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Differences in Psychological Distress for United States Native and Foreign Born Populations: Testing for Mediation of Neighborhood Satisfaction, Poverty, and Health Insurance

An Undergraduate Honors Thesis
Submitted in Partial fulfillment of
University Honors Program Requirements
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by

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Abstract

The current study examines the difference in frequency of psychological distress between people born in the United States and people born outside of the United States. Further, this study tested for mediating effects of neighborhood satisfaction, poverty status, and health insurance. This study included data from the National Health Interview Survey. Those born outside of the United States were found to report slightly better mental health outcomes. They experienced psychological distress at a lower rate than those born in the United States. Neighborhood satisfaction, living above the poverty line, and having health insurance were all negatively associated with psychological stress. Psychological distress decreased as respondents' neighborhood satisfaction increased, lived above the poverty line, and had access to health insurance. However, neighborhood satisfaction, poverty status, and access to health insurance did not have a mediating effect on the relationship between mental health and immigration. Instead, neighborhood satisfaction, poverty status, and health insurance were found to have suppression effects. If foreign-born respondents had reported these variables at levels as high as native-born respondents, their levels of psychological distress would have been even lower.

Key words: sociology, immigrant, psychological distress, mental health

Differences in Psychological Distress for United States Native and Foreign Born Populations: Testing for Mediation of Neighborhood Satisfaction, Poverty, and Health Insurance

Introduction

The U.S. immigrant population has grown substantially over the years. In 2017 there was 44.4 million immigrants residing in the U.S, which is more than quadruple the immigrant population of 9.7 million in 1960 (Radford & Noe-Bustamante 2019). Immigrants influence both the culture and economy of the United States. They bring the culture from their country of origin and the more immigrants there are the greater spillover of this culture/customs to the people already living in the country (Li et al. 2018). Immigrants also bring new information and ideas to the United States, that is beneficial to the economy. Li and colleagues (2018) state, "...immigrants stimulate entrepreneurial activities due to their ability to provide and absorb knowledge for entrepreneurship." Their knowledge can be incorporated into existing economic knowledge in the United States, which helps grow the economy.

The growing number of immigrants and their influence in the United States shows that immigrants are a major part of our society. This means it is important to understand any challenges, obstacles, or disadvantages they may face. Immigrants can face language barriers, discrimination, changes in social support and changes in social position (Alegria et al. 2017). These experiences can have a negative impact on mental health. The first goal of this research is to understand differences in mental health outcomes between U.S.-born and foreign-born respondents in the United States. A second goal of this research is to examine the mediating effects of neighborhood satisfaction, poverty status, and health insurance on mental health outcomes. I expect these factors will vary between U.S.-born and foreign-born respondents, with foreign-born respondents reporting lower levels of neighborhood satisfaction, more living below

the poverty line, and less access to health insurance and may explain the differences in mental health outcomes.

Literature Review

Immigration and Mental Health

Mental health in the United States varies across individuals from different social groups and backgrounds. There is a strong association between demographic, social, and economic characteristics and psychological distress experienced within an ethnic group (Bratter & Eschbach 2005). For example, Filipino immigrants residing in the United States on average have a higher SES compared to other immigrant groups and report lower levels of depression than Filipinos born in the United States (Mossakowski 2007). The experience of mental distress is not the same for every member of a group because of demographic, social, and economic factors. Bratter and Eschbach (2005) found that within Puerto Ricans, Native Americans, and the racially mixed who consistently reported high levels of distress, the largest difference in distress levels came from respondents who reported the lowest levels of education and income. Although they belong to the same racial group, the experienced different negative social factors. This resulted in different levels of distress. It is important to note that recent immigrants appear to have lower levels of distress, however their levels increase with duration in the United States (Bratter & Eschbach 2005).

The process of immigration itself can have a negative impact on the mental health of immigrants. Fu and Vanlandingham (2012) found that Vietnamese immigrants had worse mental health when compared to Vietnamese who never left Vietnam. Their research included three groups of respondents: immigrants, returnees, and never-leavers. Fu and Vanlandingham (2012) explain that because the results show returnees are not experiencing the same disadvantage

compared to never-leavers, the disadvantage of the immigrants is most likely from the process of migration and adapting to a new place. A negative impact of the immigration process was also found among Mexican-origin immigrants. Immigration related stressors like fear of deportation and discrimination were found to be associated with an increase in parental depression, anxiety, and hostility (Decarlo et al. 2018). This study will look at the differences in experiences of negative mental health outcomes. It is expected that respondents born outside of the United States (foreign-born) will report experiencing negative mental health outcomes more often than respondents born inside the United States (U.S.-born).

Social and Economic Factors

This study will explore the social and economic factors of neighborhood satisfaction, poverty and having health insurance. It is possible that these resources and strains vary between the U.S.-born and foreign-born respondents in the US, which could produce differences in mental health outcomes across these groups.

An important social factor is neighborhood satisfaction. Cain, Wallace, and Ponce (2017) found that viewing one's neighbors as helpful and feeling safe was positively associated with self-reported health. Having more positive feelings and experiences with one's neighborhood and neighbors was also associated with better self-reported health. Household income did have an effect on the importance of helpfulness and safety (Cain, Wallace, and Ponce 2017). The factors did not have the same influence on overall self-reported health for each income level. Stockdale et al. also looked at the importance of neighborhood factors, which they call stress-buffers, on mental health. They found that neighborhoods with greater levels of stress-buffering mechanisms had lower likelihoods of alcohol, drug, or mental health disorders (Stockdale et al. 2007). Positive factors within a neighborhood can help decrease the prevalence of negative mental

health outcomes. One goal of this research is to see if neighborhood satisfaction is a mediator for the relationship between immigration status and mental health. Many immigrant live in neighborhoods with high ethnic density. Living in neighborhoods of high ethnic density was found to have protective effects for Mexican Americans (Eschbach et al 2004). Immigrants living in ethnically concentrated neighborhoods may have stronger connections to their neighborhoods and report higher levels of neighborhood satisfaction. I hypothesize a higher level of neighborhood satisfaction will be associated with lower levels of psychological distress.

Poverty is another social factor that can affect mental health. Stockdale et al. (2007) also included neighborhood median income in their study because it represents economic stability. Median income was associated with individuals' chances of reporting mental health disorders. People in neighborhoods with higher medium income had a decreased chance of reporting anxiety or depressive disorders (Stockdale et al. 2007). Like medium income, poverty status can be a way to represent stability. A study done in Australia found financial hardship to be associated with an increased chance of reporting depression (Butterworth, Rodgers, and Windsor 2009). Higher levels of financial hardship can have a negative impact on an individual's mental health. These studies show that finances can have an effect on mental health. Immigrants may be at a disadvantage when it comes to finances. When they come to America, their roles within their family and employment can change (Dion and Dion 2001). They may not have the experience needed to find a job or are unable to find work that pays well. This research will test if poverty status mediates the relationship between nativity status and mental health. Based on prior research that income can affect mental health and immigrants can experience more financial hardships due to changing work, I hypothesize that respondents born outside of the United States

will be more likely to live below the poverty line and this will be associated with more psychological distress.

The final mediator I will test is health insurance. Whether someone has health insurance coverage or not can have an effect on health. Lack of health insurance is associated with being more likely to report being dissatisfied with life (Tran, Wassmer, & Lascher 2016). Having health insurance is good for overall satisfaction with life. One reason health insurance may be associated with life satisfaction is that it minimizes uncertainty with life (Tran, Wassmer, & Lascher 2016). Having health insurance gives people more confidence that they will be able to get treatment when needed. Without insurance, treatment can have an even bigger negative impact on one's finances. Also, those without insurance may not have a regular place to get treatment and are more likely to go undiagnosed. Access to health insurance can vary based on immigration status. More recent immigrants are less likely to have Medicaid or private insurance than immigrants who have been in the U.S. longer and people born in the U.S. (Choi 2010). The age of the immigrant also has an effect on access to health insurance. Older immigrants can have a more difficult time getting health insurance than younger immigrants (Choi 2010). Given that immigrants face more challenges accessing health insurance and not having health insurance can hurt mental health, I hypothesize that foreign born respondents will report lower rates of health insurance, which will be associated with more psychological distress.

Current Study

The first objective of this research is to test the relationship between immigration status and mental health. This study expands on prior research examining disparities in mental health outcomes between US-born and foreign born respondents by assessing differences in self-reported frequencies of psychological distress. The hypothesis is those born outside of the United

States will experience higher levels of psychological distress than those born in the United States. This is due to the different social and economic challenges immigrants can face.

This study will also examine the possible mediation effects of neighborhood satisfaction, poverty status, and health insurance on the relationship between nativity status and mental health. Prior research shows both social and economic factors can play a role in mental health outcomes. Neighborhood satisfaction can be used to help understand connection to one's community and sense of belonging. Greater satisfaction with one's neighborhood, is expected to be associated with better mental health. People with higher satisfaction with their neighborhood will report lower levels of psychological distress. Poverty status is used to test the effects an individual's financial situations can have on their mental health status. It is expected that respondents who live below the federal poverty line will experience higher levels of psychological distress. The final mediator being tested in this study is health insurance. Previous research shows that having health insurance can improve life satisfaction. This study will test whether health insurance has an association with mental health. Based on prior research, foreign-born respondents will have lower neighborhood satisfaction, higher poverty levels and be more likely to be without health insurance then US-Born. These differences in social and economic factors will explain worse mental health among immigrant groups compared to US born respondents

Methods Section

Data

The National Health Interview Survey (NHIS) is conducted yearly by the National Center for Health Statistics. A representative sample of the noninstitutionalized United States population was asked questions about overall health and demographic characteristics, as well as

questions about current health topics like insurance during face-to-face interviews. Households were identified and then within each household an adult 18 years or older and a child 17 years or younger were randomly selected (Anon 2019). This survey followed a multistage area probability design. The survey was made up of 4 parts: household, family, child, and adult. In 2017, there were 32,617 households. These households contain 78,132 persons making up 33,157 family units. Data is collected continuously throughout the year. The household response rate was 66.5%. The final response rate was 65.7 for the family component, 60.6% for the child component, and 53.0% for the adult component. Final response rates for the family component were calculated by multiplying the conditional rate (98.9%) by the household rate. Final response rates for the child and adult component were calculated by taking the conditional rate (92.1% for child and 80.7 for adult) by the final family response rate. For my research, I included only respondents who were 18 years or older at the time of the interview. The sample size is 24, 322. The sample started out with 26,742 respondents but 2,420 missing cases were omitted.

Measures

Respondents were asked whether they were born in the United States, a United States Territory, or Other. This was used to create a nativity variable with the categories of born in the United States or United States territory (U.S.-born =0) and born outside of the United States (foreign-born=1). An overall mental health variable was created with a mean of five questions that asked how often have you felt: restless, nervous, worthless, hopeless, sad, and that everything was an effort in the past 30 days (Kessler et al. 2002). For this study, mental health is defined as psychological distress. Response categories were: “none of the time” (=0), “a little of the time” (=1), “some of the time” (=2), and “most of the time” (=3). A measure of

neighborhood satisfaction was created using four questions that asked how much do you agree that: this is a close knit neighborhood, there are people you can count on in this neighborhood, people in this neighborhood can be trusted, and people in this neighborhood help each other out. The response categories for this were: “definitely disagree” (=0), “somewhat disagree” (=1), “somewhat agree” (=2), and “definitely agree” (=3). Poverty Line measured whether the respondent lived below the Federal poverty line (=0) or above the poverty line (=1). A variable for health insurance was created by looking at if the respondent has no health insurance (0) or has health insurance (1). Race was measured with five different categories: non-Hispanic white, non-Hispanic black, non-Hispanic Asian, non-Hispanic other, and Hispanic (Howell and Emerson 2016). For age, there were six age categories created: 18-29, 30-39, 40-49, 50-59, 60-69, and 70+ to account for differences in psychological distress over the life course. The sex, male = 0 and female = 1, of respondents was also included in the analysis.

Analysis Plan

To begin, I analyze multiple bivariate analyses, including one-way ANOVAs and Chi Squares. This was used to compare the means and proportions for all dependent, mediators, and control variables across the U.S.-born and foreign-born groups. Then, multivariate regression allows us to see if differences across immigration status and psychological seen in the bivariate analysis hold when including controls. Multivariate regression can also test for the hypothesized mediating effects. It will show the association of each mediator with psychological distress. Moreover, evidence of mediation is found when the coefficient for immigrant status goes down within a regression model that contains one of the mediating variables.

Results

Table 1 shows descriptive statistics of the sample. The mean for psychological distress is .45 . A majority of respondents reported being born in the United States or a United States territory, with the mean for foreign born being .14. The average response for neighborhood satisfaction is 2.12. A majority of respondents lived above the poverty line (87%) and had health insurance (91%). White was the largest racial category at 70%. Twelve percent of respondents were Hispanic, followed by black at 10%. A very small percentage of respondents reported being Asian (5%) or other (3%). Respondents were more evenly distributed across the six age categories. The largest age groups is 60 to 69 and 70 and up, both at 18%. The smallest age group is 40 to 49 at 15%.

Table 2 shows the results for both ANOVAs and chi-squared tests. A chi-squared test was done to see how race, sex, age, poverty status, and insurance coverage varied by nativity status. The distribution of race varied between those born in the United States and those born outside of the United States. 78% of respondents born in the US were white, while 23% of those born out of the U.S. reported being white. Hispanic had the highest response rate for respondents born outside of the U.S. with 42%, while only 7% of respondents born in the U.S were Hispanic. Age group distribution was more consistent across those born inside and outside of the United States. The largest age group for respondents born outside of the United States was 30-39 at 21%. For those born inside the United States, 60-69 and 70+ were both at 19%. Sex was not significant with 55% of respondents born in the United States and 53% of respondents born outside of the United States being female. Poverty status and health insurance were significant. The rates for living above the poverty line were similar between the groups. Eighty-seven percent of respondents born in the U.S and 82% of respondents born outside of the U.S lived above the poverty line. Although a majority of both groups reported having health insurance,

more of respondents born in the United States had health insurance. Ninety-three percent of respondents born in the U.S had health insurance compared to 82% of respondents born outside of the U.S..

A one-way analysis of variance (ANOVA) was calculated on respondents' nativity status with psychological distress and neighborhood satisfaction. The analysis showed that the effect of nativity status on psychological was significant. U.S.-born respondents reported fewer experiences of psychological distress (.46) than foreign-born respondents (.37). The effect of nativity status on neighborhood satisfaction was also significant. Foreign-born respondents (2.00) reported lower neighborhood satisfaction compared to U.S.-born respondents (2.14).

Table 3 shows the regressions that were calculated, examining differences in psychological distress based on immigration status with neighborhood satisfaction, poverty status, and health insurance as mediators. Race, sex, and age2 were used as control variables across each model. The first model tested to see if differences remained with the control variables included. Model 1 shows that there is a significant negative relationship between immigration status and psychological distress, with immigrants reporting fewer experiences of psychological distress. Analyses not shown, which ran the regression model by race, indicated that the differences in psychological distress across immigration status were consistent within each racial group. The next models assess main and mediation effects.

Model 2 includes neighborhood satisfaction as a potential mediator. This model showed a significant negative correlation between nativity status and psychological distress. As neighborhood satisfaction increased, the experiences of psychological distress decreased. Compared to Model 1, the coefficient for immigration status has changed. Specifically, in Model 2, the difference has grown larger indicating that if immigrants did not have lower

neighborhood satisfaction compared to US born, then their psychological distress would be even lower relative to US-born.

Model 3 includes poverty status as a potential mediator. This also shows a significant negative correlation between immigration status and psychological distress. Living above the poverty line can be better for mental health. Similar to Model 2, the change in the immigration coefficient for Model 3 again is an increase. If immigrants did not experience more poverty compared to US born, then their psychological distress would be even lower relative to US-born. Model 4 includes health insurance coverage as a potential mediator. There is a significant negative correlation between immigration status and psychological distress. Like the previous two models, the difference in the immigration coefficient is larger. This means if immigrants did not have lower rates of health insurance, then their psychological distress would be even lower relative to US-born.

Model 5 includes all mediators for neighborhood satisfaction, poverty status and health insurance coverage. Immigration status remains statistically significant across each model and shows the larger difference in Model 5 when all potential mediators are in the model. Once I found that immigrants reported better mental health compared to US-born, it was no longer possible for the potential mediators to account for these differences. Rather, these variables instead appear to have a suppression effect. Immigrants would have even better mental health than US-born respondents if their levels of neighborhood satisfaction, poverty and insurance coverage equaled those of U.S.-born respondents.

Discussion

This study examined the difference in mental health outcomes based on immigration status and tested for mediating effects of neighborhood satisfaction, poverty, and health

insurance. Mental health outcomes was found to be significantly related to immigration status, but not in the direction we hypothesized. Specifically, those born outside of the United States reporting slightly lower levels of psychological distress compared to US-born. One explanation for this is immigrants may have stronger ethnic identity. Mossakowski (2007) found that Filipino immigrants identified stronger connections to their ethnic identity and stronger ethnic identity is linked with decreased levels depressive symptoms. Immigrants may feel more connected to their ethnic identity than those born inside the United States.

Yet, as expected, foreign-born do encounter a number of social and economic disadvantages relative to US-born that negatively impact their mental health. First, respondents born outsides of the United States reported lower neighborhood satisfaction. Immigrants may create social networks that expand beyond their neighborhoods or use technology to maintain connections with family and friends in the country of birth that decreases the frequency of negative mental health outcomes (Alegria et al. 2017). So, while they may not have as strong ties to their neighborhoods, they may have other social connections.

Second, fewer respondents born outside of the United States reported living above the poverty line than those born inside the United States. The differences in poverty status was significant and may be explained by challenges immigrants can face with finding reliable employment. A study done in Canada found that a majority of the immigrants interviewed experienced “downward occupational mobility” and under-employment, despite having high levels of education and strong English abilities (Creese and Wiebe 2009). Even immigrants who are migrating with education and skills can struggle to find work. Not being able to find reliable work or work at the right skill level can lead to economic challenges for immigrants.

Third, health insurance rates were lower for respondents born outside of the United States compared to those born inside the United States. Not only can immigrants face challenges accessing health insurance, those who are able to get it can have challenges maintain it. Health insurance can be expensive. Some immigrants who are able to access health insurance may have to discontinue their plan in order to meet other needs of their family (Gurrola and Ayon 2018). This high cost of insurance can force people to choose between paying for their plan or meeting the basic needs of their family. As talked about before, immigrants can face financial hardships that would make paying for health insurance even more challenging.

Consistent with past research, neighborhood satisfaction and poverty were both found to have a negative correlation with psychological distress. Neighborhood satisfaction, poverty status, and health insurance did not have mediating effects, but did have suppression effects. A possible explanation for this draws from the study done by Fanning, Haase, and O'boyle (2010). We cannot rely on one form of capital, like social or cultural, to understand differences in mental health. Immigrants may fare better than that native born citizens in one area of capital and not do so well in others (Fanning, Haase, and O'boyle 2010). As such, it is possible to report better mental health than non-immigrants even though they experience some disadvantages.

There are some limitations to this study. The first limitation is not all respondents were asked the questions regarding mental health and thus not included in the study. Another limitation to this study is that we do not know how long immigrants have been residing in the United States. Reports of mental health problems can change over time. Holtman and Tramonte (2014) found that rates of mental health in immigrant women varied over time. The changing of access to resources, experiences, and connections over time in the United States can lead to different levels of mental health outcomes. Further, country of origin is not accounted for in this

study. Immigrants from developing countries may experience greater risk (Kirmayer et al. 2011). Knowing where an immigrant is from and how long they have lived in the US can help us understand differences in mental health outcomes by shedding light on the amount of exposures experienced in their country of origin and in the US.

While neighborhood satisfaction and poverty status are not clear mediators for differences in mental health between immigrants and US-born U.S. respondents, a difference in mental health outcomes still exists. A longitudinal study could help us better understand the differences in mental health outcomes across immigrant ad migrant groups. This type of study would help account for difference in length of time in United States, but also could be used to see how perception and understanding of mental health changes over time. During immigrants earlier years in the United States, they may retain their own cultural beliefs to evaluate their mental health. Once they have been in their new country longer, they can better understand their mental health in terms of the health care system and lifestyle here (Kwak 2018). A change in understanding of mental health may account for why rates of mental health outcomes change over time. Further research can ultimately help us understand why immigrants may report better mental health and what can be done to try and prevent the possible decline in mental health.

Table 1: Descriptive Statistics

	mean	*SD*	*min*	*max*
Dependent Concept				
Psycholgical Distress (K-6)	.45	.62	0	3
Key Demographic				
Foreign Born	.14	.34	0	1
Mediators				
Neighborhood Satisfaction	2.12	.80	0	3
Poverty Status	.87	.34	0	1
Health Insurance	.91	.28	0	1
Controls				
Female	.55	.50	0	1
Race				
White	.70	.46	0	1
Black	.10	.30	0	1
Asian	.05	.21	0	1
Hispanic	.12	.33	0	1
Other Race	.03	.17	0	1
Age Groups				
aged 18-29	.17	.37	0	1
aged 30-39	.16	.37	0	1
aged 40-49	.15	.35	0	1
aged 50-59	.17	.38	0	1
aged 60-69	.18	.38	0	1
aged 70 and up	.18	.38	0	1

N= 24,322

Table 2: Bivariate Analysis

	Nativity Status			
	US-Born	Foreign-Born	F-Value/ Chi-Square	
	Mean/Percentage	Mean/Percentage		
Dependent				
Pyschological Distress	0.46	0.37	59.3	***
Mediators				
Neighborhood Satsifaction	2.14	2.00	84.9	***
Above Poverty Line	0.87	0.82	83.2	***
Health Insurance	0.93	0.82	431.5	***
Controls				
Female	0.55	0.53	2.2	
Race			7700.0	***
White	0.78	0.23		
Black	0.11	0.08		
Asian	0.02	0.26		
Hispanic	0.07	0.42		
Other	0.03	0.02		
Age			215.5	***
18 - 29	0.17	0.15		
30 - 39	0.15	0.21		
40 - 49	0.14	0.20		
50 - 59	0.17	0.17		
60 - 69	0.19	0.14		
70 and up	0.19	0.13		

notes: N= 24,322, * p<.05, **p<.01, ***p<.001

Table 3: Liner Regresssion for Immigration Status Differences in Mental Health with Social Factors as Mediators

	Psychological Distress														
	Model 1			*Model 2*			*Model 3*			*Model 4*			*Model 5*		
	b		*se*	*b*		*se*	*b*		se	*b*		se	*b*		se
Foreign Born [a]	-.068	***	.01	-.076	***	.01	-.077	***	.01	-.075	***	.01	-.086	***	.01
Social Factors															
Neighborhood Satisfaction				-.143	***	.00							-.133	***	.00
Poverty Status							-.315	***	.01				-.289	***	.01
Health Insurance										-.080	***	.01	-.039	***	.01
Controls															
Black[b]	-.029	*	.01	-.071	***	.01	-.073	***	.01	-.031	*	.01	-.110	***	.01
Asian	-.076	***	.02	-.074	***	.02	-.081	***	.02	-.070	***	.02	-.076	***	.02
Hispanic	-.022		.01	-.057	***	.01	-.054	***	.01	-.031	*	.01	-.088	***	.01
Other	.135	***	.02	.112	***	.02	.094	***	.02	.127	***	.02	.072	***	.02
Female	.110	***	.01	.105	***	.01	.096	***	.01	.111	***	.01	.094	***	.01
Age 18 - 29[c]	.040	**	.01	.015		.01	-.009		.01	.039	**	.01	-.029	*	.01
Age 30-39	-.012		.01	-.023		.01	-.014		.01	-.013		.01	-.025		.01
Age 50-59	.031	*	.01	.029	*	.01	.024		.01	.033	*	.01	.024		.01
Age 60-69	-.059	***	.01	-.052	***	.01	-.061	***	.01	-.054	***	.01	-.051	***	.01
Age 70 and up	-.140	***	.01	-.122	***	.01	-.140	***	.01	-.132	***	.01	-.118	***	.01
Constant	.432	***		.749	***		.733	***		.504	***		1.039	***	

notes: N= 24,322, * p<.05, **p<.01, ***p<.001

[a] Reference groups is US Born. [b] reference group is White. [c] Reference group is 40-49

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