ACCULTURATION AND ATTITUDES TOWARD PSYCHOLOGICAL HELP SEEKING AMONG IRANIAN AMERICANS

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ABSTRACT

Immigrants face many psychosocial stressors when leaving their culture of origin and acclimating to a new host culture. Ethnic minorities have less positive attitudes about mental health, even though they may actually be a population that should seek psychological help. The current study examined psychological help-seeking intentions in Iranian-Americans using an acculturation framework. Forty-three participants completed an online survey that assessed psychological help-seeking and acculturation. Results indicate that positive attitudes toward seeking psychological help are not related to acculturation in the present sample of respondents. This may indicate a fundamental difference between Iranian-Americans and other ethnic minorities. However, consistent with existing research, Iranian-American females expressed more positive attitudes toward psychological help-seeking than did their male counterparts. Findings also revealed that Iranian-Americans' tolerance to mental health stigma was significantly related to their intentions to ultimately seek psychological help.

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CHAPTER 1

INTRODUCTION: ATTITUDES TOWARD PSYCHOLOGICAL HELP-SEEKING AMONG IRANIAN AMERICANS

Over the years, studies have corroborated that many individuals experiencing mental illness do not receive adequate treatment (Mojtabai, Olfson, & Mechanic, 2002). According to a survey conducted by the Substance Abuse and Mental Health Services Administration (SAMSHA), close to 46 million or 20% of American adults live with a mental illness (SAMHSA, 2010). Remarkably, only 39% of these individuals receive mental health services (SAMHSA, 2010). The survey did not include, as part of the 46 million Americans with a mental disorder, several high-risk populations for mental illness such as homeless persons, active military personnel, prisoners, hospital patients, and drug and alcohol abusers. Therefore, the numbers reported by SAMHSA may be conservative and underreport the prevalence of mental illness in America. According to Kessler, Chui, Demler, and Walters (2005), about 26.2% of Americans over 18 years of age are diagnosed with some type of mental disorder, and approximately 45% of these Americans are diagnosed with two or more disorders. If mental illness is indeed much more prevalent, then the need for effective mental health services is imperative; however, individuals in need must first be willing to access the available help. There are several factors that contribute to a person's engagement in psychological services.

Attitudes toward mental health are an important predictor of the decision to seek psychological help (Cramer, 1999; Deane & Todd, 1996), and research has suggested

attitudes toward seeking professional psychological help may vary by ethnicity and gender. For example, females tend to hold a more positive and accepting attitude toward seeking psychological help than do males (Fisher & Turner, 1970; Kelly & Achter, 1995; Mackenzie, Gekoski, & Know, 2006). In the university setting, racial and ethnic minority students experience greater stress and express less positive attitudes toward seeking psychological help than their white counterparts (Kearney, Draper, & Baron, 2005). According to the National Center for Education Statistics (2012), approximately 32% of undergraduates are first-generation Americans, and those less acclimated to American culture may experience unique psychological challenges. Compared to Caucasian students, ethnic minority students reported less positive perceptions of their university environment and less positive help-seeking attitudes (Gloria, Hird, & Navarro, 2001). Benton et al. (2003) conducted longitudinal archival research using data from university counseling centers and revealed a dramatic increase in the percentage of students that were identified as depressed, anxious, suicidal, and having a personality disorder. Mental illness and suicide rates account for 15% of the burden of disease, which is defined as the years of life lost to premature death relative to healthy Americans (WHO, 2004). Based on the statistical trends reported by the World Health Organization (WHO), Mathers and Loncar (2006) project that suicide's burden of disease will worsen in the future, and will become the 12th leading cause of death in the next 30 years. The prevalence of mental health is increasing, and there appears to be a greater risk for minority groups; therefore, the use of professional psychological help is becoming increasingly essential to their overall well-being, particularly among first- and second-generation immigrants. The

purpose of the study is to assess the factors associated with acculturation, distress, and professional mental help-seeking attitudes in Iranian Americans.

Since the Islamic revolution of 1979, more than three million Iranians have left Iran for other countries (Bozorgmehr, 2001). The U.S. Census Bureau's 2011 American Community Survey reported that there are close to half a million individuals that report their ancestry as Iranian, although other sources estimate the size of the Iranian American community to be in the range of 500,000 to two million (Hosseini, 2012). Hosseini (2012) predicts that these estimates will only increase due to continued immigration from Iran and new generations of Iranian Americans being born in the United States. To complicate matters further, the Iranians living in America are now very different than when they arrived, mainly due to the migration process and acculturation to American culture. As they entered American society, many experienced cultural shock, alienation, frustration, and depression (Jalali, 2005).

Iranian refugees experienced major language, socioeconomic, and family changes that resulted in heightened levels of stress and an increase in their susceptibility to mental illness (Jalali, 2005; Pliskin, 1992). Even though there is now a large community of Iranian Americans in the United States, there is very little research about the community's mental health care needs (Ghaffarian, 1998; Jalali, 2005; Pliskin, 1992). Additionally, Iranian Americans may be in extreme need of mental health service due to the disproportionately high drug abuse within the population. According to the UN and as reported by MSN, Iran currently has the highest drug addiction rate in the world, with estimates ranging between two to five percent of the population classified as drug addicts (Epstein, 2013). In order to provide improved mental health care to Iranian Americans, it

is imperative to survey the attitudes these individuals might have toward seeking psychological help

Psychological Help-Seeking

Psychological help-seeking is an active search for psychological assistance from a mental health provider (Morgan, Ness, & Robinson, 2003). An important factor associated with the involvement in mental health services is the actual desire to seek psychological help, and the lack of available mental health services to persons with psychological illness has been linked to decreased perceptions of need for help (Mojtabai et al., 2002). Mojtabai and colleagues (2002) also found that psychological distress does not always lead to perceptions of need for professional help. Moreover, the decision-making process to seek psychological help, after perceiving a need, is influenced by a patient's perceived severity of symptoms. Vogel, Wester, Larson, and Wade (2006) state that when symptoms are perceived as nonthreatening, the process of seeking help ceases, and if symptoms are perceived as threatening, the help-seeking process actively continues.

Psychological distress is the feeling of discomfort, anxiety, and stress in response to certain events, either clear or ambiguous, that significantly interferes with a person's level of functioning in daily living (Mojtabai et al., 2002). Although distress may not always lead to perceptions of need for professional help, it may influence the actual decision to seek help. Many studies have suggested that psychological help-seeking becomes more likely as the experienced psychological distress increases in severity (Cepeda-Benito & Short, 1998; Cramer, 1999; Kelly & Achter, 1995; Morgan et al., 2003; Pillay & Rao, 2002). Thus, a person's need for psychological help is different from

making the decision to seek psychological help, although the two are related. For example, those in non-Western cultures may not even perceive a distinction between physical and psychological health. Kwang-lil, Dongen, and Dae-Ho (1999) report that non-Western cultures somaticize psychological distress more than do Western cultures, whose members report more psychological symptoms. Chang (2007) suggested that Chinese cultures use physical descriptions such as "heartache" to convey emotional responses to avoid stigmatization of psychological symptoms, which are associated with personal weaknesses. Individuals in non-Western cultures report their feelings of psychological distress as physical manifestations. Therefore, those in non-Western cultures may not make the decision to access professional psychological help because they never perceived a need, possibly due to a lack of separation between physical and psychological problems, or refused to recognize a need because of the societal stigmatization of psychological ailments. Nonetheless, the degree of experienced psychological distress is an important antecedent for those who engage in active psychological help-seeking.

Help-Seeking Attitudes

In addition to psychological distress**,** another factor associated with engaging in psychological help-seeking is a person's attitude. An attitude is a favorable or unfavorable appraisal that an individual appends to a specific behavior, and the "more positive attitude he or she has regarding a behavior, the greater his or her intentions to perform" (Ajzen, 1991, p. 88). According to Mojtabai and colleagues (2002), an accepting attitude toward psychological help-seeking is a major determinant for actually pursuing help for mental health problems. In other words, the more positive attitudes a

person has toward seeking psychological help, the higher likelihood that he or she will actually seek mental health services when compared to those with negative attitudes. Help-seeking attitude refers to the amount of effort that a person is willing to invest in the mental health process (Cepeda-Benito, & Short, 1998; Deane & Todd, 1996). The National Comorbidity Survey (NCS) reports that respondents who did not pursue mental health services, but did perceive a need, had negative attitudes toward psychological services, such as it is "too expensive," "too time-intensive," and "too inconvenient" (Mojtabai et al., 2002, p. 83). There are many individual characteristics that may influence these attitudes; the present review will discuss the influence of gender and culture.

As previously discussed, women tend to report more positive appraisals about psychological help-seeking than men (Yoo, Goh, & Yoon, 2005). Hardin and Yanico (1983) suggest that women do not expect the therapy process to be as directive as men, and their attitudes toward mental health services are grounded in the expectation that they are to take more responsibility in sessions. Moreover, Leong and Zachar (1999) discovered that lower social restrictiveness, less authoritarian viewpoints, and more accepting opinions about mental illness predict help-seeking beyond these gender differences. Therefore, the influence of gender in help-seeking attitudes may, actually, be derived from other more relevant individual differences. Morgan and colleagues (2003) observed in a sample of students from American and Asian universities that females were more receptive toward counseling than were males, and their research also revealed a potential influence of culture on attitudes.

The results of research conducted in Canada corroborates with previous research that revealed Caucasian students held more positive attitudes toward counseling than did Asian students (Leong, Wagner, & Tata, 1995; Morgan et al., 2003). Morgan and colleagues (2003) suggested that Asian students may have been experiencing lower levels of distress and this was the reason they held less positive psychological help-seeking attitudes. Conversely, research on Chinese students in Taiwan revealed that the experienced symptoms, either somatic or affective, of these individuals were negatively related to their help-seeking attitudes (Chang, 2007). Chinese students who were less likely to seek psychological help were the ones who reported more psychological distress (Chang, 2007). To the author's knowledge, there are no studies focused specifically on the relationship between Iranian-Americans' mental health attitudes and their help-seeking behaviors. However, existing research with participants from other Asian cultures besides Iran, a country in western Asia, may provide insight into the relationship between these variables among Iranian Americans.

A direct positive relationship between help-seeking attitudes and culture was revealed in Asian-American students (Liao, Rounds, & Klein, 2005). When comparing white students enrolled at universities in California and Minnesota to students enrolled at a university in Korea, a country in northeast Asia, Yoo, and Skovholt (2001) found that Korean students utilized psychological help significantly less and held more negative attitudes than white students. In another study, gender, age, education level, continent of origin, time of residence in the United States, and previous contact with mental health treatment explained almost 25% of the total variance in psychological help-seeking attitude (Dadfar & Freidlander, 1982). Country of origin was one of the strongest

predictors in this study: people in Western countries (e.g., European) expressed significantly more positive attitudes than did people in non-Western countries (e.g., Asian). The degree of acculturation among Asian international students has been reported to shape their attitudes and subsequently, their help-seeking behaviors (Zhang & Dixon, 2003). Therefore, identification with the culture of an immigrant's host country may predict positive attitudes more than his or her country of origin. The present study will explore the cultural effects on attitudes among various immigrant groups.

Acculturation

Acculturation is a key factor for immigrants in making an effective adjustment to their new host country (Ghaffarian, 1998; Organista, Marin, & Chun, 2009). According to Berry (1997), acculturation is based on the balance of two factors: maintaining the culture of origin and participating in the host culture. Immigrants have to rapidly learn the host country's language, social conventions, government bureaucracies, laws, and job skills; all of which may lead to chronic acculturative stress, which involves psychological distress, anxiety, confusion, and insecurity (Shim & Schwartz, 2008). To make things worse, immigrant family members' acculturation goals may differ from one another, and the differences could create conflict and stress in the household (Berry, 2005). According to an online survey developed by the Iranian Studies Group at MIT, almost 50% of the 3,340 respondents felt that a lack of a common vision for the future was the primary reason that prevents the first and second generation Iranian-immigrant communities from coexisting in America (Parsinejad, Mostashari, Sanay-Haie, & Rajaei, 2005). Successful psychosocial adjustment to host cultures varies depending on an immigrant's level of acculturation (Organista et al., 2009). In other words, acclimating to a new culture will

depend on a person's identification to his or her culture of origin. Unsuccessful psychosocial adjustment may result in acculturative stress, which could lead to anxiety and depression (Organista et al., 2009). Acculturative stress that leads to mental health disorders may create a vicious cycle for immigrants because acculturation influences help-seeking attitudes, which influences help-seeking behavior. Therefore, immigrants who are acculturating unsuccessfully may not seek the mental health treatment they may need.

Berry (1980) proposed four acculturation strategies based on an immigrant's maintenance of his or her cultural identity and participation in the new host society. Individuals who want to interact with other cultures, but do not desire to maintain their own cultural identity are using the assimilation strategy. Individuals who want to maintain their own cultural identity, but do not desire to interact with other cultures are using the separation strategy. Individuals who do not want to want to maintain their own cultural identity and do not desire to interact with their host culture are using the marginalization strategy. Finally, individuals who want to maintain parts of their cultural identity as well as interact with the host society are using the integration strategy (Berry, 1980). The least beneficial acculturation strategy is marginalization, since it produces the most stress, which could lead to harmful behaviors such as substance or familial abuse (Berry, 1980). Ghaffarian (1998) indicated that using an integration strategy (adopting American culture while retaining Iranian culture) was associated with better adjustment and well-being. However, marginalization is not entirely avoidable, as the loss of interest in the heritage culture may be involuntary, possibly due to lack of exposure, and the loss of interest in interacting with the host culture could be due to ethnic discrimination and

exclusion. The integration strategy involves selectively adopting new behaviors from the new host society, while at the same time retaining features the old culture that are beneficial, and has been associated with the lowest levels of acculturative stress (Berry, 1980; 2003; 2005; Organista et al., 2009). The present study will examine which acculturation strategy is most commonly used in the sample of Iranian-American participants, and which strategy is associated with the most positive help-seeking attitudes.

Iranian Americans

Although there have been few studies focusing on Iranian Americans, studies of acculturation have reported differences in psychosocial adjustment in other ethnic minorities, including Latino Americans, African Americans, and Asian Americans (Leong et al., 1995; Liao, Rounds, & Klein, 2005; Wallace & Constantine, 2005; Yoo & Skovholt, 2001). Understanding the fundamental differences between American and Iranian culture provides insight into potential obstacles Iranian Americans face in acculturating successfully. Brown and Landreth (1983) succinctly describe some of the major differences between the Iranian and American cultures:

> Iran has a history of monarchy; America is a democracy. Iran has a Zoroastrian-Moslem heritage; America has a Judeo-Christian heritage. Iran is old; America is young . . . The majority of Iranians are members of extended families; the majority of Americans are members of nuclear families." (p. 238)

Furthermore, Iranian families are extremely patriarchal, as the father is the unquestionable head of the family with absolute authority over the extended family, including the grandchildren (Jalali, 2005). Sam (2006) states that relative to men, Iranian

women are more susceptible to acculturative stress as it relates to acclimating to a new culture. Moreover, the Iranian culture emphasizes males as the authority figure in a family, and more authoritarian positions have been shown to be associated with less positive attitudes (Leong & Zachar, 1999). Therefore, the present study examines gender differences in attitudes toward seeking psychological help.

Mental health professionals must have an appropriate understanding of the factors, such as quality of life, that contribute to the mental health needs of Iranian Americans. Foroughi, Misajon, and Cummins (2001) compared quality of life measures, defined as a general subjective satisfaction with current life circumstances, among Iranian-Australian, native-born Australians, and Iranians residing in Iran, and revealed quality of life was associated with age of immigration; people who immigrated at older ages reported lower subjective quality of life or well-being. These researchers also found that the number of years as a resident of one's host country did not predict his or her level of successful adjustment (Foroughi et al., 2001). For replication purposes, the age of immigration will be investigated in the present study.

The Present Study

The present study investigates the relationship between acculturation and attitudes toward psychological help-seeking among Iranian Americans. Prior use of mental health services was a predictor of positive help-seeking attitudes (Wallace & Constantine, 2005); therefore, the present study will also inquire about prior mental health treatment. The principal investigator hopes to fill a gap in the current literature by examining predictors of psychological help-seeking among Iranian Americans. First and second generation immigrants with varying ages, lengths of time in America, and gender may

experience acculturation differently; therefore, the present study will assess these variables and their relationship with psychological help-seeking.

Hypotheses

Iranian Americans who identify more with the American culture will hold more positive attitudes toward seeking psychological help than those who identify more with Iranian culture. Iranian Americans who utilize Berry's (1980) integration strategy will have more positive psychological help-seeking attitudes than individuals who use the separation and assimilation acculturation strategies. Women will hold more positive attitudes toward seeking psychological help than will Iranian American men. First generation Iranian Americans will hold less positive attitudes toward seeking professional psychological help than will second generation Iranian Americans. Psychological help-seeking attitudes, the continuous acculturation score, number of years of residency in America, and a participant's degree of acculturation as measured by the VIA will positively predict previous access to mental health services. Psychological help-seeking intentions will be positively correlated with the stigma tolerance subscale, which measures a person's willingness to seek help even if there is a perceived stigma.

CHAPTER 2

STUDY

Method

Participants

There were 43 respondents in the present sample; 12 males, 23 females, and eight who did not identify with a gender. All of the participants were of Iranian ancestry, possessed Iranian and American dual citizenship, and were at least 18 years old (M_{age} = 47.37, SD_{age} = 13.11). There were 38 participants who identified being the first generation of immigrants to America, five participants who identified being the second generation, and two who identified with the third generation. Participants were sampled from the researcher's social network, Network of Iranian American Professionals of Orange County (NIPOC), and the Iranian American student associations at four public universities in Southern California.

Measures

A packet containing eight instruments was provided to participants. The entire survey took between 15 and 30 minutes to complete. The survey packet was provided hard copy to volunteer participants.

Demographics. Participants completed a 12-item socio-demographic questionnaire that asked each respondent's gender, marital status, level of education, living situation, residency, employment status, annual income, age, and generational

status. Following the initial socio-demographics questionnaire, participants were asked to provide any self-reported health conditions in the past year, whether they have ever accessed mental health services in the United States, and their perceived ratings of physical health using a Likert-type scale.

Acculturation level. To assess participants' level of acculturation, the Iranian Acculturation Scale (IAS) (Shahim, 2007) and the Vancouver Index of Acculturation (VIA) (Ryder, Alden, & Paulhus, 2000) were administered. The Iranian Acculturation Scale (IAS) (Shahim, 2007) measures language usage, family-related attitudes, values, and cultural identity, and is grounded in Berry's (1999) multidimensional model of acculturation. The acculturation index is a mean score ranging from low acculturation (1) to high acculturation (3) to the American culture. The IAS asks questions related to four factors (language; cultural identity; family-related attitudes; and family-related values), and provides a single score. The resulting score can be used as a continuous scale variable, but for the present study, all of the items were divided by four (representing the IAS factors) to give an average total score and was interpreted as an ordinal scale variable according to Berry's (1980) model: 1 = separation strategy; 2 = integration strategy; and 3 = assimilation strategy (this scale does not consider the marginalization strategy; Shahim, 2007). The IAS was standardized on a sample of 119 Iranians born in Canada and has good internal consistency ($\alpha = 0.83$). According to Yamada (2006), this instrument is not age-specific and may contain items inappropriate for later life. Despite these shortcomings, this scale is important to use because it can be interpreted in terms of Berry's (1980) acculturation model.

The Vancouver Index of Acculturation (VIA), designed by Ryder et al. (2000), was also be administered in order to assess participants' level of acculturation. The VIA separates scores into two subscales (one for culture of origin and another for the host culture) and distinguishes between the acquisition of and practices from the new American culture versus the loss of practices from the heritage cultural with a 20-item scale. Ten items measure a respondent's engagement in the American (mainstream) culture and the other ten items measure engagement in his or her heritage culture; giving two subscale scores. Participants were asked to indicate their degree of agreement using a 9-point scale: 1 (Disagree) to 9 (Agree). An example item is, "I am comfortable interacting with typical American people." The VIA has acceptable internal consistency; Cronbach's alphas for the Heritage subscale and Mainstream subscale were .79 and .75, respectively (Ryder et al, 2000). The VIA scores of the current sample were acceptable for both the Heritage (α = .861) and Mainstream (α = .804) subscales. The VIA was included because it provides two distinct measures of identification with the mainstream culture (America) and with the heritage culture (Iranian).

Satisfaction with Life Scale (SWLS). Diener, Emmons, Larsen, and Griffin (1985) developed the SWLS to measure perceived psychological well-being (Pons, Atienza, Balaguer, & Garcia-Merita, 2000). There are five items that comprise this scale. Example items on the SWLS are, "In most ways my life is close to ideal" and, "The conditions of my life are excellent." The SWLS has good internal reliability (r = .61 - .81) and divergent construct validity with the Beck Depression Inventory (r = -.72; Blais, Vallerand, Pelletier, & Briere, 1989) and general psychological distress (r = -.55).

Attitudes Toward Seeking Professional Psychological Help (ATSPPHS-SF).

Iranian Americans' attitudes toward seeking psychological help was measured using the Attitude Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPHS-SF) (Fisher & Farina, 1970). The scale contains 29 Likert-type items with four subscales: Recognition, Tolerance, Interpersonal, and Confidence. Due to problems related to reliability, a condensed version of the ATSPPHS scale was developed, the ATSPPH-SF, by Fischer and Farina (1995) for use in research. The shortened scale includes 10 items that examine attitudes toward seeking psychological help. Participants were asked to indicate their degree of agreement using a 4-point scale (0 = Disagree to 4 = Agree) with 10 statements about seeking mental health services; higher scores indicate more positive attitudes. For example, an item on the ATS-SF is, "I might want to have psychological counseling in the future" and a reverse coded item is, "Personal and emotional troubles, like many things, tend to work out by themselves."

The ATSPPHS-SF has good internal reliability ($\alpha = .84$), test-retest reliability ($r = .80$) over a one-month period, and discriminates between college students who chose to seek psychological help versus those who did not (Fisher & Farina, 1995). Due to acceptable psychometric properties and use in previous research, the ATSPPHS-SF will be used in the present study. The ATSPPHS-SF does not measure intentions to seek psychological help; however, research has suggested that attitudes are positively related to intentions to seek psychological help and negatively associated with self-concealing tendencies (Vogel et al., 2005). Vogel and colleagues (2005) based their interpretations on data from college students enrolled in a large Midwestern University in the United States, so the relationship between attitudes and intentions may not exist for Iranian

immigrants. Therefore, the relationship between scores on the ATSPPHS-SF scale and a different measurement of intentions and self-concealing tendencies (stigma tolerance) toward help-seeking behavior was assessed.

Belief About Psychological Services (BAPS). The BAPS is an 18-item measure of beliefs about psychological help-seeking that shares six questions in common with the ATSPPHS, and the BAPS positively correlates with the ATSPPHS-SF (r = .71; Ægisdóttir & Gerstein, 2009). Attitudes, beliefs, and intentions are often confused and used interchangeably, but the BAPS is an instrument that separates these concepts into three different subscales: Intentions to seek psychological services, Stigma Tolerance, and Expertness. The intentions subscale refers to the probability that a respondent would seek mental health services from a professional if the situation arose in the future (e.g. "At some future time, I might want to see a psychologist"). The stigma tolerance subscale refers to the open-mindedness of a respondent to mental health services, despite the stigma that may exist (e.g., "If I thought I needed psychological help, I would get this help no matter who knew I was receiving assistance"). The expertness subscale refers to a respondent's confidence in a psychologist's ability to provide helpful psychological treatment (e.g., "Psychologists provide valuable advice because of their knowledge about human behavior"). The internal reliability reported in the literature for the Intentions, Stigma Tolerance, and Expertness subscales were between .69 and .81 (Vogel et al., 2005). For the present study, internal reliability measures for the Intentions (α = .826), Stigma Tolerance (α = .81), and the Expertness (α = .735) subscales were acceptable.

Procedure

Participants were directed to a Qualtrics survey, an online survey distribution service, where participants completed the survey in English. Once the participants accessed the survey, they were asked to read an informed consent form with a brief description of the study and a denotation of their rights as research participants. Next, participants completed each of the scales described above; the order of the scales was randomized to control for order effects. Once the scale questions were answered, participants were directed to a final demographic questionnaire that asked socio-demographic and general health questions.

Results

The current study hypothesized that Iranian Americans who identify more with American culture than Iranian culture will report more positive attitudes toward seeking psychological help. Using the two VIA subscales, a cultural identity variable was created to group the participants into one of two possible groups: whether each participant identified more with Iranian culture or with American culture. Two participants were excluded from the first analysis because their scores indicated that they endorsed both the Iranian and American culture equally. Participants who identified more with the Iranian Culture reported equally positive ratings toward psychological help-seeking (M = 30.88, SD = 7.05) as participants who identified more with American Culture (M = 30.46, SD = 3.43), $t(28) = 0.20$, $p = .845$).

To assess the second hypothesis, the IAS scores were averaged to be interpreted in Berry's (1980) acculturation framework. According to their scores, participants in the present study only used two strategies, assimilation and integration. Therefore, an

independent samples *t*-test was conducted on ATSPPH scores. Positive attitudes toward seeking psychological help did not significantly differ between participants who used the integration strategy ($M = 28.95$, $SD = 6.67$) and participants who used the assimilation strategy ($M = 32.25$, $SD = 3.24$), $t(33) = -1.81$, $p = .080$.

Gender differences in psychological help-seeking attitudes were assessed with a series of independent samples t-tests. Females ($M = 31.52$, $SD = 5.05$) reported significantly higher ATSPPH scores than did males ($M = 27.18$, $SD = 5.71$), $t(30) = -2.21$, $p = .035$. When assessing the three BAPS subscales, one additional gender difference emerged. Males ($M = 4.35$, $SD = 0.84$) reported significantly less belief in the potential of psychologists to help (BAPS Expertness) than did females ($M = 4.95$, $SD = 0.75$), $t(32) = -2.14$, $p = .040$. The difference in scores between males ($M = 4.17$, $SD = 1.02$) and females ($M = 4.69$, $SD = 0.63$) on the BAPS Intent subscale was non-significant, $t(31) = -1.84$, $p = .075$. Likewise, the difference in scores between males ($M = 4.29$, $SD = 1.02$) and females ($M = 4.89$, $SD = 0.71$) on the BAPS Stigma Tolerance subscale was non-significant, $t(32) = -2.00$, $p = .053$.

There were not enough second or third generation Iranian participants in the present dataset, so the fourth hypothesis regarding generational differences could not be tested. A binary logistic regression tested the fifth hypothesis, which stated that the ATSPPH, IAS, number of years of residency in America, and VIA American subscale would predict whether a participant had previously accessed mental health services. This analysis resulted in a non-significant regression model, $F(4, 26) = 1.12$, $p = .370$.

The sixth and final hypothesis stated that there would be a positive correlation between participants' intentions to seek psychological help and their tolerance toward

stigma related to receiving mental health services. As predicted, the BAPS Intention subscale and the BAPS Stigma Tolerance subscale were significantly and positively correlated, $r = .355$, $p = .034$ (Table 1).

Discussion

The findings of the current study did not support the hypothesis that positive attitudes toward seeking psychological help were related to acculturation among Iranian American participants. When using the VIA subscales to create the cultural identification grouping variable, no differences between psychological help-seeking attitudes were revealed. The current study used another measure of acculturation, based on Berry's (1980) framework, to compare attitudes toward seeking psychological help between those who used different acculturation strategies. There were no differences between participants who used the assimilation strategy and participants who used the integration strategy in terms of endorsement of positive attitudes toward seeking psychological help. The hypothesis regarding generational differences in psychological help-seeking attitudes could not be assessed in the current study. These attitudes toward seeking psychological help, the VIA acculturation subscale scores, and the number of years of residency in America did not significantly predict whether participants accessed mental health services in the past. Based on these findings, it appears that positive attitudes toward psychological help-seeking and acculturation are not related in Iranian Americans; there could be fundamental differences between Iranian Americans and other ethnic minorities in terms of acculturation.

Although the differences reported above are conflictual with the findings of other immigrant groups, one consistent finding was that gender was related to help-seeking

attitudes among Iranian Americans. Findings revealed gender differences that were consistent with Mackenzie and colleagues (2006). Females reported more positive psychological help-seeking attitudes and stronger beliefs in expert psychologists to help with mental health concerns than did male participants. Indicating that the gender difference reported in previous research was also observed in the current sample of Iranian Americans.

To further assess the relationship between attitudes, beliefs, and intentions, the BAPS subscales were used to determine if a participant's stigmatizing beliefs about mental health was related to his or her intentions to actually seek psychological help. The results revealed a positive and significant relationship between the BAPS Stigma Tolerance and Intentions subscales, which was the only supported hypothesis of the current study. This finding suggests that Iranian Americans who can accept the stigma associated with seeking mental help are the individuals who are more likely to plan to seek the mental help. The implication is that completely eradicating the existence of mental health stigma may not be necessary for this population, but merely increasing awareness and understanding of psychological issues in a manner that facilitates tolerance may be sufficient to increase the prevalence of Iranian Americans in the mental health setting.

Table 1. Correlation Matrix for the Variables in Interest in the Present Study.

	IAS Continuous	ATSPPH	BAPS INTENT	BAPS STIGMA TOLERANCE	BAPS EXPERTNESS
IAS Continuous	1	.353*	.198	.403*	.381*
ATSPPH	.353*	1	.586**	.643**	.478**
BAPS INTENT	.198	.586**	1	.355*	.555**
BAPS STIGMA TOLERANCE	.403*	.643**	.355*	1	.583**
BAPS EXPERTNESS	.381*	.478**	.555**	.583**	1

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

Strengths, Limitations, and Future Directions

The lack of relationship between the variables of the current study may have been attributed to the small, homogeneous sample. The current study only had responses from immigrants who used either the assimilation or integration strategies (Berry, 1980) and the inventory was only offered in English, which may have restricted the sample to those who are well-adjusted to American culture. Moreover, there were only 13 participants who had disclosed that they had accessed mental health services previously. Future studies may want to investigate other outcome variables, such as informal mental health practices (e.g., comfort in talking to loved ones or friends about personal problems) in order to better understand predictors of Iranian Americans' usage of mental health services. Despite these limitations, this study examines an underrepresented group in the literature and it is important to understand whether or not existing research on other groups is relevant for understanding the Iranian American population. For example, there could be differences in how Iranians experienced acculturating into American society.

According to the Public Affairs Alliance of Iranian Americans (PAAIA), the four benchmarks of assimilation include language proficiency, intermarriage, spatial concentration, and socio-economic status (PAAIA, 2014). The first benchmark of assimilation is language proficiency, therefore successful assimilation into American culture would be referring to English fluency. The instruments used in the study were all delivered in English, so there were no strictly Farsi-speaking participants in the current sample. It would be interesting for future research to assess immigrants living in America that have not adopted the English language and have stayed limited to maintaining their Iranian culture; this subset of immigrants may use the separation strategy, only

interacting with their culture of origin and not the host culture. The second benchmark of assimilation is intermarriage (PAAIA, 2014). Approximately 50% of Iranian Americans within the years of 1995 and 2007 married non-Iranian Americans, and only 21% of Iranian Americans reported interacting exclusively with other Iranian Americans outside of work settings (PAAIA, 2014). The Small Business Administration conducted a study that ranked Iranian Americans in the top 20 immigrant groups with the highest rate of business ownership in America (PAAIA, 2014). Considering the four benchmarks of Iranian American assimilation, it appears that a majority of Iranians have assimilated into the United States culture, maybe more so than other recent immigrant groups.

As mentioned previously, a limitation of the current study is the small, homogeneous sample. The findings of the current study did not support the hypotheses, suggesting that there may actually be a difference in the Iranian American immigrant group relative to the other immigrant groups mentioned earlier (Asia, Yoo, & Skovholt, 2001; Liao, Rounds, & Klein, 2005; Zhang & Dixon, 2003). Regardless, acculturation, measured in multiple ways, was not associated with positive attitudes toward seeking psychological help in the Iranian American respondents of the current study. Perhaps Iranian Americans face unique challenges to accessing mental health services and researchers are only beginning to understand the factors that may predict their psychological help-seeking behavior.

APPENDIX A

INFORMED CONSENT

CONSENT TO ACT AS A HUMAN PARTICIPANT
INFORMED CONSENT
Iranian American Survey

Dear Participant,

My name is Aryan Ansari. I am a graduate student at California State University, Fullerton.

You are invited to participate in a research study on mental health services. The purpose is to assess your cultural opinions and mental health to assist in the understanding of Iranian American culture. Once you give your consent, you will be asked to fill out a self-report survey.

Total time to fill out the survey is estimated to be between 15 and 30 minutes. There contains no foreseeable risks for participants. All information that is obtained will remain confidential and anonymous; moreover, your name will not be kept with your responses. Data collected will be stored on a password protected computer. The data will be retained for future analysis and publication. Research records will be kept confidential to the extent allowed by law.

Should you feel uncomfortable answering any of the questions, you may choose not to answer. If you have any questions or concerns, please contact be via email at aansari@csu.fullerton.edu. If you have questions about the rights of human research participants, please contact the CSUF IRB Office at 657.278.7640 or irb@fullerton.edu.

By signing below, you agree that . . .
- are least 18 years of age
- willingly agree to participate in this survey
- have read and understood the information provided
- understand that you may withdraw your consent and discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled

Sign: _____ Date:_____

APPENDIX B

PROVIDED STUDY PACKET

VIA (20 questions)

Instructions: Carefully read *each* question, as some will ask you about *Iranian* culture and some will ask about *American* culture.
Please circle *one* of the numbers to the right of each question to indicate your degree of agreement or disagreement.

Circle the number in the appropriate column	*Completely Disagree*								*Completely Agree*
1. I often participate in *Iranian* cultural traditions.	1	2	3	4	5	6	7	8	9
2. I often participate in *American* cultural traditions.	1	2	3	4	5	6	7	8	9
3. I would be willing to marry a person from the *Iranian* culture.	1	2	3	4	5	6	7	8	9
4. I would be willing to marry a white *American* person.	1	2	3	4	5	6	7	8	9
5. I enjoy social activities with people from the *Iranian* culture.	1	2	3	4	5	6	7	8	9
6. I enjoy social activities with people from the *American* culture.	1	2	3	4	5	6	7	8	9
7. I am comfortable interacting with people of the *Iranian* culture.	1	2	3	4	5	6	7	8	9
8. I am comfortable interacting with typical *American* people.	1	2	3	4	5	6	7	8	9
9. I enjoy entertainment (e.g. movies, music) from the *Iranian* culture.	1	2	3	4	5	6	7	8	9

10. I enjoy *American* entertainment (e.g. movies, music).	1	2	3	4	5	6	7	8	9
11. I often behave in ways that are typically *Iranian*.	1	2	3	4	5	6	7	8	9
12. I often behave in ways that are typically *American.*	1	2	3	4	5	6	7	8	9
13. It is important for me to maintain or develop the practices of the *Iranian* culture.	1	2	3	4	5	6	7	8	9
14. It is important for me to maintain or develop *American* cultural practices.	1	2	3	4	5	6	7	8	9
15. I believe in the values of the *Iranian* culture.	1	2	3	4	5	6	7	8	9
16. I believe in mainstream *American* values.	1	2	3	4	5	6	7	8	9
17. I enjoy the jokes and humor of the *Iranian* culture.	1	2	3	4	5	6	7	8	9
18. I enjoy *American* jokes and humor.	1	2	3	4	5	6	7	8	9
19. I am interested in having friends from the *Iranian* culture.	1	2	3	4	5	6	7	8	9
20. I am interested in having *American* friends.	1	2	3	4	5	6	7	8	9

IAS (26 questions)

Instructions: Read each question carefully and please select the response below each statement that *most accurately* reflects what is true for you.

1. In what language do you usually think?

A: Only Farsi (Persian)
B: More often Farsi (Persian)
C: Both English & Farsi (Persian)
D: More often English
E: Only English

2. When did you read a book in Farsi (Persian)?

A: During the last 30 days
B: During the last 6 months
C: During the last year
D: More than a year ago
E: I never read in Farsi (Persian)

3. When did you read a newspaper (or Internet news) in Farsi (Persian)?

A: During the last 7 days
B: During the last 30 days
C: During the last year
D: More than a year ago
E: I never read in Farsi (Persian)

4. When did you watch Iranian TV or Video, or listen to the radio in Farsi?

A: During the last 7 days
B: During the last 30 days
C: During the last year
D: More than a year ago
E: I never Watch Iranian TV or Video, or listen to the radio in Farsi (Persian)

5. When did you last listen to Persian music?

A: During the last 7 days
B: During the last 30 days
C: During the last year
D: More than a year ago

6. What type of food do you eat more often?

A: More often Iranian
B: Iranian more than Non-Iranian
C: Iranian and Non-Iranian to the same level
D: Non-Iranian more than Iranian
E: More often Non-Iranian

7. How important is it that the Iranian tradition be followed?

A: Is very important
B: Is somewhat important
C: Is not very important
D: Is not important at all

8. How often do you attend Iranian recreational events?

A: Once in a month
B: Few times in a year
C: Rarely
D: Never

9. How often do you attend Iranian religious events?

A: Once in a month
B: Few times in a year

C: Rarely
D: Never

10. What language do you use (would you use) to communicate with your spouse?
A: Only Farsi (Persian)
B: More Often Farsi (Persian)
C: Both English & Farsi (Persian)
D: More Often English
E: Only English

11. What language do you use (would you use) to communicate with your children?
A: Only Farsi (Persian)
B: More Often Farsi (Persian)
C: Both English & Farsi (Persian)
D: More Often English
E: Only English

12. What language do you use when you speak with your Iranian friends?
A: Only Farsi (Persian)
B: More Often Farsi (Persian)
C: Both English & Farsi (Persian)
D: More Often English
E: Only English

13. In what language are your reading skills better?
A: Farsi (Persian)
B: Both English & Farsi (Persian) D: English & other languages
E: English

14. In what language are your writing skills better?
A: Farsi (Persian)
B: Both English & Farsi (Persian) D: English & other languages
E: English

15. What ethnic group do you identify?
A: Only Iranian nationality
B: More with Iranian nationality
C: With Iranian & Western nationalities equally
D: More with Western nationality
E: Only Western nationality

16. How do you see your future and progress in the United States?
A: I will not experience any progress
B: I will not experience much progress
C: I will experience progress
D: I will progress very much

17. Did you come to the United States to improve the future of your children?
A: Completely agree
B: Agree
C: Somewhat agree
D: Do not agree
E: Do not agree at all

18. Did you come to the United States to improve your career opportunities?
A: Completely agree
B: Agree
C: Somewhat agree
D: Do not agree
E: Do not agree at all

19. Marriage of children should be arranged…

A: By parents
B: By parents and with agreement of children
C: The couples should arrange the marriage themselves

20. To what extent do you celebrate holidays such as Christmas?

A: Very often
B: Somewhat
C: Never

21. Dating for a female teenager …

A: Should be allowed
B: Under supervision of parents can it be allowed
C: Never should be allowed

22. Association of female teenagers and young adults of the opposite sex…

A: Should be allowed
B: Under supervision of parents can it be allowed
C: Never should be allowed

23. Out of ten of your friends, how many are Iranian?

A: 1 to 2 persons
B: 3 to 5 persons
C: 6 to 8 persons
D: 9 to 10 persons

24. What is the major consideration in choosing a spouse for your children?

A: Similarity of religion
B: Similarity of nationality
C: Similarity of religion and nationality are equally important
D: Individuals should be chosen regardless of their religions and nationalities

25. Dating of male teenagers …

A: Should be allowed
B: Under supervision of parents can it be allowed
C: Never should be allowed

26. Association of male teenagers and young adults of the opposite sex …

A: Should be allowed
B: Under supervision of parents can be allowed
C: Never should be allowed

SWLS (5 questions)

Instructions: Please indicate (circle *one* number) your agreement by selecting the appropriate response from the following scale:

Circle the appropriate response:	Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
1. In most ways my life is close to ideal.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
2. The conditions of my life are excellent.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
3. I am satisfied with my life.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
4. So far I have gotten the important things I wanted in life.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
5. If I could live my life over, I would change almost nothing.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

ATSPPHS-SF (10 questions)

Instructions: Read each statement carefully and indicate your degree of agreement using the scale on the right (circle *one* number):

	Disagree	**Partly Disagree**	**Partly Agree**	**Agree**
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	**0**	**1**	**2**	**3**
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	**0**	**1**	**2**	**3**
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	**0**	**1**	**2**	**3**
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	**0**	**1**	**2**	**3**
5. I would want to get psychological help if I were worried or upset for a long period of time.	**0**	**1**	**2**	**3**
6. I might want to have psychological counseling in the future.	**0**	**1**	**2**	**3**
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.	**0**	**1**	**2**	**3**
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	**0**	**1**	**2**	**3**
9. A person should work out his or her own problems; getting psychological counseling would be a last resort.	**0**	**1**	**2**	**3**
10. Personal and emotional troubles, like many things, tend to work out by themselves.	**0**	**1**	**2**	**3**

BAPS (18 questions)

Instructions: Please read the following statements and rate them using the scale provided. Circle the number that most accurately reflects your attitudes and beliefs about seeking psychological help. There are no "wrong" answers, just rate the statements as you honestly feel or believe.

Circle the number in the appropriate column	**Strongly Disagree**					**Strongly Agree**
1. If a good friend asked my advice about a serious problem, I would recommend that he/she see a psychologist.	1	2	3	4	5	6
2. I would be willing to confide my intimate concerns to a psychologist.	1	2	3	4	5	6
3. Seeing a psychologist is helpful when you are going through a difficult time in your life.	1	2	3	4	5	6
4. At some future time, I might want to see a psychologist.	1	2	3	4	5	6
5. I would feel uneasy going to a psychologist because of what some people might think.	1	2	3	4	5	6
6. If I believed I was having a serious problem, my first inclination would be to see a psychologist.	1	2	3	4	5	6
7. Because of their training, psychologists can help you find solutions to your problems.	1	2	3	4	5	6
8. Going to a psychologist means that I am a weak person.	1	2	3	4	5	6
9. Psychologists are good to talk to because they do not blame you for the mistakes you have made.	1	2	3	4	5	6
10. Having received help from a psychologist stigmatizes a person's life.	1	2	3	4	5	6
11. There are certain problems that should not be discussed with a stranger such as a psychologist.	1	2	3	4	5	6
12. I would see a psychologist if I was worried or upset for a long period of time.	1	2	3	4	5	6
13. Psychologists make people feel that they cannot deal with their problems.	1	2	3	4	5	6
14. It is good to talk to someone like a psychologist because everything you say is confidential.	1	2	3	4	5	6
15. Talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	1	2	3	4	5	6
16. Psychologists provide valuable advice because of their knowledge about human behavior.	1	2	3	4	5	6
17. It is difficult to talk about personal issues with highly educated people such as psychologists.	1	2	3	4	5	6
18. If I thought I needed psychological help, I would get this help no matter who knew I was receiving assistance.	1	2	3	4	5	6

K6 (6 questions)

Instructions: The following questions are about how you have been feeling during the **past 30 days**.

	All	Most	Some	A little	None	Don't know	Refuse to answer
1. About how often during the past 30 days did you feel **nervous** – would you say **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?	**4**	**3**	**2**	**1**	**0**	**-**	**-**
2. During the past 30 days, about how often did you feel **hopeless** – **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?	**4**	**3**	**2**	**1**	**0**	**-**	**-**
3. During the past 30 days, about how often did you feel **restless or fidgety**? (**All** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?)	**4**	**3**	**2**	**1**	**0**	**-**	**-**
4. How often did you feel **so depressed that nothing could cheer you up?** (**All** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?)	**4**	**3**	**2**	**1**	**0**	**-**	**-**
5. During the past 30 days, about how often did you feel that **everything was an effort?**	**4**	**3**	**2**	**1**	**0**	**-**	**-**
6. During the past 30 days, about how often did you feel **worthless?**	**4**	**3**	**2**	**1**	**0**	**-**	**-**

RS (25 questions)

Instructions: Please read each statement and circle the number to the right of each statement.

Circle the number in the appropriate column	Strongly Disagree						Strongly Agree
1. When I make plans, I follow through with them.	1	2	3	4	5	6	7
2. I usually manage one way or another.	1	2	3	4	5	6	7
3. I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
4. Keeping interested in things is important to me.	1	2	3	4	5	6	7
5. I can be on my own if I have to.	1	2	3	4	5	6	7
6. I feel proud that I have accomplished things in life.	1	2	3	4	5	6	7
7. I usually take things in stride.	1	2	3	4	5	6	7
8. I am friends with myself.	1	2	3	4	5	6	7
9. I feel that I can handle many things at a time.	1	2	3	4	5	6	7
10. I am determined.	1	2	3	4	5	6	7
11. I seldom wonder what the point of it all is.	1	2	3	4	5	6	7
12. I take things one day at a time.	1	2	3	4	5	6	7
13. I can get through difficult times because I've experienced difficulty before.	1	2	3	4	5	6	7
14. I have self-discipline.	1	2	3	4	5	6	7
15. I keep interested in things.	1	2	3	4	5	6	7
16. I can usually find something to laugh about.	1	2	3	4	5	6	7
17. My belief in myself gets me through hard times.	1	2	3	4	5	6	7
18. In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
19. I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
20. Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
21. My life has meaning.	1	2	3	4	5	6	7
22. I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
23. When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
24. I have enough energy to do what I have to do.	1	2	3	4	5	6	7
25. It's okay if there are people who don't like me.	1	2	3	4	5	6	7

Demographic Questionnaire (19 questions)

1. AGE:_____ | **2. GENDER:**

3. MARITAL STATUS:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed

4. EDUCATION:

- ☐ Less than 8th grade
- ☐ Less than 12th grade
- ☐ Completed high school
- ☐ Technical/Vocational Training
- ☐ Completed some college
- ☐ Bachelor's degree
- ☐ Graduate Degree

5. How many years of formal education did you complete?

6. LIVING SITUATION:

- ☐ Live alone
- ☐ Live with spouse
- ☐ Live with relatives
- ☐ Live with children
- ☐ Live with friends
- ☐ Other

7. RESIDENCE:

- ☐ House
- ☐ Apartment/Townhouse
- ☐ Other
- ☐ Retirement Community
- ☐ Assisted Living

8. How long have you lived in the United States (in years)? _____

9. What age (in years) were you when you came to the United States? _____

10. Are you the 1st, 2nd, or 3rd generation in your family to reside in the United States?

11. EMPLOYMENT STATUS:

- ☐ Full-time
- ☐ Part-time
- ☐ Unemployed
- ☐ Homemaker
- ☐ Retired
- ☐ Disabled

12. OCCUPATION (OR FORMER OCCUPATION)?

_____

13. GROSS ANNUAL INCOME:

- ☐ Less than $12,000
- ☐ $13,000 - $20,000
- ☐ $21,000 – 35,000
- ☐ $36,000 - $50,000
- ☐ $51,000 – $65,000
- ☐ $66,000 or more

14. How would you describe your health these days?

- ☐ Very poor
- ☐ Somewhat poor
- ☐ Poor
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good
- ☐ Excellent

15. Is your health better now, about the same, or worse than a year ago?

- ☐ Better
- ☐ About the same
- ☐ Worse

16. Would you say your health is better, the same, or worse than most people your age?

- ☐ Better
- ☐ About the same
- ☐ Worse

17. How much do health troubles stand in the way of doing the things you want to do?

- ☐ Not at all
- ☐ A little (some things)
- ☐ A great deal

18. Regarding your health over the past year, have you had any of the following conditions?

Blood pressure problems	Yes	No
Stroke	Yes	No
Nervous or tense	Yes	No
Sleep troubles	Yes	No
Depression	Yes	No
Anxiety	Yes	No

19. Have you accessed (or tried to access) mental health services in the United States?

YES **NO**

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