The Role of Ethnic Identity and Acculturation in the Well-being of Somali Immigrants

Iman Ofleh

A thesis in partial fulfillment of the requirements for the degree of Master of Arts

Department of Psychology

Carleton University
Ottawa, Ontario

May 2005

Your file Votre référence
ISBN: 0-494-10065-6
Our file Notre référence
ISBN: 0-494-10065-6

Table of Contents

Abstract

This study explored the role of ethnic identity and acculturation in the well-being of Somali immigrants and the mediating role of social support and coping skills. Participants (N=171; 61 males, 110 females) of a diverse age range (from 18 to 62 years) were recruited from the Somali community and invited to complete a questionnaire concerning their experiences as immigrants. Consistent with Social Identity Theory, regression analyses indicated that a strong ethnic identification was related to greater perceived support from others in the Somali community, a more problem-focused approach to dealing with stress, and to positive psychological well-being (lower depressive and anxiety symptoms and higher quality of life). In addition, although ethnic identity and acculturative strategies were related, they showed different patterns of association with social support, coping, and well-being. Consistent with acculturation theory (Berry, 1990) integrative acculturation was positively linked to psychological well-being, whereas marginalization and assimilation strategies were related to poorer well-being. Furthermore, a mediated model emerged that showed emotion-focused coping served as at least a partial mediator in the relationship between acculturation strategies and psychological well-being. Theoretical and applied implications for these findings were discussed.

Immigration is often considered a highly stressful experience for the individual who must deal not only with the stressors that bring on the flight (e.g., civil war, economic hardships), but as well, with the stress of leaving loved ones and a familiar environment behind (Gonsalves, 1992; Short & Johnston, 1997). Once they arrive at their new countries, the effects of these stressors are compounded by limitations in language, diminished social support networks, a loss of status, and a general sense of threat to their ethnic identity (Gonsalves, 1992; Lay & Nguyen, 1998; Sagiv & Schwartz, 1995). The impacts of these new stressors are evident in various domains of well-being, including poor adjustment to school and work environments, greater reports of psychological distress including, depression and anxiety, and an overall sense of pessimism towards the future (Brissette, Scheier, & Carver, 2002; Gonsalves, 1992; Sagiv & Schwartz, 1995).

Immigrants who are also visible minorities not only experience cultural disruption and isolation, but may become targets of negative stereotypes and discrimination (Noh & Kaspar, 2003; Phinney, Horenczyk, Liebkind, & Vedder, 2001a; Rogler, Cortes, & Malgady, 1991). Racial discrimination in itself has potential adverse effects on the psychological well-being of visible minorities, who experience it as a chronic, unpredictable, intermittent, and sometimes ambiguous stressor in their daily lives (Branscombe, Schmitt, & Harvey, 1999; Jetten, Branscombe, Schmitt, & Spears, 2001; Utsey, Chae, Brown, & Kelly, 2002). Taken together, all of these factors may render the individual more vulnerable to the development of stress-related psychiatric disorders and reduced levels of general happiness and life satisfaction. However, as not all individuals experience these poor outcomes, it was the goal of the present thesis to examine some of the individual differences and social resources that contribute to an immigrant's resilience or vulnerability to compromised well-being.

Of particular interest were the factors associated with psychological well-being among Somali immigrants to Canada. Somali immigrants, along with other refugees exposed to civil wars, represent a significant community that may suffer from many of the stressors associated with immigration, in addition to the potential long-term effects of surviving wartime experiences in their home country. They also are at risk for the adaptive stressors that accompany settlement in a new country (Lay & Nguyen, 1998; Oh, Koeske, & Sales, 2002; Williams, & Berry, 1991). Finally, these immigrants face an added threat to their well-being through their membership in a visible minority group and its associated experiences (Utsey et al., 2002). Thus, Somali immigrants are clearly at high risk for stress-related disturbances. Nonetheless, many do make the adjustment with minimal, if any, reduction to their well-being and indeed come to serve as important resources for immigrants that follow.

In the context of examining well-being as a function of belonging to a stigmatized group, it has been noted that individuals who report higher identification with such groups may experience the least depression or self-esteem loss when their identity is threatened (Branscombe et al., 1999; Frable, Platt, & Hoey, 1998; Jetten et al., 2001; Schmitt & Branscombe, 2003). However, because ethnic identity and adaptive practices are negotiated and constructed in the context of immigrants' interactions with members of both the in-group and the out-group, this greater identification with the in-group may represent a potential resource to deal with external threats (increased in-group social support). However, it may also present a source of threat if it hinders the process of adaptation (Lay & Nguyen, 1998; Noh & Kaspar, 2003; Oh et al., 2002). Indeed, forging new social support networks and adapting to the cultural milieu of their adopted country has been related to successful acculturation (Roysircar-Sodowsky & Maestas, 2000; Utsey et al., 2002). Thus, in the present study, the coping mechanisms associated with support

groups within the immigrant community and with the host society were examined because of their relevance to both ethnic identity and acculturation. Finally, because Somali immigrants are at a high risk for stressors associated with settlement, as well as exposure to discrimination within their host country, the role of these experiences in relation to psychological well-being and the buffering effects of social support and coping strategies was explored.

Acculturation

Berry (1997) defined acculturation as the process of "how individuals who have developed in one cultural context manage to adapt to new contexts that result from migration" (p. 6). Acculturation, in this context, refers to the cultural changes that occur when members of each culture are exposed to the social norms and habits of the other culture. However, the influence of one culture on the other is dictated by numerical, economic, and political powers of the members of a group. Immigrants, refugees, sojourners, and expatriate workers are often minorities in a host country, and the influence of the majority culture is generally larger and more influential than the one they exert in reciprocity (Berry, 1997; Hornsey & Hogg, 2000; Utsey et al., 2002). Therefore, the migrating group is referred to as an acculturating group for whom the process of adopting the cultural practices of the larger group is of significance to their adaptation and psychological well-being. Similar to immigration, acculturation is considered a stressful process for an immigrant (Berry, 1990, 1992; Sue and Sue, 1990), which may lead to compromised psychological well-being and experiences of alienation and identity confusion (Berry, 1990, 1992). However, many factors influence an immigrant's vulnerability to these outcomes including the acculturation strategies that are adopted.

Acculturation strategies involve two main factors: cultural maintenance and contact and participation (Berry, 1990; Berry, 1997). Cultural maintenance refers to the extent to which

individuals consider their cultural, or ethnic identity to be important and strive to maintain it. Contact and participation refer to the extent to which individuals become involved in other cultural groups, especially the dominant group.

When these two dimensions are considered simultaneously, four acculturation strategies emerge: assimilation, separation, integration, and marginalization. Assimilated individuals do not wish to maintain their cultural identity, but instead seek daily interaction with members of the host culture. Separated individuals strive to maintain their original cultures, and minimize their interaction with members of the host cultures. Integrated individuals seek daily interactions with members of the host culture, while keeping an interest in maintaining their original culture. Finally, marginalized individuals do very little to maintain the customs and habits of their original culture, and do not seek contact with other cultures (Berry, 1997). Clearly, each of these orientations will have different implications for the adaptation of the individual to the host culture.

These acculturation strategies have been studied in light of immigrants' psychological well-being, and typically find that integrated immigrants who maintain their cultural identity while seeking contact with other groups, especially the dominant groups, report greater satisfaction with their lives and lower psychological distress (Berry, 1997; Hornsey & Hogg, 2000; Lieber, Chin, Nihira, & Mink, 2001; Noh & Kaspar, 2003; Sodowsky & Lai, 1997). Although increased integrative acculturation is associated with higher socioeconomic achievement and larger social adaptation, it also increases contact with the dominant group and the exposure of the individual to incidences of discrimination and social stressors (Finch & Vega, 2003; Leong, 2001). Perhaps for this reason, individuals who are integrated demonstrate the greatest well-being, as these individuals have the advantage of access to the resources that are

contingent upon assimilation with the dominant group, yet continue to benefit from the social support resources provided by their own cultural group (Contreras, Lopez, Rivera-Mosquera, Raymond-Smith, & Rothstein, 1999). Thus, acculturation is clearly a process rather than a goal (Hornsey & Hogg, 2000).

Ethnic Identity

Somewhat contradictory to the benefits of integrating into their new cultures, there is evidence that immigrants who demonstrate a strong ethnic identity are better able to cope with immigration and settlement stressors, and report lower incidences of psychological distress, including depression and anxiety (Phinney, 1992; Phinney et al., 1998, 2001a). Ethnic identity is a shared set of ideals, values, attitudes, and behaviours that one holds as a member of a distinct ethnic group (Utseyet al., 2002). An ethnic or social identity is "that part of an individual's self-concept that derives from his/her knowledge of membership of a social group (or groups) together with the emotional significance attached to that membership" (Tajfel, 1981). As a component of social identity, ethnic identity is particularly important when the ethnicity of the host country's majority is different from that of the immigrant group (Phinney, 1992; Phinney et al., 2001a, 2001b). Although one might assume that an ethnic identity is 'brought with' the immigrant based on their country of origin, an ethnic identity is more likely to evolve as a function of the individual's displacement into a new society.

Consistent with the notion of acculturation as a process, a sense of ethnic identity is not static, or an identity that is present or develops uniformly in every immigrant or across every situation (Utsey et al., 2002). According to Phinney's model of ethnic identity development (1992), immigrants will go through different phases of developing a sense of identity, and there are individual differences in timing and the number of phases experienced. The first phase of

ethnic identity development involves an *unexamined ethnic identity*, which is marked by a lack of exploration of one's ethnicity and an unquestioned acceptance of the values of the host society. This phase is often characterized by a rejection of one's own culture and identity, as it involves an attempt to 'fit in' to the new society, much like Berry's definition of an acculturated identity.

The second phase is the *ethnic identity search* and it is often prompted by a "shocking personal or social event that temporarily dislodges the person from his or her worldview, making the person receptive to a new interpretation of his or her identity" (Phinney, 1996, p.69). Witnessing or experiencing an ethnically motivated slur is an example of such an event. The immigrant gains a greater commitment to learn as much as he or she can about their racial heritage by becoming more curious about their heritage, history and customs, and likely seeking out other immigrants from their native country.

Finally, the *achieved ethnic identity* phase is marked by a confident and well-defined sense of belonging to an ethnic group from which a person can derive pride, and self-esteem in the context of their new host culture. Achieving this level of identity has been associated with psychological well-being. Roberts, Phinney, Masse, Chen, Roberts, and Romero (1999) noted that among young adolescents from diverse ethnic groups in the US, ethnic identity was positively related to measures of psychological well-being such as coping ability, self-esteem, and optimism, and negatively to measures of loneliness and depression. Research indicates that ethnic identity is also associated with outcome variables such as academic achievement (Arellano & Padilla, 1996), and the ability to cope with discrimination and psychological well-being (Chavira & Phinney, 1991; Phinney & Chavira, 1995). Not surprisingly, as noted earlier, a strong ethnic identity was associated with better access to social support (Berry, 1990, 1997; Noh

& Kaspar, 2003; Phinney, Horenczyk, Liebkind, & Vedder, 2001a), which in turn may moderate the effects of discrimination (Noh & Kaspar, 2003). Acquiring support from other members of their ethnic group may buffer individuals from the negative impacts of the discriminatory events they encounter by reducing distress and uncertainty through the provision of guidance and validation from one another (Hogg, 1996), and by minimizing the feelings of rejection emanating from the actions of out-groups (Branscombe et al., 1999; Schmitt & Branscombe, 2002)

Insight into the role that a social identity plays in terms of providing the individual with the capacity to better contend with discrimination might be gained through consideration of Social Identity Theory (Brown, 2002; Hornsey & Hogg, 2000). Social Identity Theory considers the intergroup processes (identification, in-group bias, out-group discrimination, and prejudice) involved when people evaluate and respond to their own social groups (in-groups) and other social groups (out-groups) in different intergroup situations (Brown, 2000). Specifically, when a person's social identity (e.g., based on social group memberships such as age, gender, ethnicity, or occupation) becomes salient in a particular social context (e.g., as new immigrants in a country), it influences the way in which threats from the social environment are perceived, and how they are dealt with (Tajfel & Turner, 1986; Turner, 1982). For the Somali immigrant, ethnic identity includes multiple dimensions (e.g., cultural, racial, and religious), any one of which might render his or her identity salient and distinctive within a given context.

According to Tajfel (1982, 1986), one of the rewards of identifying with a certain group is to gain a positive self-concept, if such a membership compares well to that of other groups. However, when one's social identity is one of disadvantage, a negative social identity may develop (Brown, 2000; Tajfel, 1982; Tajfel & Turner, 1986). Indeed, members of stigmatized or socially-devalued groups are more likely to suffer adverse psychological, social, and

physiological effects (Allison, 1998; Clark, Anderson, Clark, & Williams, 1999; Crocker, et al., 1998; Dion, 2002; Lieber, Chin, Nihira, & Mink, 2001; Thompson, Anderson, & Bakeman, 2000). However, these effects are not true of all group members. Indeed, contrary to the findings of reduced well-being, others have demonstrated that belonging to a devalued group can sometimes provide a stronger basis for collective identification, solidarity and action than belonging to a positively-valued group, particularly when the group is under threat (Abrams & Hogg, 1988; Branscombe & Ellemers, 1998; Branscombe, Ellemers, Spears, & Doosje, 1999; Brewer, 1991; Dion, 2002; Doosje, Ellemers & Spears, 1995; Ellemers, 1993; Schmitt & Branscombe, 2003). Moreover, those who are highly identified with the group may experience the least depression or self-esteem loss (Branscombe et al., 1999; Frable, Platt, & Hoey, 1998; Jetten et al., 2001; Schmitt & Branscombe, 2003).

Under threat conditions, group members with a strong social identity may be motivated to act to enhance the status of the group. In addition, these group members may be most likely to gain social support from other in-group members. Presumably such in-group support may facilitate the effective collective action-taking, which ought to enhance the status of the group as a whole, along with the status of individual in-group members (Beaton & Tougas, 1997; Breton, 1998; Foster & Matheson, 1995; Louis & Taylor, 1999; Noh & Kaspar, 2003; Wright & Taylor, 1998). Thus, the development of a strong ethnic identity may provide a buffer against stress-related symptoms, as it facilitates the development and implementation of adaptive coping and resources.

Stress, Coping, and Well-being

Building on Lazarus and Folkman's (1984) transactional model of stress and coping, Berry (1997) paid close attention to the stressors faced by an immigrant during adaptation to a

new culture, the appraisal of these stressors, and the choice and implementation of coping strategies to effectively deal with them. Immigrants often face stressors that are sometimes traumatic, extending for a long period of time, or stressors for which they do not have adequate resources with which to cope (e.g., a lack of an established social support network), and hence may have difficulties adapting, and their psychological well-being may suffer (Lazarus, 2000; Lazarus & Folkman, 1984; Valentiner, Holahan & Moos, 1994). Additionally, immigrants face multiple stressors that may include leaving family and friends behind, as well as those related to their new environment including discrimination, language difficulties, lack of financial resources, unemployment or under employment, and a general feeling of not belonging to their new country (Hovey, 1999). For some, there is an added stress of intergenerational conflict due to varying levels of acculturation in a family, with the younger members adapting more quickly to their environment and facing pressure from their parents to maintain traditional values (Contreras et al., 1999). Given the multiple and pervasive stressors encountered by an immigrant, their coping resources are likely critical to their well-being.

Consistent with Lazarus and Folkman's (1984) transactional model of stress and coping, an individual facing a stressor appraises the severity of the threat and evaluates the coping resources available to respond to it. If the individual copes with the stressor effectively, using either problem management, or emotional regulation, or a combination of these strategies, the outcome is reflected in better psychological functioning. While both problem-focused and emotion-focused coping are often used to deal with a stressor, some researchers consider problem-focused coping to be more psychologically adaptive than emotion-focused coping (Lazarus, 2000). Nonetheless, emotion-focused coping may be adaptive in those instances where the individual cannot control the event itself, or when multiple stressors occur simultaneously or

extend over a long period of time (Lazarus, 2000; Lazarus & Folkman, 1984), which typifies the situation of the immigrant.

In the context of an immigrant's acculturation to their host society, it is important to distinguish between coping strategies and resources and how they may affect psychological adjustment. Coping strategies refer to the actual cognitive and behavioural strategies that are used to manage stressful demands (Lazarus and Folkman, 1984). As already noted, these strategies are often classified as problem-focused or emotion-focused. However, these broad categories subsume multiple strategies, such as rumination, cognitive restructuring (re-evaluating the relation between the person and the threat), positive activity (constructive or recreational activities), social support seeking (as a buffer or venting outlet), religion, and humor (Carver, Scheier, & Weintraub, 1989; Endler & Parker, 1990; Matheson & Anisman, 2003; Nolen-Hoeksema, 1998).

Coping resources, on the other hand, refer to the characteristics of a person's disposition (e.g., optimism) or environment (e.g., social support availability), and point to available means when a person evaluates a stressful situation and chooses a particular set of coping behaviours (Lazarus, 2000; Lazarus & Folkman, 1984). While these resources are often considered stable, in the case of immigrants, such resources have been considerably altered. For instance, leaving family and friends behind may entail loss and a reduction in effective social support. Other external coping resources that are important include support from community organizations, financial resources, access to multiple environments that allow individuals to distract themselves from a particular stressful environment, and so on. Not only are these environmental resources compromised, but the individual's internal coping resources might also be compromised, due to

potential reductions in self-esteem, optimism, and even personal skills such as proficiency in the host language (Farver, Narang, & Bhadha, 2002; Finch & Vega, 2003; Hovey, 1999).

Schaefer and Moos (1992) report that people with more coping resources (both internal and external) tend to rely upon problem-focused coping or emotional approach coping, rather than on emotional avoidance or acceptance-resignation coping. In essence, the resources and strategies involved in the coping process represent a stabilizing aspect of functioning that can help a person retain psychosocial adaptation during stressful periods. Many immigrants, however, must contend with a diminished social support network, and as a result, they may be particularly vulnerable to the maladaptive coping such as more passive and ruminative thinking (Baranowsky et al., 1998; Brissette et al., 2002; Nieves-Grafals, 2001; Valentiner et al., 1994).

Social support resources. Despite their diminished social support networks, many immigrants facing stressors must use the psychosocial resources that are available in order to cope. Social support has many forms and functions, and can meet a variety of physical and non-physical needs. While social support may include receiving information, instruction or emotional support from different sources (Thoits 1986), social support exchanged in a network of friends and family as a product of shared duties and experiences also provides a strong resource needed to deal with stressors (Neufield & Harrison 1995). This type of in-group support may provide immigrants with a buffer against the difficulties they encounter in adapting to a new society (Tix & Frazier, 1998; Valentiner, Holahan, & Moos 1994.), not only as an aid in coping with immediate stressors, but might also reinforce confidence in the immigrant and provide concrete tools to deal with ongoing stressors such as discrimination (Berry, 1997; Hovey, 1999).

Surprisingly, some researchers (Sarason, Shearin, Pierce, & Sarason, 1987; Thoits, 1986) have suggested that the perception of social support being available may have a greater effect on one's well-being than actually receiving support. Indeed, some have argued that actually receiving support may work *against* individuals' ability to deal with stress and can actually cause poor adjustment (Sarason, et al., 1987), as the quality and nature of support and expectations emanating from it (e.g., reciprocity) may not always be effective in dealing with the situation. Thus, as noted previously, the psychosocial context can provide both a potential source of coping with stressors, as well as representing a source of stress . The mixed utility of support may be particularly evident in the instance of immigrants, as seeking social support from the in-group solely as a way to deal with stressors may limit their motivation and hence access to opportunities to find other resources or practical problem-solving ideas. As a new immigrant who must adapt both socially and economically, this internal network may be inadequate to respond to stressors in the larger community (Nieves-Grafals, 2001; Valentiner et al., 1994). Thus, an important aspect of the present research was to distinguish between the social support sought from others within the Somali community, as well as from those in the host community to determine their relevance to well-being.

The Present Study

The goal of the present study was to evaluate the role of ethnic identity and acculturative strategies in the well-being of Somali immigrants, and to assess the mediating roles of social support resources and styles of coping. Somali immigrants face multiple stressors in their adaptation to Canadian society. In addition to general stressors in their everyday lives such as language, relationship, and employment challenges, members of this population face stressors specific to their immigrant and ethnic status. These latter stressors include ongoing problems not

only with the larger society, but as well, with members of their family and the in-group due to the cultural changes necessary in adapting to a new society (Berry, 1990, 1997; Hornsey & Hogg, 2000). Moreover, Somali immigrants represent a group at high risk for exposure to traumatic violence both before and during their flight from a civil war. As members of a visible minority group, they are also at risk for the effects of ongoing exposure to discrimination.

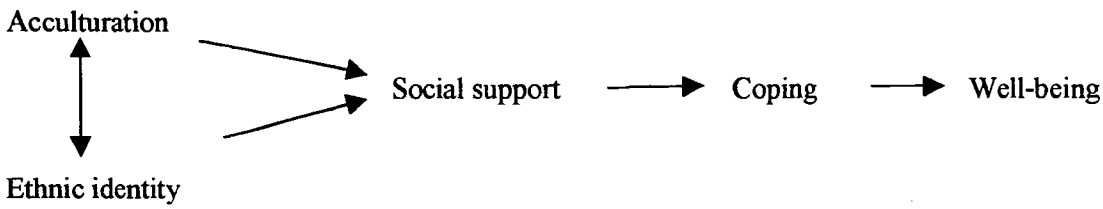
Of particular interest in the present study were the links between ethnic identity and acculturation strategies, and their relations with coping resources (perceived social support) and coping strategies, which in turn promote psychological well-being. Developing strong ties with their community may protect the immigrant's ethnic identity from 'disappearing' in a new country and provide them with the in-group resources that might help diminish the probability that they will fall into using maladaptive coping strategies, such as passive emotion-focused coping and rumination, and hence reduce the psychological distress that might otherwise be associated with their immigrant status (Noh & Kaspar, 2003; Phinney et al., 2001a; Rogler et al., 1991).

Although social identity theory supports the notion that seeking social support from the in-group may serve as a source of affirmation which leads to greater psychological well-being (Hornsey & Hogg, 2000; Tajfel, 1978, 1979), such in-group support may not be unilaterally effective. Successful adaptation to Canadian culture is necessary for economic survival and social participation. Higher levels of acculturation are associated with the enhancement of social support networks within the dominant culture, and hence the greater availability of problem-solving strategies to buffer psychological distress when facing chronic stressors (Noh & Kaspar, 2003; Oh, Koeske, & Sales, 2002). Thus, the relative effectiveness of support from within the ethnic group versus from the host group was a primary focus of the present thesis.

Given the above, and as depicted in Figure 1, the present study examined the following hypotheses:

1. Ethnic identity would be related to acculturation strategies, and in particular a stronger ethnic identity would predict greater separation and integration strategies, and lower levels of marginalization or assimilation.
2. Ethnic identity and acculturation strategies reflecting integration and separation would be predictive of greater perceived social support from the in-group, whereas the acculturation strategies involving assimilation, as well as integration would be related to perceiving greater support from the out-group .
3. Perceived support from the in-group would be related to reduced endorsement of emotion-focused coping, whereas support from the out-group may facilitate problem-focused coping.
4. Social support resources and coping strategies would be predictive of psychological well-being.
5. The relations between ethnic identity and acculturation and psychological well-being would be mediated by social support resources and coping strategies.

Figure 1: Model outlining the relationship between ethnic identity and acculturation and psychological well-being



Method

Participants and Procedure

Somali participants (N=171) from a wide range of settings including postsecondary institutions and community centers were recruited through flyers, local and community newspapers and through social service workers. After providing their informed consent, participants responded to demographic questions and a set of questionnaires in English assessing ethnic identity, acculturation, coping, and psychological well-being (Appendix A). At the end of the session, full debriefing and contact information should they need referral to counseling were provided.

Participants comprised 61 (35.7%) men and 110 (64.3%) women between the ages of 18 and 62 (M = 29.09, SD = 11.27). Their length of stay in Canada was between 0.6 and 20 years (M = 11.3, SD = 3.65), with the majority (67.9%, n = 110) having been in Canada for at least 10 years. Civil war began in Somalia in 1988, and most of the participants (76.6%, n = 112) reported that they fled Somalia between 1988 and 1994 with the remainder leaving after 1995 (11%, n = 16) or before 1987 (12.4%, n = 18). Of these participants, 28.1% (n = 47) reported that they have been exposed directly to warfare combat. Of the participants who spent time in a refugee camp before they came to Canada (13.3%, n = 22), more than half (n = 12) spent more than 6 months in the camp. Most participants have become Canadian citizens (78.9%, n = 135), with the remainder being landed immigrants (16.4%, n = 28) or refugee claimants (3.5%. n = 6). Most participants had a high school diploma (35.6%, n=61) or had college/ trade school training or university degrees (39%, n = 68), with very few having either had less than a high school education (4.7%, n = 8), or advanced graduate/professional degrees (4.1%, n = 7). Finally, most

of the participants indicated having parents or siblings in Canada (77.2%, n=132), with 87% (n=147) having other family or relatives in Canada.

Measures

Multigroup Ethnic Identity Measure Scale. Phinney's (1992) 12-item scale was used to assess ethnic identification. This measure includes questions such as "I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs", which were rated from 1 (strongly disagree) to 4 (strongly agree). It has been suggested that two factors could be derived from the scale (Phinney, 1992), including a developmental and cognitive component (ethnic identity search) and an affective component (affirmation, belonging, and commitment). In the present study, however, following a principal factor analysis, the scree plot indicated a one-factor solution, explaining 44.4% of the variance. Based on item-total correlations, one item was found to be negatively related to the total score, but was not reasonable to reverse given its conceptual interpretation wherein agreement ought to reflect stronger identification ('I think a lot about how my life will be affected by my being Somali'). This item was therefore eliminated. Mean scores across the remaining 11 items were used as an index of ethnic identity, such that higher scores reflected a stronger identity. As seen in Table 1, the inter-item reliability of the final scale was excellent.

Acculturation strategies. Barry (2001) developed the 29-item East Asian Acculturation Measure (EAAM) scale based on the four dimensions of acculturation outlined by Berry (1992), but modified for use with a Somali population. The EAAM defines acculturation in terms of the social interaction and communication response styles (both competency and ease/comfort in) that individuals adopt when interacting with individuals and groups from their own and another culture. Questions tap into the four dimensions that include *Assimilation* (e.g., "I feel more

comfortable socializing with Canadians than I do with Somalis"), *Separation* (e.g., "I feel more relaxed when I am with a Somali than when I am with a Canadian"), *Integration* (e.g., "I feel very comfortable around both Canadians and Somalis"), and *Marginalization* (e.g., "I find that both Somalis and Canadians often have difficulty understanding me"). Responses were made along a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Preliminary to including this measure, , five Somalis (3 women and 2 men, aged 20-55) read the questions and provided feedback concerning the appropriateness of the questions for this population. There was consensus that four of items of the items from the original scale did not apply to Somalis, and so these were removed and replaced with more population appropriate items for the relevant subscales (e.g., "Somali people should give up their cultural habits and become like the Canadian majority"). In the present study, a scree plot derived following a principal factor analysis indicated a four factor solution (explaining 45.4% of the variance). Items demonstrating loadings greater than .45 indicated that the four factors corresponded to the four different acculturation strategies that the scale was intended to assess. Reliabilities for each of the subscales created by averaging responses to the relevant items were adequate (see Table 1). Marginalization strategies were correlated with assimilation (r =.37, p<.001), integration (r=-.34, p<.001), and separation (r=.19, p<.05). Integration was related to separation (r=-.19, p<.05) but unrelated to assimilation (r=.11, *ns*) while assimilation was unrelated to separation (r=.03, *ns*).

Perceptions of social support. Bertera's (1997) 12-item scale was used to assess consumption of social support, but was modified to reflect support from Somali and from non-Somali individuals, respectively. Responses were made along a 5-point scale ranging from 0 (not at all) to 4 (about every day). The mean support received from each of Somali and non-Somali sources were computed, such that higher scores represented greater perceived support.

Both subscales demonstrated high internal reliabilities (see Table 1), and reported levels of support from each of these sources were moderately positively related (r=.36, p<.001).

Coping strategies. To assess coping strategies, the Survey of Coping Profile Endorsement (SCOPE; Matheson & Anisman, 2003) was used. The scale comprises 50 items that assess 14 strategies that differentiate between various stress-related disturbances and between university students reporting varying degrees of anxiety and depressive symptomatology (Matheson & Anisman, 2003; Matheson, Kelly, Cole, Tannenbaum, Dodd, & Anisman, 2005). The strategies assessed include five cognitive/behavioral responses (problem-solving, cognitive restructuring, active distraction, religion, and rumination) and nine socio-emotional responses (avoidance, humor, social-support seeking, emotional expression, other- and self-blame, emotional containment, wishful thinking, and passive resignation). Respondents indicated whether they had demonstrated each of the behaviours as a way of dealing with stressors in recent months. Their endorsement of each coping behaviour was made along a 5-point scale ranging from 0 (never) to 4 (almost always).

Although 14 subscales are typically formed from these responses, the scree test derived from a principal factor analysis of the 14 subscale scores produced a two-factor solution, explaining 55.2% of the variance. Based on factor loadings of greater than .45, the two superordinate dimensions were problem-focused coping (comprising problem-solving, cognitive restructuring, active distraction, humour, social-support seeking, and religious faith) and emotion-focused coping (comprising rumination, emotional expression, other- and self-blame, emotional containment, passive resignation, and wishful thinking). These two dimensions showed high internal reliabilities with Cronbach's αs of .82 and .88, respectively, and they were moderately positively correlated (r=.52, p<.001)

Beck Depression Inventory. The 21-item Beck Depression Inventory (BDI) was used as a measure of depressive symptoms (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). Each item comprised 3-4 statements ranging in the extent to which they were symptomatic, from not at all (e.g. "I do not feel sad") to highly symptomatic (e.g. "I am so sad or unhappy that I can't stand it") and scores could range from 0 to 63. Participants marked which statement of each set most accurately reflected them. Responses were summed (possible range was 0 to 63) to provide an index of depressive symptomatology, and demonstrated good internal reliability (see Table 1).

Beck Anxiety Inventory. The Beck Anxiety Inventory (BAI) is a 21-item scale that measures the severity of self-reported anxiety symptoms (Beck, 1990). It consists of descriptive statements of anxiety symptoms which are rated on a 4-point scale ranging from 0 (not at all) to 3 (severely; I could barely stand it); summed scores could range from 0 to 63. A summed score reflected the extent of anxious symptomatology, and this score demonstrated good internal reliability.

Quality of life (QOL). This 7-item scale (Schwarz & Strack, 1991) measures satisfaction with life in domains from physical health to work and social life. It consists of items asking about satisfaction with a certain domain (e.g. "In general, how satisfied or dissatisfied are you with your physical health as it is right now?"). Responses were made along a 10-point scale ranging from 0 (Completely Dissatisfied) to 10 (Completely Satisfied). Summed scores could range from 0 to 70 and the scale demonstrated good internal reliability (see Table 1).

Table 1. Descriptive Statistics (Means, Standard Deviations) and Inter-item Reliabilities.

Measure	*n*	Mean	*SD*	No. of Items	α
Ethnic Identity	158	3.34	0.74	11	.88
Acculturation					
Marginalization	171	2.09	0.75	8	.84
Integration	171	3.52	0.73	6	.70
Assimilation	171	2.59	0.44	6	.75
Separation	171	2.57	0.52	5	.63
Social Support					
In-group	171	1.29	0.84	12	.89
Out-group	168	0.69	0.71	12	.89
Coping Strategies					
Problem-focused	170	2.26	0.71	6	.82
Emotion-focused	170	1.73	0.80	7	.88
Beck Depression	158	10.15	9.66	21	.89
Beck Anxiety	162	10.89	11.80	21	.93
Quality of Life	168	6.23	2.30	7	.92

Results

Descriptive Analyses

Depressive symptoms varied considerably within the present sample (range=0 to 44; M=10.15, SD=9.66). The majority of participants 57% (n=90) reported relatively low BDI scores, between 0 and 9. A further 22.1% (n=35) reported scores between 10 and 18, which is indicative of mild to moderate depressive symptoms, whereas 17.1% (n=27) reported scores between 19 and 29, reflecting moderate to severe symptoms. Only 3.8% (n=6) of participants had scores between 30 and 63, which was within a range of severity that might reflect clinical major depression (Groth-Marnat, 1990). Anxiety symptoms also varied (range=0 to 53; M=10.9, SD=11.8), but with the majority of participants reporting minimal anxiety (scores between 0 and 7; n=84, 51.9%) levels. Nonetheless, a significant proportion reported mild (scores between 8 and 15; n=28, 17.3%), moderate (scores between 16 and 25; n=30, 18.5%) or severe symptoms (greater than 26; n=20, 12.3%) (Beck & Steer, 1993). Not surprisingly, given these distributions, participants' quality of life scores were also highly varied (range=0.14 to 10; M=6.23, SD=2.29), but tended to be positive. Depressive symptoms were correlated with both greater anxiety symptoms (r=.64, p<.001) and reduced life satisfaction scores (r=-.52, p<.001). Anxiety symptoms were also related to lower life satisfaction (r=-.42, p<.001).

The levels of depressive symptoms reported by women (M = 10.94, SD = 9.88) did not differ from those evident among men (M = 8.83, SD = 9.20), $t(156) = 1.33$, *ns*. Sex was also not related to levels of anxiety, $t(160) = .33$, *ns*, or life satisfaction $t(166) = 1.53$, *ns*. Similarly, there were no differences between women and men on their self-reported levels of ethnic identity, $t(169) = .22$, *ns*, or any of the acculturation strategies, including marginalization, $t(169) = .08$, *ns*, integration, t (169) = .07, *ns*, assimilation, t (169) = 1.03, *ns*, and separation, t (169) = 1.45, *ns*.

Age was not significantly related to depressive symptoms(r=-.13, *ns*) or life satisfaction (r=.03, *ns*), although older participants reported significantly fewer anxiety symptoms than did younger participants (r=-.35, p<.001). Interestingly, ethnic identification was weaker among older participants (r=-.20, p<.01), although older participants were more likely to endorse separation as an acculturation strategy (r=.18, p<.05), and less likely to endorse integration (r=-.30, p<.001) or assimilation (r=-.16, p<.05) strategies.

Participants' length of stay in Canada was mildly positively related to the endorsement of integrative acculturation strategies (r=.18, p<.05), but was not related to the remaining acculturation strategies involving marginalization (r=-.02, *ns*), separation (r=-.03, *ns*) or assimilation (r=-.06, *ns*) or ethnic identity (r=.10, *ns*). Finally, participants' length of stay in Canada was not related to the three indices of well-being, depression (r=.05, *ns*), anxiety (r=0.14, *ns*) or satisfaction with life (r=.06, *ns*).

Ethnic Identity and Acculturation Following Immigration to Canada

It was expected that the development of a strong ethnic identity may provide a buffer against stress-related symptoms by facilitating the use of adaptive acculturative strategies. To assess the relation between ethnic identity and acculturation, ethnic identity was regressed onto the four acculturation strategies simultaneously. Ethnic identity was highly related to the acculturation strategies endorsed, R^2 = .366, F(4, 166)=25.50, p<.001. Although ethnic identification demonstrated significant positive zero-order correlations with all but one of the acculturation strategies (separation) (see Table 2), the regression coefficients indicated that only higher levels of integration and lower assimilation were significant additive predictors of ethnic identity. Although the regression coefficient for separation was significant, it was likely serving a suppressor role. Thus, it appears that a stronger ethnic identity was associated with an increased

likelihood of endorsing an integration strategy, and a reduced likelihood of assimilating with the host group.

Table 2 - Regression Analysis (Pearson Correlations and Standardized Regression Coefficients) Assessing the Prediction of Ethnic Identity from the Acculturation Subscales

	r	β	R^2_{total}
Acculturation			.366***
Marginalization	-.26***	-.03	
Integration	.53***	.53***	
Assimilation	-.30***	-.23**	
Separation	.09	.21**	

**p <.01; ***p <.001

Ethnic Identity, Acculturation and Psychological Well-being

Given the strength of the relations between ethnic identity and acculturation, and to evaluate their association with psychological well-being, the three indices of well-being were each regressed onto ethnic identity and all four acculturation strategies simultaneously. As seen in Table 3, depressive symptoms, R^2 = .157, $F(5, 152)=5.65$, $p<.001$, anxiety, R^2 = .170, $F(5, 156)=6.37$, $p<.001$, and quality of life scores, R^2 = .247, $F(5, 162)=10.64$, $p<.001$, were all related to ethnic identity and the acculturation strategies that were endorsed. The acculturation strategies that reflected marginalization and assimilation (i.e., a lack of cultural maintenance) were both related to greater symptoms of depression and anxiety, as was reduced identification with one's group (but only with depressive symptoms). However, only marginalization shared unique variance with these outcomes (the significant regression coefficient for ethnic identity in relation to anxiety was likely a statistical artifact reflecting suppression, given the non-significant

zero-order correlation). Quality of life was similarly correlated with ethnic identity and these acculturation strategies, but additionally, was associated with greater integration. However, once again, only the endorsement of marginalization shared unique variance with compromised quality of life.

Table 3 - Regression Analysis (Pearson Correlations and Standardized Regression Coefficients) Assessing the Relations Between Ethnic Identity & Acculturation Subscales (Predictor Variables) and Psychological Well-being (Outcome Variables).

	Depression			Anxiety			QOL		
	r	β	R^2_{total}	r	β	R^2_{total}	r	β	R^2_{total}
Predictors			.157***			.170***			247***
Ethnic Identity	-.24**	-.14	.00	-.23**			.27***	.06	
Marginalization	.36***	.29**	.35***	.30**			-.45***	-.39***	
Integration	-.18	.01	-.15	-.05			.30***	.19	
Assimilation	.23**	.09	.23**	.12			-.22**	-.06	
Separation	.09	.04	.04	-.03			-.01	.10	

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

Relations among Ethnic Identity, Acculturation and Social Support and Coping Strategies

It was hypothesized that both the strength of ethnic identity and the choice of acculturative strategy employed might influence the type of social support Somali immigrants sought (in-group vs. out-group). To assess this possibility, each of the dimensions of social support was regressed onto ethnic identity and the four acculturation strategies simultaneously. Although identity and acculturation strategies were significantly related to perceived support from both the in-group, R^2 = .109, $F(5, 165)=4.04$, $p<.01$ and out-group, R^2 = .215, $F(5, 162)=8.88$, $p<.001$, as expected, the patterns of relations with specific acculturative strategies differed. Consistent with expectations, as seen in Table 4, a strong ethnic identity along with greater endorsement of

integrative acculturation strategies were associated with a greater propensity to seek in-group social support. Moreover, greater consumption of out-group social support was linked to integrative acculturation strategies as well as higher levels of assimilation. Seeking out-group support was also less likely to be reported when a separation strategy was endorsed, although this strategy did not predict unique variance over and above the effects of endorsing integrative or assimilation acculturation strategies.

Table 4 - Regression Analysis (Pearson Correlations and Standardized Regression Coefficients) Assessing the Relations Between Acculturation Subscales (Predictor Variables) and Social Support Consumption (Outcome Variables).

	In-group			Out-group		
	r	β	R^2_{total}	*r*	β	R^2_{total}
Predictors			.109***			.215***
Ethnic Identity	30***	.24**		.04	-.09	
Marginalization	-.07	.06		-.02	.04	
Integration	.25***	.26***		.36***	.42***	
Assimilation	-.11	-.11		.21**	.21**	
Separation	-.06	-.02		-.21**	-.14	

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

To determine whether ethnic identity strength and the choice of acculturative strategy would influence the type of coping style endorsed, each of emotion-focused and problem-focused coping was regressed onto these predictors. Ethnic identity and acculturation strategies were significantly related to emotion-focused coping, R^2 = .141, F(5, 164)=5.40, p<.001, but not to problem-focused coping, R^2 = .034, F(4, 165)=1.15, *ns*. As seen in Table 5, in line with expectations, the increased endorsement of marginalization and assimilation strategies, and the

reduced tendency to employ integration was associated with a greater tendency to endorse emotion-focused coping strategies. However, as with the measures of well-being, only the endorsement of marginalization was uniquely related to emotion-focused coping.

Table 5 - Regression Analysis (Pearson Correlations and Standardized Regression Coefficients) Assessing the Relations Between the Predictor Ethnic Identity and Acculturation Subscales (Predictor Variables) and Coping Skills (Outcome Variables).

	Problem-focused			Emotion-focused		
	r	β	R^2_{total}	*r*	β	R^2_{total}
Predictors			.034			.141***
Ethnic Identity	.16*	.20*		-.09	.09	
Marginalization	-.07	-.06		.34**	.27**	
Integration	.08	.07		-.19*	-.08	
Assimilation	.01	.04		.23**	.12	
Separation	-.02	.01		.07	-.01	

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

Relations between Social Support and Coping Strategies

Having an effective social support network may facilitate of the ability to implement effective coping skills, and it may be through the provision of these skills that the individual is more likely to report fewer symptoms of depression and anxiety. To assess the relations between social support consumption and coping, each of the problem-focused and emotion-focused coping strategies was regressed onto the two sources of support. Only seeking in-group social support consumption was a significant predictor of problem-focused coping, $F(2, 164)=3.60, p<.05$.

Given that only emotion-focused coping was related to acculturative strategies, the

possibility that coping might serve as a distal mediator of the acculturative strategies and well-being via its link to social support was not tenable. Rather, to the extent that both coping and social support seeking might be related to well-being (and hence both might serve as direct mediators in the relation between identity and acculturation and well-being), it is likely that their effects were additive.

Table 6 - Regression Analysis (Pearson Correlations and Standardized Regression Coefficients) Assessing the Relations Between Social Support Perceptions (Predictor Variables) and Coping Skills (Outcome Variables).

	Problem-focused			Emotion-focused		
	r	β	R^2_{total}	*r*	β	R^2_{total}
Social Support			.042*			.024
In-group	.19*	.22*		-.02	.04	
Out-group	-.01	-.09		-.15	-.17	

*$p<.05$

Relations Among Social Support, Coping Skills and Psychological Well-being

To evaluate whether social support seeking and coping demonstrated additive effects in the prediction of well-being, each of the indices of well-being was regressed onto social support perceptions and coping simultaneously. As seen in Table 7, these factors significantly predicted depressive symptoms, $R^2 = .193$, $F(4, 150)=8.94$, $p<.001$. However, neither in-group nor out-group social support seeking were related to depressive symptoms, whereas symptomatology was higher as a function of individuals' greater propensity to endorse emotion-focused coping. The significant regression coefficient for problem-focused coping suggested that it was serving as a suppressor variable given the non-significant zero-order correlation; this was the case for its relation

for all three indices of well-being.

Anxiety symptoms were significantly predicted by both support seeking and coping, $R^2 = .263$, $F(4, 153)=13.66$, $p<.001$. As seen in Table 7, anxiety was associated with a greater propensity to endorse emotion-focused coping, as well as with greater perceptions of in-group support. Finally, quality of life scores were regressed onto coping skills and social support simultaneously, $R^2 = .129$, $F(4, 159)=5.89$, $p<.001$. Greater life satisfaction was uniquely associated with lower endorsement of emotion-focused coping. Thus, as predicted, the maladaptive emotion-focused coping was related to all three indices of well-being. Given that emotion-focused coping was related both to acculturation strategies and well-being, it was a viable mediator in the relation between acculturation and psychological well-being.

Table 7 - Regression Analysis (Pearson Correlations and Standardized Regression Coefficients) Assessing the Relations Between Social Support Perception and Coping Skills (Predictor Variables) and Psychological Well-being (Outcome Variables).

	Depression			Anxiety			QOL		
	r	β	R^2_{total}	*r*	β	R^2_{total}	*r*	β	R^2_{total}
		$.193^{***}$			$.263^{***}$			$.129^{**}$	
Social Support									
In-group	.07	.13		$.22^{**}$	$.23^{**}$		.05	-.02	
Out-group	.05	.07		.10	.12		.10	.05	
Coping Skills									
Problem-focused	-.02	$-.27^{**}$		.14	$-.18^{*}$		.02	$.24^{**}$	
Emotion-focused	$.35^{***}$	$.49^{***}$		$.42^{***}$	$.54^{***}$		$-.29^{***}$	$-.41^{***}$	

$^{*}p<.05$; $^{**}p<.01$; $^{***}p<.001$

One of the primary goals of this study was to assess the mediating role of social support and coping skills in the relations between ethnic identity and acculturation strategies and psychological well-being. In line with Baron and Kenny (1986), a relation was viewed as possibly mediated when the zero-order correlations (1) between predictors and outcome variables were significant (2) between predictors and mediators were significant, and (3) between mediators and outcomes were significant. Thus, the previous analyses determined the viability of the various mediated models delineating the relations between ethnic identity and acculturative strategies and well-being. Following consideration of the significance of various correlational paths, the only models that were tenable concerned the relations between the endorsement of marginalization, integration and assimilation strategies and each of the three dimensions of well-being, and the extent to which these relations were mediated by the increased use of emotion-focused coping strategies.

Depressive symptoms. As both marginalization and assimilation strategies showed significant zero-order correlations with depressive symptoms, the mediating role of emotion-focused coping in these relations was investigated.

- *Marginalization* ⟶ *Emotion-focused coping* ⟶ *Depression*

When emotion-focused coping skills were controlled for, marginalization continued to significantly predict depressive symptoms, $\beta=.27, p<.01$, as did emotion-focused coping, $\beta=.26, p<.01$. However, the amount of variance explained by marginalization dropped from 12.7% to 6.2%, suggesting that emotion-focused coping was at least a partial mediator in the relation between marginalization and depressive symptoms. Indeed the indirect mediated path was significant, Sobel $t = 2.77, p<.01$, accounting for 52.1 % (12.7%-6.2%/12.7%) of the variability in this relation.

- *Assimilation* ⟶ *Emotion-focused coping* ⟶ *Depression*

When emotion-focused coping skills were controlled for, assimilation was no longer a significant predictor of depressive symptoms, β=.15, *ns,* whereas emotion-focused coping was significant, β=.32, $p<.001$. Indeed the mediated path was significant, Sobel $t = 2.45$, $p<.05$, with emotion-focused coping accounting for 83.5 % (12.7%-2.1%/12.7%) of the variability in the relation between assimilation and depressive symptoms.

Anxiety symptoms. Both marginalization and assimilation strategies showed significant zero-order correlations with anxiety symptoms. Thus, the mediating role of emotion-focused coping was investigated.

- *Marginalization* ⟶ *Emotion-focused coping* ⟶ *Anxiety*

When emotion-focused coping skills was controlled for in the regression, marginalization continued to predict anxiety symptoms, β=.21, $p<.01$, as did emotion-focused coping β=.33, $p<.001$. The amount of variance explained by marginalized dropped from 17.4% to 3.9% suggesting that emotion-focused coping was a partial mediator in the relation between marginalization and anxiety symptoms. The mediated path was indeed significant, Sobel $t = 3.19$, $p<.005$, with emotion-focused coping accounting for 77.6 % (17.4%-3.9%/17.4%) of the variability in this relation.

- *Assimilation* ⟶ *Emotion-focused coping* ⟶ *Anxiety*

As with depressive symptoms, when emotion-focused coping skills were controlled for, assimilation was no longer a significant predictor of anxiety symptoms (β=.12, *ns)* whereas emotion-focused coping was significant (β=.39, $p<.001$). The amount of variance explained by assimilation dropped from 17.4% to 1.4% suggesting that emotion-focused coping was a full

mediator in the relation between assimilation and depressive symptoms, Sobel $t = 2.61, p<.01$, accounting for 92 % (17.4%-1.4%/17.4%) of the variability in this relation.

Quality of life. Satisfaction with life scores were found to be related to integration and assimilation, the mediating role of emotion-focused coping was investigated.

- *Assimilation* ⟶ *Emotion-focused coping* ⟶ *Quality of Life*

When emotion-focused coping skills were controlled for, as with the stress symptomatologies, assimilation was no longer a significant predictor of satisfaction with life scores ($\beta=-.15$, *ns*). However, emotion-focused coping was a significant predictor ($\beta=-.26, p<.01$). The amount of variance explained by assimililation dropped from 8.8% to 2.2% suggesting that emotion-focused coping was a full mediator in the relation between assimilation and quality of life. The mediated path was indeed found to be significant, Sobel $t = -2.28, p<.05$, accounting for 75% (8.8%-2.2%/8.8%) of the variability in this relation.

- *Integration* ⟶ *Emotion-focused coping* ⟶ *Quality of Life*

When emotion-focused coping skills were controlled for, integration continued to predict satisfaction with life satisfaction scores ($\beta=.25, p<.01$), as did emotion-focused coping ($\beta=-.25, p<.01$). The amount of variance explained by integration dropped from 8.8% to 6.1% suggesting that emotion-focused coping might be at least a partial mediator in the relation between integration and quality of life. The mediated path was significant, Sobel $t = 1.98, p<.05$, accounting for 30.7% (8.8%-6.1%/8.8%) of the variability in this relation.

Summary

Ethnic identity and acculturation strategies were predictive of increased depressive affect and anxiety and lower quality of life. It had originally been argued that the relations between these variables were likely mediated by the availability of appropriate coping resources (social support), and the ability to implement effective coping strategies. However, of these possible mediators, only emotion-focused coping was related to both the predictors (acculturative strategies) and indices of well-being. The mediational analyses indicated that, emotion-focused coping was a partial mediator in the relationship between marginalization and symptoms of depression and anxiety, but that these two predictors also had significant independent (additive) effects. A similar partially mediated model was found for the role of emotion-focused coping and the relation between integration and quality of life. However, emotion-focused coping fully mediated the relations between an assimilation strategy and the three indices of well-being.

Discussion

The present study investigated the role of ethnic identity and acculturation in the well-being of Somali immigrants, as well as the mediating role of social support and coping resources. Previous research exploring ethnic identity and acculturation defined these as two related, yet distinct constructs important to the psychological well-being of immigrants (Berry, 1997; Farver, Narang, Bhadha, 2002; Lieber, Chin, Nihira, Mink, 2001; Phinney et al., 2001a). Consistent with this research, and as hypothesized, the results of the present study found that greater ethnic identification was related to acculturation behaviours reflecting higher levels of integration, whereby immigrants retained their original culture while adapting to that of their new country. In addition, identification was related to lower tendencies to employ acculturation strategies that did not include in-group contact or participation, such as marginalization and assimilation. Surprisingly, although ethnic identification was related to integrative acculturation, it was not associated with separation strategies, which would also have entailed higher contact with the other Somalis and little contact with the host group.

There may be a number of reasons for the lack of relation between ethnic identification and endorsing a separation strategy. A strong ethnic identity is typically defined in highly adaptive terms, including pride in one's culture, and acknowledging its centrality to one's sense of self. As such, it may be that this ability to recognize the value of the identity entails not only positive interactions with the in-group, but an ability to retain this positive sense of self in out-group contexts. Alternatively, isolation from the out-group may reflect other underlying motives, including, for example, lower levels of social and economic adaptation due to language difficulties that result in individuals turning to their ethnic community for reasons of perceived personal failure rather than ethnic pride. Finally, it is possible that these individuals felt that their

cultural and religious values were threatened by the integration into the wider culture. For example, one father who was interviewed indicated that "we don't mix with Canadians very much because we don't want our young children to forget their customs and faith". Nonetheless, it should be noted that the present sample was highly self-selected, and may not represent the range of individuals that endorsed an acculturation strategy entailing separation. Of particular importance was that participation required some degree of fluency in English; those individuals who refrain from contact with the host group due to a language barrier may differ from those who are not limited by this factor. Thus, the findings should be interpreted with caution in regards to newer Somali immigrants whose linguistic and adaptation skills have yet to develop. Moreover, Somali immigrants have faced the consequences of the civil war and are now members of a visible minority with all the challenges that entails. Thus, the results of the study should be interpreted with caution in regards to other immigrants.

Consistent with previous research (Berry, 2001; Deaux, 2000; Liebkind, 1996; Utsey et al., 2002), and in line with the notion that a high ethnic identity is adaptive, the present study demonstrated that higher ethnic identification was linked to fewer symptoms of depression and higher levels of self-reported quality of life. Previous research findings also suggest that strong ethnic identity was associated with better access to social support (Berry, 1990, 1997; Lee et al., 2004; Noh & Kaspar, 2003; Phinney et al., 2001), which may help with an immigrant's ability to deal with the effects of racism and discrimination (Noh & Kaspar, 2003; Phinney & Chavira, 1995). In line with this, the present study noted that ethnic identification was associated with greater perceptions of in-group social support, although, not surprisingly, it was not associated with differential levels of perceived support from the host society. However, such perceptions of in-group social support were associated with *higher*, rather than lower levels of anxiety (but was

not related to the other indices of well-being). This finding was not expected, but is reminiscent of research that has demonstrated that actually receiving social support may sometimes be associated with negative consequences. For example, it may be that in-group support is not always effective, in that in-group members might sometimes promote an inappropriate response (Coyne, Wortman, & Lehman, 1988; Ross & Mirowsky, 1989). In addition, receiving social support may result in feelings of indebtedness, which may serve as a source of stress in itself (Revenson, Schiaffino, Majerovitz, & Gibofsky, 1991). Finally, however, it must be recalled that, although the hypotheses of the present study were directional, the design was correlational. Thus, it may be that those individuals who seek support are the ones who are experiencing the greatest anxiety (Barrera, 1986).

It was also argued in the present study that social support would facilitate more effective coping efforts, and in particular that in-group support would be associated with a reduced tendency to employ emotion-focused coping strategies. Such strategies involve rumination, emotional expression, blame, emotional containment, passive resignation, and wishful thinking. Contrary to expectations, increased perceptions of in-group support were not related to reduced emotion-focused coping, but were moderately related to greater endorsement of problem-focused efforts (which includes problem-solving, reinterpreting negative situations as positive, i.e., cognitive reappraisal, and getting involved in constructive activities). Similarly, a strong ethnic identification was also uniquely associated with higher levels of problem-focused, but not emotion-focused coping. Thus, it appears that in-group support may be viewed as a resource for group members to change or adapt to their situation, rather than as an emotional outlet. Surprisingly, however, greater endorsement of problem-focused coping efforts did not appear to be related to higher levels of psychological well-being. Rather, well-being among this sample of

Somali immigrants was more strongly related to their reduced propensity to employ emotion-focused coping, which as noted, were not diminished as a function of their ability to rely on social support from other in-group members, or their strength of identification with the Somali community. Certainly this relation between emotion-focused coping and well-being has been documented in previous research (Lazarus, 2000; Matheson & Anisman, 2003), and it may be that it is not altered by factors uniquely derived from immigrants' cultural community.

Thus, the Somali immigrants in the present study who reported a strong ethnic identity were more likely to perceive strong support from their in-group, and to rely on problem-focused coping efforts. For example, one participant commented that "coming from a large extended family and being close to other Somalis in the neighbourhood gives me the strength to build a successful business in Ottawa". Although such identification was also associated with greater well-being, this increased well-being did not appear to be a function of the resources that were derived from the Somali community. Once again, this pattern of relations is correlational, and so it is possible that individuals who already demonstrated greater well-being were more confident in their ethnic group identity, and hence were more likely to become involved with and contribute to the Somali community. Indeed, another participant spoke of his volunteer work with young Somalis saying, "Somalis can contribute a lot to Canadian life through education and make their community stronger".

As noted earlier, ethnic identity was associated with individuals' acculturative strategies. However, these concepts may tap into unique aspects of the immigrant experience, with the former reflecting their sense of self-identity and esteem, and the latter being a function of their approach to the immigration experience. Nonetheless, there were some common patterns of relations. Consistent with the findings for a strong ethnic identity, as well as previous

acculturation research (Berry, 1997; Berry, Kim, Minde & Mok, 1987; Phinney & Devich-Navarro, 1997), an integrative strategy was associated with greater quality of life. However, it appears that the strategies that entailed a disconnection from the immigrant's cultural community had a more pervasive effect on their well-being; thus, marginalization and assimilation strategies were related to increased depressive and anxious symptoms as well as lower quality of life. These finding suggest that individuals endorsing these strategies might experience reduced in-group support, which in turn would predict well-being, but this was not supported by the present data. Those individuals who endorsed a more integration strategy also perceived high levels of out-group support, along with greater in-group support. However, even among these individuals, this support did not play the expected role in enhancing problem-focused coping efforts, nor in buffering individuals against psychological symptoms or reduced quality of life. However, the perceptions of out-group social support were associated with the reduced endorsement of emotion-focused coping. Out-group support may alleviate the need for emotion-focused coping efforts through the establishment of institutional and organizational supports, such as a school counselor or a social worker who may provide the individual with concrete support in receiving information and instruction.

As noted earlier, emotion-focused coping was a consistent predictor of higher levels of depressive and anxiety symptoms and lower quality of life, although it was not related to factors emanating from individuals' ethnic identity. However, higher levels of emotion-focused coping were associated with greater use of marginalization and assimilation strategies, and with lower levels of integration. Thus, individuals' acculturative approach may have been linked to coping behaviours that served to enhance or threaten their psychological well-being. In line with this possibility, the mediating role of emotion-focused coping was investigated. The pattern of

mediated relations differed for each of the acculturative strategies. In particular, the relations between assimilation and all three indices of well-being appeared to be fully mediated by the increased propensity to use emotion-focused coping. It is possible that an assimilation approach is in itself distressing, evoking a need for emotion-focused coping to express this distress. For example, assimilated individuals may find it difficult to connect with their in-group, and as one participant commented "I hate it when other Somalis tell me I am not Somali enough or religious enough, it causes some distress". In a like manner, another participant commented that what he found distressing was "not being able to get across the point that I am Somali to Somalis despite my physical characteristics, attire, the way I speak, how I carry myself, assuming I'm too Canadian". For some assimilated individuals, the rejection by other Somalis may precipitate the greater endorsement of emotion-focused coping as a way to deal with the feelings of rejection and isolation, which undermine their psychological well-being.

In contrast, the relation between adopting a strategy of marginalization and depressive or anxious symptoms was only partially mediated by emotion-focused coping, and not at all mediated by coping in relation to quality of life. Thus, it appears that marginalization may reflect factors over and above emotion-focused coping that undermine individuals' well-being. For instance, those who are already suffering from poor psychological well-being may find themselves isolated from both the in-group and the out-group and increasingly reliant on emotion-focused coping in the absence of physical and informational support. Some Somali immigrants had been exposed to prior trauma due to exposure to the civil war, and these experiences may have had a greater impact on psychological well-being, and also undermined their ability to adapt to the immigration experience. One father whose wife had partial paralysis as a result of a bullet injury during their flight from Somalia stated "I find it difficult to be a

breadwinner and a carer of my wife. Our children behave like Canadians and don't help out at all, no Somali or Canadian helps us". Another highly isolated participant commented on the difficulties he faced both inside and outside his community "I am tired of people treating me like I don't exist". The use of emotion-focused coping seemed to have heightened the effect of marginalization on psychological well-being and consequently, the reporting of greater depressive and anxiety symptoms. Future research may use a prospective design to assess the relationship between past experiences and acculturation strategies endorsed.

Integration was the most adaptive acculturation strategy in that it was positively linked to greater quality of life. In addition, the reduced emotion-focused coping associated with integration served as partial mediating variable in this relation, but this acculturative strategy also had an additive effect on the quality of life that was not accounted for by the endorsement of more adaptive coping skills. Much like a strong ethnic identification, it is possible that relations between well-being and an integration strategy are reciprocal, in that the immigrants who were most satisfied with their lives were more likely to adopt more active efforts to deal with stressors, and to become more socially and culturally involved and integrated. One participant who was particularly active in the community and the owner of a business highlighted that "like other immigrant communities, we will become successful too when we push education and business among Somalis and become more politically active too because politics is always important".

Taken together, the present results suggest that although ethnic identification and the acculturation strategies adopted are linked, and both are predictive of well-being and quality of the life, the underlying processes differ. Although ethnic identification was associated with increased in-group support and problem-focused coping, these processes did not account for the

relation between identification and more positive well-being. Acculturative strategies were not associated with support from the immigrant community, and although they were related to coping efforts, they were most strongly associated with emotion-focused propensities, and these propensities were, in turn, predictive of psychological symptoms and quality of life. Theoretically, these two constructs should be further examined in future studies, particularly the mechanisms through which they contribute to the adaptation and psychological well-being of immigrants.

In conclusion, the findings of the present study are in line with research stemming from Social Identity Theory supporting the psychological benefits of identifying with one's ethnic group. Moreover, unique to the situation of the immigrant, and in line with acculturation theory, there also appear to be psychosocial benefits stemming from the process of integration with the host society, but only when it occurs in conjunction with establishing and maintaining close contact with the in-group. High ethnic identification and an integrative acculturative strategy facilitated perceptions of a strong social support network, which was further linked to the endorsement of effective coping skills. Although it is possible that ethnic identity and adaptation to the immigration experience motivate the individual to become involved with their ethnic community and to employ 'healthy' strategies for coping with life's stressors, it is also possible that connection with a strong community facilitates the individual's ability to retain a feeling of ethnic pride and the strength to face the issues arising from integrating with a vastly different cultural society.

Immigrants who are able to contribute to a supportive network and community can ease the integration of newer immigrants into the wider community. They, in turn, may gain the benefits of active social participation. Unfortunately, there was a significant proportion of the sample

that did not appear to adopt an effective approach to the immigration experience, but instead were marginalized from their own community, and may (assimilated), or may not, have connected with the host society. These individuals who did not benefit from the support emanating from the Somali community demonstrated the greatest compromises in well-being. It is possible that other factors may have undermined these individuals' psychological health, such as prior trauma experiences, which might have been alleviated if they had the help of an appropriate in-group support network. The role of the immigrant community in facilitating individuals' ability to derive meaning from their past experiences, especially those that may have occurred in their home country, and to find positive strategies for present adaptation may be an important issue to be addressed in future research.

Appendix A

Informed Consent

The purpose of an informed consent is to ensure that you understand the purpose of the study and the nature of your involvement. The informed consent has to provide sufficient information such that you have the opportunity to determine whether you wish to participate in the study.

Study Title: Ethnic identity, acculturation, coping, and social support among Somali immigrants.

Study Personnel: Iman Ofleh (Researcher, 520-2600 ext. 2683)
Dr. Kim Matheson (Faculty Investigator, 520-2684)

If you have any ethical concerns about how this study, please contact Dr. M. Gick (Chair of the Carleton University Research Ethics Committee for Psychological Research, 520-2600, ext. 2664) or Dr. J. Logan (Chair, Department of Psychology, 520-2648).

Purpose and Task Requirements: The goal of this present study is to evaluate the health and well-being of Somali immigrants. We are asking you to fill out a number of questionnaires regarding your background (e.g., family history), personal characteristics (e.g., how you cope with things in your life, health), and possible past trauma experiences, such as loss of a loved one, assault, etc. We will also be asking some participants for several saliva samples to look for physical indications of stress and potential health risks. Providing a saliva sample simply involves having a piece of dental cotton in your mouth for two minutes and then placing it in a test tube. The questionnaires will take about 90 minutes to complete.

Potential Risk and Discomfort: There are no physical risks in this study. Some individuals may experience discomfort when asked to respond to personal, sensitive questions that require focusing on the stress associated with the recent events.

Anonymity/Confidentiality: The data collected in this study will be kept confidential. Because we will want to keep track of your answers in this questionnaire to match them with your saliva samples, we will have to be able identify who you are on your questionnaire. However, we take special precautions to make sure that no-one else will be able to identify you and what your responses were. We will be doing this by putting a code on your questionnaire. Identifying information for each code will be kept in a separate and secured file by one of the research investigators who will keep this information confidential.

Right to Withdraw: Your participation in this study is entirely voluntary. At any point during the study you have the right to not complete certain questions or to withdraw with no penalty whatsoever.

I have read the above description of the study concerning how psychological and social factors may influence my health and well-being. The data collected will be used in research publications and/or for teaching purposes. My signature indicates that I agree to participate in the study, and this in no way constitutes a waiver of my rights.

Full Name (please print): _____
Participant Signature: _____
Date: _____

Researcher Signature: _____
Date: _____

Appendix B

*Participant Code:*_____

Background information

Date on which you're completing this survey: Day_____ Month _____

Time of day you're starting it: _____ pm

- Sex: Female / Male (please circle one)
- Age: _____
- What year did you leave Somalia? _____
- How long have you been living in Ottawa? _____ yrs _____mths
- What is your citizenship status?

_____	Canadian citizen	Since what year?_____
_____	Landed immigrant	Since what year?_____
_____	Refugee claimant	Since what year?_____

- Are you currently employed full-time_____ ; part-time _____ ; not at all_____
- Are you a student full time _____; part time _____ ; not at all_____
- What is your highest level of education completed? (Please check one)

Less than high school	_____	High school	_____
College and/or trade school	_____	Some university	_____
University	_____	Graduate/ Professional	_____

- How many people are there in Canada that you personally would consider a close friend?

  a) Number of friends from Somalia _____

  b) Number of Canadian friends _____

  c) Number of friends from other countries _____

- Do you have parents or siblings in Canada?(circle one) No Yes
- Do you live with family members or relatives in Canada? (circle one) No Yes
- What is your relationship status? (please check the one that applies best to you)

_____ Single/Never married _____ Dating and/or Engaged

_____ Married/Cohabitating _____ Separated/ Divorced

_____Widowed

- How long have you been in your current relationship? _____ years OR _____ months

- Do you have children? (circle one) No Yes
  If yes, how many?_____

- What is your first language? _____

- What is your religion, if any? _____

YOUR HEALTH

- Do you currently smoke? (circle one) No Yes
  If yes, how many cigarettes/day? _____

- Are you currently being treated for any physical condition? (circle one) No Yes
  If yes, please specify _____

- Are you on any of the following medications (please check all that apply):

  _____ Anti-inflammatories (please specify)_____
  _____ Anti-hypertensives (please specify)_____
  _____ Anti-depressants (please specify) _____
  _____ Anti-anxieties (please specify) _____
  _____ Birth control pill
  _____ Other Prescription drugs (please specify) _____
  _____

- Have you ever been in psychological therapy or counseling? (please check one)

_____ No, I have never been in therapy
_____ Yes, but I am no longer
_____ Yes, and still am

If yes, how long ago were you in, or have you been in therapy?
Began _____ month/year and continued until _____ month/year

- Do you have any visible physical disability? (circle one) No Yes
  If so, please specify _____

- Do you have ***diabetes***? (circle one) No Yes
  If yes, which type? (circle one) Type I Type II
  What year were you diagnosed? _____

Appendix C

The Multigroup Ethnic Identity Measure (MEIM)

In Canada, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Hispanic or Latino, Black or African Canadian, Asian Canadian, Chinese, Filipino, Caucasian or White, Italian Canadian, and many others.

These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Use the numbers below to indicate how much you agree or disagree with each statement.

(1) Strongly disagree (2) disagree (3) Neutral (4) Agree (5) Strongly Agree

____ 1. I have spent time trying to find out more about Somalia, such as its history, traditions, and customs.

____ 2. I am active in organizations or social groups that include mostly Somali members.

____ 3. I have a clear sense of being Somali and what it means for me.

____ 4. I think a lot about how my life will be affected by my being Somali.

____ 5. I am happy that I am Somali.

____ 6. I have a strong sense of belonging to my ethnic group.

____ 7. I understand pretty well what being Somali means to me.

____ 8. In order to learn more about my ethnic background, I have often talked to other people about my ethnic group

____ 9. I have a lot of pride in my ethnic group.

____ 10. I participate in Somali cultural practices, such as special food, music, or customs.

____ 11. I feel a strong attachment towards my ethnic group.

____ 12. I feel good about my Somali cultural background.

Acculturation scale

When people from different cultures come into contact with one another, they interact and develop relationships with their own ethnic group and the larger society. The following are statements are about these interactions.

Use the numbers below to indicate how much you agree or disagree with each statement.

(1) Strongly disagree (2) disagree (3) Neutral (4) Agree (5) Strongly Agree

____ 1. I write better in English than in Somali.

____ 2. Most of the music I listen to is Somali.

____ 3. I tell jokes both in English and in Somali.

____ 4. Generally, I find it difficult to socialize with anybody, Canadian or Somali.

____ 5. When I am in my apartment/ house, I typically speak Somali.

____ 6. My closest friends are Somali.

____ 7. Somalis should be involved in Canadian society and maintain their cultural heritage.

____ 8. I sometimes feel that neither Canadians nor Somalis like me.

____ 9. If Somali people are to be successful, they should forget their cultural origins.

____ 10. I prefer going to social gatherings where most of the people are Somali.

____ 11. I have both Canadian and Somali friends.

____ 12. There are times when I think no one understands me.

____ 13. I get along better with Canadians than Somalis.

____ 14. I feel that Somalis treat me as an equal more than Canadians do.

____ 15. I feel that both Somalis and Canadians value me.

____ 16. I sometimes find it hard to communicate with people.

____ 17. I feel that Canadians understand me better than Somalis do.

____ 18. It would be better if Somali people had nothing to do with Canadians.

____ 19. I feel very comfortable around both Canadians and Somalis.

(1) Strongly disagree (2) disagree (3) Neutral (4) Agree (5) Strongly Agree

____ 20. I sometimes find it hard to make friends.

____ 21. Somali people should give up their cultural habits and become like the Canadian majority.

____ 22. I feel more relaxed when I am with a Somali than when I am with a Canadian.

____ 23. Sometimes I feel that Somalis and Canadians do not accept me.

____ 24. I feel more comfortable socializing with Canadians than I do with Somalis.

____ 25. Somalis should not date non-Somalis.

____ 26. Sometimes I find it hard to trust both Canadians and Somalis.

____ 27. Most of my friends are Canadian.

____ 28. I find that both Somalis and Canadians often have difficulty understanding me.

____ 29. I find that I do not feel comfortable when I am with other people.

BECK INVENTORY

On this questionnaire are groups of statements. Please read the entire group of statements of each category. Then pick out ONE statement in that group which best describes the way you feel. Check off the number beside the statement you have chosen.

---

1. ___ 0 = I do not feel sad
   ___ 1 = I feel sad or blue
   ___ 2a = I am blue or sad all of the time and I can't snap out of it
   ___ 2b = I am so sad or unhappy that it is very painful
   ___ 3 = I am so sad or unhappy that I can't stand it

2. ___ 0 = I am not particularly pessimistic or discouraged about the future
   ___ 1 = I feel discouraged about the future
   ___ 2a = I feel I have nothing to look forward to
   ___ 2b = I feel I won't every get over my troubles
   ___ 3 = I feel that the future is hopeless and things cannot improve

3. ___ 0 = I do not feel like a failure
   ___ 1 = I feel I have failed more than the average person
   ___ 2a = I feel I have accomplished very little that is worthwhile or that means anything
   ___ 2b = As I look back on my life, all I can see is a lot of failures
   ___ 3 = I feel I am a complete failure as a person

4. ___ 0 = I am not particularly dissatisfied
   ___ 1a = I feel bored most of the time
   ___ 1b = I don't enjoy things the way I used to
   ___ 2 = I don't get satisfaction out of anything anymore
   ___ 3 = I am dissatisfied with everything

5. ___ 0 = I don't feel particularly guilty
   ___ 1 = I feel bad or unworthy a good part of the time
   ___ 2a = I feel quite guilty
   ___ 2b = I feel bad or unworthy practically of the time now
   ___ 3 = I feel as though I am very bad or worthless

6. ___ 0 = I don't feel I am being punished
   ___ 1 = I have a feeling that something bad may happen to me
   ___ 2 = I feel I am being punished or will be punished
   ___ 3a = I feel I deserve to be punished
   ___ 3b = I want to be punished

7. ___ 0 = I don't feel disappointed in myself
   ___ 1a = I am disappointed in myself
   ___ 1b = I don't like myself

___2 = I am disgusted with myself
___3 = I hate myself

8. ___0 = I do not feel I am any worse than anybody else
___1 = I am very critical of myself for my weaknesses or mistakes
___2a = I blame myself for everything that goes wrong
___2b = I feel I have many bad faults

9. ___0 = I don't have thoughts of harming myself
___1 = I have thoughts of harming myself but I would not carry them out
___2a = I feel I would be better off dead
___2b = I have definite plans about committing suicide
___2c = I feel my family would be better off if I were dead
___3 = I would kill myself if I could

10. ___0 = I don't cry anymore than usual
___1 = I cry more now than I used to
___2 = I cry all the time now. I can't stop it
___3 = I used to be able to cry but now I can't cry at all even though I want to

11. ___0 = I am no more irritated now than I ever am
___1 = I get annoyed or irritated more easily than I used to
___2 = I get irritated all the time
___3 = I don't get irritated at all the things that used to irritate me.

12. ___0 = I have not lost interest in other people
___1 = I am less interested in other people than I used to be
___2 = I have lost most of my interest in other people and I have little feeling for them
___3 = I have lost all my interest in other people and don't care about them at all

13. ___0 = I make decisions about as well as ever
___1 = I am less sure of myself now and try to put off making decisions
___2 = I can't make decisions anymore without help
___3 = I can't make decisions at all anymore

14. ___0 = I don't feel I look any worse than I used to
___1 = I am worried that I am looking old or unattractive
___2 = I feel that there permanent changes in my appearance and they make me look unattractive
___3 = I feel that I am ugly or repulsive looking

15. ___ 0 = I can work about as well as before
___ 1a = It takes extra effort to get started at doing something
___ 1b = I don't work as well as I used to
___ 2 = I have to push myself very hard to do anything
___ 3 = I can't do any work at all

16. ___ 0 = I can sleep as well as usual
___ 1 = I wake up more tired in the morning than I used to
___ 2 = I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
___ 3 = I wake up early every day and can't get more than 5 hours sleep

17. ___ 0 = I don't get anymore tired than usual
___ 1 = I get tired more easily than I used to
___ 2 = I get tired from doing anything
___ 3 = I get too tired to do anything

18. ___ 0 = My appetite is no worse than usual
___ 1 = My appetite is not as good as it used to be
___ 2 = My appetite is much worse now
___ 3 = I have no appetite at all any more

19. ___ 0 = I haven't lost much weight, if any, lately
___ 1 = I have lost more than 5 pounds
___ 2 = I have lost more than 10 pounds
___ 3 = I have lost more than 15 pounds

20. ___ 0 = I am no more concerned about my health than usual
___ 1 = I am concerned about aches and pains or upset stomach or constipation or other unpleasant feelings in my body
___ 2 = I am so concerned with how I feel or what I feel that it's hard to think of much else
___ 3 = I am completely absorbed in what I feel

21. ___ 0 = I have not noticed any recent change in my interest in sex
___ 1 = I am less interested in sex than I used to be
___ 2 = I am much less interested in sex now
___ *3 = I have lost interest in sex completely*

Beck Anxiety Inventory

Please rate how much you have been bothered by each of the following symptoms over the past week.

0 1 2 3
Not at all **Severely (I could barely stand it)**

____ 1. Numbness or tingling
____ 2. Feeling hot
____ 3. Wobbliness in legs
____ 4. Unable to relax
____ 5. Fear of the worse happening
____ 6. Dizzy or lightheaded
____ 7. Heart pounding or racing
____ 8. Unsteady
____ 9. Terrified
____ 10. Nervous
____ 11. Feelings of choking
____ 12. Hands trembling
____ 13. Shaky
____ 14. Fear of losing control
____ 15. Difficulty breathing
____ 16. Fear of dying
____ 17. Scared
____ 18. Indigestion or discomfort in abdomen
____ 19. Faint
____ 20. Face flushed
____ 21 Sweating (not due to heat)

Hassles Scale

Please read the following items and indicate whether that situation has happened to you in the *last 3 months* and how stressful you have found it.

(0) Didn't happen to me (1) Happened, but was not at all stressful (2) Somewhat stressful
(3) Moderately stressful (4) Very stressful (5) Extremely stressful

____ 1. People didn't respect my cultural/ religious values.

____ 2. I had to take care of my siblings and/or relatives.

____ 3. My income is not enough to support my family or myself.

____ 4. I've been discriminated against because of my ethnic origin.

____ 5. People of my ethnic origin told me that I should be more religious.

____ 6. Because of family responsibilities, I don't have time to spend with my friends.

____ 7. I have to work hard to send my family money.

____ 8. I've seen friends treated badly because of their ethnic origin.

____ 9. Since I don't speak English well, it was hard interacting with others.

____ 10. I had serious arguments with family members.

____ 11. I've been forced to accept low paying jobs.

____ 12. Since I don't speak English well or have an accent when I speak, people have treated me with rudeness.

____ 13. I felt that family members are losing their religion.

____ 14. I felt lonely and isolated because of lack of family unity.

____ 15. I've had problems getting a good job because of my immigration status.

____ 16. I can't decide if certain actions are made because of my ethnic origin or because the person is rude.

____ 17. People of my ethnic origin think I've become too 'Canadian'.

____ 18. Being too close to family interfered with my goals.

____ 19. I felt I will never regain the status/ respect I had in Somalia.

____ 20. People looked down on me because I practice my cultural/ religious values.

____ 21. I felt guilty leaving family/ friends in Somalia.

____ 22. Because I have to work and support my family, I can't go back to school.

____ 23. I felt uncomfortable because I had to choose between the Somali and Canadian way of doing things.

____ 24. I felt that family members are losing their religion.

____ 25. My personal goals conflicted with family goals.

____ 26. There's been physical violence among family members.

CONSUMPTION OF SOCIAL SUPPORT SCALE (CGSS)

In the past few months, how often have you been the recipient of these activities from other people? Please read each statement carefully and underline or circle the answer that best describes your experience.

---

1. You received some information from others which helped you understand a situation

Somali Person: Not at all Once or twice About once a week Several times a week About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week About every day

2. You were checked back from people who had helped you to see if you had followed their advice

Somali Person: Not at all Once or twice About once a week Several times a week About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week About every day

3. You received information from others on how to do something

Somali Person: Not at all Once or twice About once a week Several times a week About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week About every day

4. You received feedback from others on how you were doing without saying it was good or bad

Somali Person: Not at all Once or twice About once a week Several times a week About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week About every day

5. You were told from others that you are O.K. just the way you are

Somali Person: Not at all Once or twice About once a week Several times a week About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week About every day

6. You received interest and concern from others in your well-being

Somali Person: Not at all Once or twice About once a week Several times a week About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week
About every day

7. You had someone who listened to you talking about your private feelings
Somali Person: Not at all Once or twice About once a week Several times a week
About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week
About every day

8. You had someone who joked and kidded to try cheering you up
Somali Person: Not at all Once or twice About once a week Several times a week
About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week
About every day

9. You were provided with transportation from others
Somali Person: Not at all Once or twice About once a week Several times a week
About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week
About every day

10. You were helped by others to do something that needed to be done
Somali Person: Not at all Once or twice About once a week Several times a week
About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week
About every day

11. You were provided by others with a place where you could get away for a while
Somali Person: Not at all Once or twice About once a week Several times a week
About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week
About every day

12. You were loaned or given something by others (a physical object other than money) that you needed
Somali Person: Not at all Once or twice About once a week Several times a week
About every day

Non-Somali Person: Not at all Once or twice About once a week Several times a week
About every day

SCOPE

The purpose of this questionnaire is to find out how people deal with their problems or the stresses in their lives. The following are activities that you may have done to deal with *the event you described on the previous page.* After each activity, please indicate the extent to which you may have used this as a way of dealing with the event in recent weeks.

Ordinarily, in recent weeks have you	*Never*	*Seldom*	*Sometimes*	*Often*	*Almost Always*
1. accepted that there was nothing you could do to change your situation?	0	1	2	3	4
2. tried to just take whatever came your way?	0	1	2	3	4
3. talked with friends or relatives about your problems?	0	1	2	3	4
4. tried to do things which you typically enjoy?	0	1	2	3	4
5. sought out information that would help you resolve your problems?	0	1	2	3	4
6. blamed others for creating your problems or making them worse?	0	1	2	3	4
7. sought the advice of others to resolve your problems?	0	1	2	3	4
8. blamed yourself for your problems?	0	1	2	3	4
9. exercised?	0	1	2	3	4
10. fantasized or thought about unreal things (eg., the perfect revenge, or winning a million dollars) to feel better?	0	1	2	3	4
11. been very emotional compared to your usual self?	0	1	2	3	4
12. gone over your problems in your mind over and over again?	0	1	2	3	4
13. asked others for help?	0	1	2	3	4
14. thought about your problems a lot?	0	1	2	3	4
15. became involved in recreation or pleasure activities?	0	1	2	3	4
16. worried about your problems a lot?	0	1	2	3	4
17. tried to keep your mind off things that are upsetting you?	0	1	2	3	4
18. tried to distract yourself from your troubles?	0	1	2	3	4
19. avoided thinking about your problems?	0	1	2	3	4
20. made plans to overcome your problems?	0	1	2	3	4
21. told jokes about your situation?	0	1	2	3	4
22. thought a lot about who is responsible for your problems (besides yourself)?	0	1	2	3	4
23. shared humorous stories etc. to cheer yourself and others up?	0	1	2	3	4
24. told yourself that other people have dealt with	0	1	2	3	4

problems such as yours?					
25. thought a lot about how you have brought your problems on yourself?	0	1	2	3	4
26. decided to wait and see how things turn out?	0	1	2	3	4
27. wished the situation would go away or be over with?	0	1	2	3	4
28. decided that your current problems are a result of your own past actions?	0	1	2	3	4
29. gone shopping?	0	1	2	3	4
30. asserted yourself and taken positive action on problems that are getting you down?	0	1	2	3	4
31. sought reassurance and moral support from others?	0	1	2	3	4
32. resigned yourself to your problems?	0	1	2	3	4
33. thought about how your problems have been caused by other people?	0	1	2	3	4
34. daydreamed about how things may turn out?	0	1	2	3	4
35. been very emotional in how you react, even to little things?	0	1	2	3	4
36. decided that you can grow and learn through your problems?	0	1	2	3	4
37. told yourself that other people have problems like your own?	0	1	2	3	4
38. wished I was a stronger person or better at dealing with problems?	0	1	2	3	4
39. looked for how you can learn something out of your bad situation?	0	1	2	3	4
40. asked for God's guidance?	0	1	2	3	4
41. kept your feelings bottled up inside?	0	1	2	3	4
42. found yourself crying more than usual?	0	1	2	3	4
43. tried to act as if you were not upset?	0	1	2	3	4
44. prayed for help?	0	1	2	3	4
45. gone out?	0	1	2	3	4
46. held in your feelings?	0	1	2	3	4
47. tried to act as if you weren't feeling bad?	0	1	2	3	4
48. taken steps to overcome your problems?	0	1	2	3	4
49. made humorous comments or wise cracks?	0	1	2	3	4
50. told others that you were depressed or emotionally upset?	0	1	2	3	4

QUALITY OF LIFE QUESTIONNAIRE

This questionnaire asks you for your views about your health in general and how it affects your daily life. Of particular interest are your feelings and perceptions of your health in the PAST TWO (2) WEEKS.

GENERAL HEALTH

1. In general, would you say your health is (circle one number):

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. How often in the PAST TWO (2) WEEKS ...

a. Did you feel worn out?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

b. Did you have a lot of energy?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

c. Did you feel full of pep?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

d. Did you have enough energy to do the things you wanted to?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

e. Did you feel tired?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

---

For each of the following questions, please circle the number that comes closest to the way you have been feeling DURING THE PAST TWO (2) WEEKS.

a. How much of the time did you have difficulty reasoning and solving problems, for example, making plans, making decisions, learning new things?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

b. How much of the time did you forget, for example, things that happened recently, where you put things, appointments?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

c. How much of the time did you have trouble keeping your attention on any activity for long?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

d. How much of the time did you have difficulty doing activities involving concentration & thinking?

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

---

WORK BEHAVIOR

4. DURING THE PAST TWO (2) WEEKS:

a. I felt enthusiastic about my work.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

b. I did not do my work as carefully and accurately as usual.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

c. I felt tired and sleepy at work.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

d. I was not accomplishing as much at work as usual.

1	2	3	4	5	6

None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

e. I have had no trouble concentrating at work.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

f. I have been able to keep up at work .

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

---

SOCIAL INTERACTION

5. DURING THE PAST TWO (2) WEEKS:

a. I show less interest in other people's problems, for example, don't listen when they tell me about their problems, don't offer to help.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

b. I act irritable toward those around me, for example, snap at people, give sharp answers, criticize easily.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

c. I show less affection.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

d. I make many demands, for example, insist that people do things for me, tell them how to do things.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

f. I act disagreeable to family members, for example, I act spiteful, I am stubborn.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

g. I am paying less attention to my family and/or friends.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

h. I am not acting as I usually do to take care of my family and/or friends.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

i. I am not joking with family members and/or friends as I usually do.

1	2	3	4	5	6
None of the time	A little of the time	Some of of the time	A good bit the time	Most of the time	All of the time

---

7. (a) In general, how satisfied or dissatisfied are you with your physical health as it is right now?

Completely Dissatisfied	0	1	2	3	4	5 Neutral	6	7	8	9	10	Completely Satisfied

(b) In general, how satisfied or dissatisfied are you with your working life as it is right now?

Completely Dissatisfied	0	1	2	3	4	5 Neutral	6	7	8	9	10	Completely Satisfied

(c) In general, how satisfied or dissatisfied are you with your social life as it is right now?

Completely Dissatisfied	0	1	2	3	4	5 Neutral	6	7	8	9	10	Completely Satisfied

(d) In general, how satisfied or dissatisfied are you with your home life as it is right now?

Completely Dissatisfied	0	1	2	3	4	5 Neutral	6	7	8	9	10	Completely Satisfied

(e) In general, how satisfied or dissatisfied are you with your emotional state as it is right now?

Completely Dissatisfied	0	1	2	3	4	5 Neutral	6	7	8	9	10	Completely Satisfied

(f) In general, how satisfied or dissatisfied are you with your recreational life as it is right now?

Completely Dissatisfied	0	1	2	3	4	5 Neutral	6	7	8	9	10	Completely Satisfied

(g) In general, how satisfied or dissatisfied are you with your life as a whole right now?

Completely Dissatisfied	0	1	2	3 Neutral	4	5	6	7	8 Satisfied	9	10	Completely

Appendix D

Debriefing

Stressful experiences may result in a wide range of mood disturbances, including depression and anxiety, as well as physical illness. People react differently, though, to the impact of stressors. Among the variables that influence the impact of stressors is the extent of a person's social support network, coupled with the individual's ability to cope behaviorally with the challenges.

Generally, coping with a stressor may involve several different strategies, including

1. problem solving (active efforts or planning in order to eliminate or diminish stress),
2. cognitive restructuring (re-evaluating the relation between the person and the threat),
3. emotion-focused coping (managing emotional distress or using emotional responses as methods of dealing with the stressor, including but not limited to emotional expression, emotional containment, blame, withdrawal, denial or passivity),
4. seeking social support (as a buffer or venting outlet; the latter may also involve a component of emotional expression, or humour), and religion.

The coping strategy selected may vary as a function of the specific threat encountered, and the history of dealing with threats of a similar nature. Several coping efforts may be used at the same time, and some people are more likely to use some strategies. For example, someone who is optimistic more generally and feels like they have control over their lives may be more likely to adopt a problem-solving strategy that someone who feels helpless. In this study, we are looking at how different individuals cope with the stresses of immigration and adaptation to Canada. We have measured the various coping styles described above. In addition, we will be using the saliva samples and cardiac measures obtained to look for physical indications of stress (e.g. increased levels of salivary cortisol; a stress hormone) and potential health risks. As we are interested in how social identity affects the establishment of a social support network, we have also asked about your ethnic identity and acculturation, and your social network resources.

We are also interested in coping strategies and physical response to stressors by people who are depressed or anxious about prior life events, some of which may have been fairly traumatic, and present stressors. We believe that coping strategies make a difference on these factors, and if so, individuals might be trained to use strategies that are most appropriate for a given situation. This is the long-term goal of our work.

We are particularly interested in the experiences of the Somali community because its members are often facing multiple stressors due to their status as new immigrants and their membership in a visible minority group. We hope to study those factors such as social support that may help individuals cope with stressors.

Contacts

The following people are involved in this research project and may be contacted at any time if you have any further questions about the project, what it means, or concerns about how it was conducted: Iman Ofleh, Researcher, Department of Psychology, 520-2600 ext. 2683
Dr. K. Matheson, Professor, Dept. of Psychology, 520-2684

If you have any ethical concerns about how this study was conducted, please contact the following:
Dr. M. Gick, Chair of the Carleton University Research Ethics Committee for Psychological Research, 520-2600, ext. 2664
Dr. John Logan, Chair of the Department of Psychology, Carleton University, 520-2648

If you have any worries or concerns about your personal well-being, you can contact:
Distress Centre: Ottawa And Region
160 Elgin Street, Main Plaza
Ottawa, Ontario Canada K2P 2M3
Tel: (613) 238-1089 Web Site: www.dcottawa.on.ca

If you have experienced any situations of discrimination as a result of your ethnic or religious identity, you can contact:
Bias Crimes Unit: Ottawa Police Services
474 Elgin Street
Ottawa, Ontario K2P 2J6
Tel: (613) 236-1222 – ask for Bias Crime division Web Site: http://www.ottawapolice.on.ca

The following are associations that may welcome individuals interested in information or contact:
Somali Centre for Family Services
1719 Bank Street, Suite 303
Ottawa, ON K1V 7Z4
Tel: (613) 526-2075 Fax: (613) 526-2803
E-mail: information@somalifamilyservices.org

Ottawa Community Immigrant Services Organization
959 Wellington St., Ottawa, ON, K1Y 4W1
Tel: (613) 725-0202 Fax: (613) 725-9054 E-mail: info@ociso.org
Ottawa Muslim Association
257 Northwestern Ave
Ottawa, Ontario
Tel: (613) 725 0004 Web Site: http://www.kentus.f2s.com/html/oma_frame.htm

List Community Health Centers

Carlington Community & Health Services
900 Merivale Road
Ottawa, Ontario K1Z 5Z8
(613) 722-4000
www.carlington.ochc.org

Centretown Community Health Centre
420 Cooper St.
Ottawa, Ontario K2P 2N6
(613) 233-4443
www.centretownchc.org

Pinecrest-Queensway Health & Comm. Services
1365 Richmond Road, 2nd Floor
Ottawa, Ontario K2B 6R7
(613) 820-4922
www.pinecrest-queensway.com

Sandy Hill Community Health Centre
221 Nelson St.
Ottawa, Ontario K1N 1C7
(613) 789-1500
www.sandyhillchc.on.ca

Somerset West Community Health Centre
55 Eccles Street
Ottawa, Ontario K1R 6S3
(613) 238-8210
www.swchc.on.ca

SouthEast Ottawa Centre
1355 Bank Street, Suite 600
Ottawa, Ontario K1H-8K7
(613) 737-5115
www.seochc.on.ca

References

Allison, K. W. (1998). Stress and oppressed category membership. In J. K. Swim and C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 145-170). San Diego, CA: Academic.

Baranowsky, A.B., Young, M., Johnson, S., Williams-Keeler, L., & Mccarrey, M. (1998). PTSD Transmission: A review of secondary traumatization in Holocaust survivor families. *Canadian Psychology, 39*, 248 – 256.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.

Barrera, M., Jr. (1986). Distinctions between social support concepts, measures, and models. *American Journal of Community Psychology, 14*, 413-445.

Beaton, A.M., & Tougas, F. (1997). The representation of women in management: The more, the merrier? *Personality and Social Psychology Bulletin, 23*, 773-782.

Berry, J. (1990). Psychology of acculturation. In J. Bergman (Ed.), *Nebraska Symposium on Motivation* (Vol.37, pp. 201-234). Lincoln, NE: University of Nebraska Press.

Berry, J. W., Poortinga, Y. H., Segall, M. H. & Dasen, P. R. (1992). *Cross-cultural psychology: Research and applications*. New York: Cambridge University Press.

Berry, J. (1997). Immigration, acculturation and adaptation. *Applied Psychology, An International Review, 46,* 5-68.

Bourhis, R. Y., Moise, L.C., Perreault,, S., & Senecal, S. (1997). Towards an interactive acculturation model: A social psychological approach. *International Journal of Psychology, 32,* 369-386.

Branscombe, N. R., & Ellemers, N. (1998). Coping with group-based discrimination: Individualistic versus group-level strategies. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective* (pp. 243-266). San Diego, CA: Academic.

Branscombe, N.R., Ellemers, N., Spears, R., & Doosje, B. (1999). The context and content of social identity threats. In N. Ellemers, R. Spears & B. Doosje (Eds.), *Social Identity: Context, commitment, content,* (pp. 35-58) Oxford: Blackwell.

Branscombe, N.R., Schmitt, M.T., & Harvey, R.D. (1999). Perceiving pervasive discrimination among African-Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology, 77*, 135-149.

Brewer, M. B., (1991). The social self: On being the same and different at the same time. *Personality and Social Psychology Bulletin, 17*, 475-482.

Brissette, I., Scheier, M. F., Carver, C. S (2002). The role of optimism in social network development, coping, and psychological adjustment during a life transition. *Journal of Personality and Social Psychology, 82*, 102-111.

Brown, R. (2000). Social identity theory: Past achievements, current problems and future challenges. *European Journal of Social Psychology, 30*, 745-778.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56*, 267-283.

Chavira, V., & Phinney, J. S. (1991). Adolescents' ethnic identity, self-esteem, and strategies for dealing with ethnicity and minority status. *Hispanic Journal of the Behavioral Sciences, 13*, 226 –227.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*, 805-816.

Contreras, J., López, I., Rivera, E., Raymond-Smith, L., & Rothstein, K. (1999). Social support among Puerto Rican adolescent mothers: The moderating effect of acculturation. *Journal of Family Psychology, 13*, 228-243.

Coyne, J. C., Wortman, C. B., Lehman, & Lehman, D. R. (1988). The other side of social support: Emotional overinvolvement and miscarried helping, *Marshaling Social Support* London: Sage

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. Gilbert, S. T. Fiske, and G. Lindzey (Eds.), *Handbook of social psychology* (4th ed., pp. 504-553). Boston: McGraw Hill.

Deaux, K. (2000). Surveying the landscape of immigration: Social psychological perspectives. *Journal of Community & Applied Social Psychology, 10*, 421-431.

Dion, K. K., & Dion, K. L. (2001). Gender and cultural adaptation in immigrant families. *The Journal of Social Issues, 57*, 511-521.

Dion, K. L. (2002). The social psychology of perceived prejudice and discrimination. *Canadian Psychology, 43*, 1-10.

Endler, N. S., & Parker, J. D. A. (1990). Multidimensional assessment of coping: A critical evaluation. *Journal of Personality and Social Psychology, 58*, 844-854.

Ellemers, N. (1993). The influence of socio-structural variables on identity enhancement strategies. *European Review of Social Psychology, 4*, 27-57.

Farver, J. M., Narang, S. K., Bhadha, B. R. (2002). East meets West: Ethnic identity, acculturation, and conflict in Asian Indian families. *Journal of Family Psychology, 16,* 338-350.

Finch, B., Vega, W.A. (2003). Acculturation stress, social support, and self-rated health among Latinos in California. *Journal of Immigrant Health, 5,* 109-117.

Foster, M. D. & Matheson, K. (1995). Double relative deprivation: Combining the personal and political. *Personality and Social Psychology Bulletin, 21,* 1167-1177

Frable, Deborah E.S., Platt, L., Hoey, S. (1998). Concealable stigmas and positive self-perceptions: Feeling better around similar others. *Journal of Personality and Social Psychology, 74,* 909-922.

Gonsalves, C. J. (1992). Psychological stages of the refugee process: A model for therapeutic interventions. *Professional Psychology: Research & Practice, 23,* 382-389.

Hobfoll, S. E. (2002). Social and psychological resources and adaptation. *Review of General Psychology, 6,* 307-324.

Hogg, M.A., & Abrams, D. (1988). *Social identifications: A social psychology of intergroup relations and group processes.* London: Routledge.

Hornsey, M. J. & Hogg, M. A. (2000). Assimilation and diversity: An integrative model of subgroup relations. *Personality and Social Psychology Review, 4,* 143-156.

Hovey, J. D. (1999). Psychosocial predictors of acculturative stress in Central American immigrants. *Journal of Immigrant Health, 1,* 187-194.

Jetten, J., Branscombe, N.R., Schmitt, M., & Spears, R. (2001). Rebels with a cause: Functions of identification with a self-selected socially devalued group. *Personality and Social Psychology Bulletin, 27,* 1204-1213.

Joiner, T. E., Walker, R.L. (2002). Construct validity of a measure of acculturative stress in African Americans. *Psychological Assessment, 14,* 462-466.

Lay, C., Nguyen, T. (1998). The role of acculturation-related and acculturation non-specific daily hassles: Vietnamese-Canadian students and psychological distress. *Canadian Journal of Behavioural Science, 30,* 172-181.

Lazarus, R.S. & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lazarus, R. S. (2000). Toward better research on stress and coping. *American Psychologist, 55,* 665-673.

Leong, F.T.L. (2001). The role of acculturation in the career adjustment of Asian American workers: A test of Leong and Chou's (1994) formulations. *Cultural Diversity and Ethnic Minority Psychology, 7,* 262-273.

Lieber, E., Chin, D., Nihira, K., Mink, I. T. (2001). Holding on and letting go: Identity and acculturation among Chinese immigrants. *Cultural Diversity & Ethnic Minority Psychology, 7,* 247-261.

Louis, W. R., and Taylor, D. M. (1999). From passive acceptance to social disruption: Towards an understanding of behavioral responses to discrimination. *Canadian Journal of Behavioural Science, 31,* 19-28.

Matheson, K. & Anisman, H. (2003). Systems of coping associated with dysphoria, anxiety and depressive illness: A multivariate profile perspective. *Stress, 6,* 223–234.

Matheson, K., Kelly, O., Cole, B., Tannenbaum, B., Dodd, C., & Anisman, H. (in press). Parental bonding and depressive affect: The mediating role of coping resources. British Journal of Social Psychology.

Neufeld, A. & Harrison, M. J. (1995). Reciprocity and social support in caregivers' relationships: Variations and consequences. *Qualitative Health Research, 5,* 348-365.

Nieves-Grafals, S. (2001). Brief therapy of civil war-related trauma: A case study. *Cultural Diversity & Ethnic Minority Psychology, 7,* 387-398.

Noh, S., Kaspar, V. (2003). Perceived discrimination and depression: Moderating effects of coping, acculturation, and ethnic Support. *American Journal of Public Health, 93,* 232-239.

Nolen-Hoeksema, S. (1998) Ruminative coping with depression, In J. Heckhausen and C.S. Dweck, (eds), *Motivation and self-regulation across the life span.* Cambridge University Press, Cambridge, UK, pp 237–256.

Nolen-Hoeksema, S., Davis, C. G. (1999). "Thanks for sharing that": Ruminators and their social support networks. *Journal of Personality and Social Psychology, 77,* 801-814.

Oh, Y., Koeske, G. F., Sales, E. (2002). Acculturation, stress, and depressive symptoms among Korean immigrants in the United States. *Journal of Social Psychology, 142,* 511-527.

Phinney, J. (1992). The Multi-group Ethnic Identity Measure: A new scale for use with adolescents and you adults from diverse groups. *Journal of Adolescent Research, 7,* 156-176.

Phinney, J., & Chavira V. (1995). Parental ethnic socialization and adolescent outcomes in ethnic minority families. *Journal of Research on Adolescents, 5,* 13-53.

Phinney, J., Madden, T., & Santos, L. (1998). Psychological variables as predictors of perceived discrimination among minority and immigrant adolescents. *Journal of Applied Social Psychology, 28*, 937-953.

Phinney, J., Horenczyk, G., Liebkind, K., & Vedder, P. (2001a). Ethnic identity, immigration, and well-being: An interactional perspective. *Journal of Social Issues, 57*, 493-510.

Phinney, J., Romero, I., Nava, M., & Huang, D. (2001b). The role of language, parents, and peers in ethnic identity among adolescents in immigrant families. *Journal of Youth and Adolescence, 30*, 135-153.

Phinney, J. (2003). Ethnic Identity and Acculturation. In K. Chun, P. Ball, & G. Marin, (Eds.), *Acculturation: Advances in theory, measurement, and applied research (pp. 63-81)* Washington, DC: American Psychological Association.

Pines, A. M., Ben-Ari, A., Utasi, A., Larson, D. (2002). A cross-cultural investigation of social support and burnout. *European Psychologist, 7*, 256-264.

Revenson, T.A., Schiaffino, K.M., Majerovitz, S.D., & Gibofsky, A. (1991). Social support as a double-edged sword: The relation of positive and problematic support to depression among rheumatoid arthritis patients. *Social Science and Medicine, 33*, 807-813.

Roberts, R., Phinney, J., Masse, L., Chen, Y., Roberts, C., and Romero, A. (1999). The structure of ethnic identity in young adolescents from diverse ethnocultural groups. *Journal of Early Adolescence, 19*, 301-322.

Rogler, L. H., Cortes, D. E., Malgady, R. G. (1991). Acculturation and mental health status among Hispanics: Convergence and new directions for research. *American Psychologist, 46*, 585-597.

Ross, C. E., & Mirowsky, J. (1989). Explaining the social patterns of depression: Control and problem-solving or support and talking. *Journal of Health and Social Behavior. 30*, 206-19.

Roysircar-Sodowsky, G., & Maestas, M. V. (2000). Acculturation, ethnic identity, and acculturative stress: Evidence and measurement. In R.H. Dana (Ed.), Handbook of cross-cultural and multicultural assessment, 131-172. Mahwah, NJ: Lawrence Erlbaum.

Rudmin, Floyd W. (2003). Critical history of the acculturation psychology of assimilation, separation, integration, and marginalization. *Review of General Psychology, 7*, 3-37.

Sagiv, L., Schwartz, S. H. (1995). Value priorities and readiness for out-group social contact. *Journal of Personality and Social Psychology, 69*, 437-448.

Sarason, B. R., Shearin, E. N., Pierce, G. R., & Sarason, I. G. (1987). Interrelations of social support measures: Theoretical and practical Implications. *Journal of Personality and Social Psychology, 12,* 813-832.

Schaefer, J.A., & Moos, R.H. (1992). Life crises and personal growth. In B.N. Carpenter, (Ed.). *Personal coping: Theory, research, and application* (pp. 149-170): Praeger, CT.

Schmitt, M. T., & Branscombe, N. R. (2002). The internal and external causal loci of attributions to prejudice. *Personality and Social Psychology Bulletin, 28,* 620-628.

Schmitt, M. T., Branscombe, N. R. (2003). Will the real social dominance theory please stand up? *British Journal of Social Psychology, 42,* 215-219.

Schwarz, N. & Strack, F. (1991). Evaluating one's life: A judgment model of subjective well-being. In F. Strack, M. Argyle, & N. Schwarz (Eds. *Subjective well-being: An interdisciplinary perspective.* (Pp. 27-48). Oxford: Pergamon Press.

Short, K. H., Johnston, C. (1997). Stress, maternal distress, and children's adjustment following immigration: The buffering role of social support. *Journal of Consulting and Clinical Psychology, 65,* 494-503.

Sodowsky, G.R., Lai, W.W.M., & Plake, B.S. (1991). Moderating effects of sociocultural variables on acculturation attitudes of Hispanic and Asian Americans. *Journal of Counseling & Development, 70,* 194-204.

Sodowsky, G. R., & Lai, E. W. M. (1997). *Asian immigrant variables and structural models of cross-cultural stress.* In A. Booth, A. C. Crouter, & N. Landale (Eds.), Immigration and the family: Research and policy on U.S. immigrants (pp. 211-237). Mahwah, NJ: Lawrence Erlbaum.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice (2nd ed.).* New York: John Wiley and Sons.

Tajfel, H. (1978). Social categorization, social identity and social comparison. In H. Tajfel (Ed.), *Differentation Between Social Groups.* London: Academic Press.

Tajfel, H. (1979). Individuals and groups in social psychology. *British Journal of Social and Clinical Psychology, 18,* 183-190.

Tajfel, H. (1982). *Social identity and intergroup relations,* Cambridge, England: Cambridge University Press.

Tajfel, H. and Turner, J. C. (1986). The social identity theory of inter-group behavior. In S. Worchel and L. W. Austin (eds.), *Psychology of Intergroup Relations.* Chigago: Nelson-Hall.

Tix, A. P., Frazier, P. A. (1998). The use of religious coping during stressful life events: Main effects, moderation, and mediation. *Journal of Consulting and Clinical Psychology, 66*, 411-422.

Thoits, P.A. (1986). Multiple identities: Examining gender and marital status differences in distress. *American Sociological Review, 51*, 259-272.

Thompson, P., Anderson, L. P., Bakeman, R. A. (2000). Effects of racial socialization and racial identity on acculturative stress in African American college students. *Cultural Diversity and Ethnic Minority Psychology, 6,* 196-210.

Uchino, B. N., Cacioppo, J. T., Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. *Psychological Bulletin, 119*, 488-531.

Utsey, S.O., Chae, M.H., Brown, C.F., Kelly, D. (2002). Effect of ethnic group membership on ethnic identity, race-related stress, and quality of life. *Cultural Diversity and Ethnic Minority Psychology, 8,* 366-377.

Valentiner, D. P., Holahan, C. J., & Moos, R. H. (1994). Social support, appraisals of event controllability, and coping: An integrative model. *Journal of Personality and Social* Psychology, 66, 1094-1102.

Williams, C. L. & Berry, J. W. (1991). Primary prevention of acculturative stress among refugees: Application of psychological theory and practice. *American Psychologist, 46*, 632-641.

Wright, S. C., & Taylor, D. M.. (1998). Responding to tokenism: Individual action in the face of collective injustice. *European Journal of Social Psychology, 28*, 647-667.