
h) My doctor or primary care physician
i) A doctor at my campus health center
j) A religious leader in my community
k) A family friend (including South Asian "aunties" and "uncles")
l) Strangers on an online forum about mental health

5. Samir decides to turn to a mental health professional to seek mental health treatment. If you were Samir, how willing would you be to utilize each of the following mental health treatments?

1 = very willing **2** = slightly willing **3** = indifferent **4** = slightly unwilling **5** = very unwilling

- Individual (or one-on-one) counseling or therapy with a mental health professional. This would entail you meeting with a mental health professional (such as a counselor, therapist, psychologist, or clinical social worker) to talk about your problems at a regularly scheduled time every week or every couple of weeks.

- Family counseling or therapy. This would entail a mental health professional meeting with you and some or all of your family members every week or couple of weeks. The professional would help you and your family members improve communication, resolve conflicts, and learn how to support each other.

- Medication. This would entail a mental health professional or doctor prescribing you a medication to relieve symptoms of your anxiety.

- Group counseling or therapy with other students at your college or university. This would entail you meeting with a mental health professional and a group of students who are struggling with similar problems every week or every couple of weeks.

6. Samir decides he wants to undergo counseling or therapy. He learns that he can meet in person with a therapist at the campus counseling center, or he can meet with the therapist virtually online. If you were Samir, which type of therapy would you prefer? (Please answer what your preference would be prior to the COVID-19 pandemic.)

    - In person, face-to-face counseling/therapy with a mental health professional
    - Virtual or online counseling/therapy with a mental health professional

Appendix E

Consent Form

THE UNIVERSITY OF RHODE ISLAND

IRB
Exempt Consent

Dr. Gary Stoner
Department of Psychology

You are being asked to take part in a research study. The purpose of the research study is to understand people's attitudes and preferences about seeking help for mental health difficulties. Please read the following before agreeing to be in the study. If you agree to be in this study, it will take you approximately fifteen minutes to complete this survey. Questions will be asked about the supports you would consider using if you were struggling with a mental health concern. You will be compensated by Qualtrics for completing this survey.

Your responses will be strictly anonymous. The responses may be used in a doctoral student's dissertation project or research paper.

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the investigators of this study or the University of Rhode Island (URI). Your decision will not result in any loss of benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the survey at any point during the process; additionally, you have the right to request that the researchers not use any of your responses.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have questions about the study at any time, feel free to contact Dr. Gary Stoner from the Psychology Department at the University of Rhode Island, at 401-874-4234.

Additionally, you may contact the URI Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also contact the IRB if you have questions, complaints or concerns which you do not feel you can discuss with the investigator. The University of Rhode Island IRB may be reached by phone at (401) 874-4328 or by e-mail at researchintegrity@etal.uri.edu. You may also contact the URI Vice President for Research and Economic Development by phone at (401) 874-4576.

If you would like to keep a copy of this document for your records, please print or save this page now. You may also contact the researcher to request a copy.

By clicking below to be taken to the survey, you indicate that you have read and understood the above and volunteer to participate in this study.

<< INSERT LINK or "Continue" button >>

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