THE PSYCHOLOGICAL FUNCTIONING OF BOSNIAN REFUGEES RESIDING IN THE UNITED STATES: AN EXAMINATION OF THE IMPACT OF TRAUMA, ACCULTURATION, COMMUNITY CONNECTEDNESS, PERCEIVED DISCRIMINATION AND ETHNIC IDENTITY

by

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The psychological functioning of Bosnian refugees residing in the United States: An examination of the impact of trauma, acculturation, community connectedness, perceived discrimination and ethnic identity

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ABSTRACT

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The worldwide population of refugees continues to grow, and a significant proportion of these individuals experience poor physical, psychological, social and occupational functioning. Empirical research examining specific pre- and post-migrations factors which predict psychological functioning and help-seeking among refugees is scarce. The present study will obtain cross-sectional, self-report data from 204 Bosnian refugees living in the US. Trauma is expected to have a direct positive relationship with symptoms of depression and post-traumatic stress disorder (PTSD), and a direct negative relationship with well-being and help-seeking, and will be controlled in subsequent analyses. The integration style of acculturation is predicted to lead to the most positive outcomes, whereas the separation and marginalization strategies are expected to be positively related to symptoms of depression and PTSD and negatively relates to well-being and help-seeking. Perceived discrimination is expected to be positively related to

symptoms of depression and PTSD and negatively related to well-being and help-seeking. In addition, connectedness to Bosnian versus US communities will be examined as an alternative conceptualization of acculturation. Finally, exploratory hypothesis will examine whether high ethnic identity salience attenuates or strengthens the negative effects of discrimination on depression and PTSD symptomatology, as well as the positive effect on well-being.

1. Introduction

An immigrant is defined as "a person who comes to a country to take up permanent residence (Merriam-Webster Dictionary)." Not every person who emigrates from their home country does so voluntarily. Many who must leave their country of origin do so because of serious threat to their lives. These immigrants are generally referred to as refugees. The Bureau of Population, Refugees, and Migration of the United States Department of State defines a refugee as "a person who is outside his/her country and is unable or unwilling to return to that country because of a well-founded fear that he/she will be prosecuted because of race, religion, nationality, political origin, or membership in a particular social group" (United States Department of State, 1996). This definition does not include persons who have been displaced because of a natural disaster. In addition, persons who have been dislocated, but have not crossed an international border, are not considered refugees by the United States government.

The World Health Organization reports that there are over 50 million refugees and displaced persons worldwide, more than 50 percent of whom are women and children from low-income countries. It is estimated that 5 million refugees are either traumatized or display a chronic mental disorder. Another 5 million have psychosocial dysfunction that impairs their functioning and the functioning of the community. Many of the remaining refugees also face significant distress and suffering (World Health

Organization, 2005). In addition to pre-migration stressors, refugees and immigrants face challenges related to adjusting to life in the host country, including acculturation, loss of or change in employment, new socioeconomic status, membership in a minority group, language difficulties, involvement in legalization processes and loss of or changes in social networks (Bemak & Chung, 2002).

For most refugees and immigrants, difficulties associated with starting a life in a new country further exacerbate the effects of the harmful environments left behind in the home country, such as poverty, lack of opportunity for the future or political strife. Refugees in particular, due to facing volatile, often traumatic situations preceding their migration (e.g. war, political persecution), are generally acknowledged to be the most vulnerable of immigrants as a whole to experiencing psychological distress (Werkuyten & Nekuee, 1999) and are at a higher risk for psychological problems and disorders (Sundquist, Bayard-Burfield, Johansson & Johansson, 2000; Mollica & Caspi-Yavin, 1996). As such, the current study focused on refugees, and not immigrants in general.

Psychological burden associated with post-migration compounds the psychological burden due to pre-migration factors. Intrapersonal, interpersonal and contextual factors all come to bear on the adjustment process associated with relocation to a new country. The current study focused on several of these factors, including the acculturation process, ethnic identity, social networks, and the experience of prejudice and discrimination. However, before discussing these in more detail, it is pertinent to mention other variables which also come to bear on the psychological adjustment of refugees, but which are beyond the scope of the present study.

Relocation to a new country constitutes a critical life transition, and individual differences in stress appraisals and coping strategies will impact subsequent psychosocial functioning and well-being. Self-efficacy for the adjustment process represents one important intrapersonal factor which will predict individual responses to the stressors associated with relocation, such as lack of employment and loss of social support. That is, a refugee's self-perceived competence and capability to successfully navigate different types of environmental demands will influence adaptive and maladaptive responses to the relocation process. Strong relocation self-efficacy could moderate the impact of the environmental stressors on psychological distress and well-being (Jerusalem & Mittag, 1995). A similar concept is cultural competence, which has been defined as "the ability of people to function effectively and efficiently in a culture at a level consistent with their own goals and social roles" (Westermeyer, 1989, pp. 27). Cultural competence includes knowledge about the culture in which one lives, as well as language facility and social skills needed for an individual to fulfill social roles in a given society. Cultural competence is evidenced in language ability, awareness of current social norms and the ability to accomplish everyday tasks (e.g. shopping, using social services) (Westermeyer, 1989). Individuals who are more culturally competent will likely experience a more positive adjustment process. Sense of mastery and control are also pertinent variables which affect the psychological adjustment of refugees. Several studies have found that sense of mastery and control moderate the relationship between acculturation and psychological distress and well-being (Liebkind & Jasinskaja-Lahti, 2000; Sundquist, Bayard-Burfield, Johansson & Johansson, 2000).

Individual differences in personality, as well as other demographic factors which will be discussed below, also influence the adjustment process. Neuroticism or negative emotionality is one of the most studied of all personality traits, and has been linked to increased risk for psychopathology and poor psychosocial functioning (Mischel, Shoda & Smith, 2003). Recent research suggests that neuroticism or negative emotionality may actually be part of an underlying dimension including self-efficacy, self-esteem and locus of control (Caspi, Roberts & Shiner, 2005). Individuals high in neuroticism/negative emotionality are generally vulnerable to stress, lacking in confidence, easily frustrated and insecure in relationships (Caspi, et. al, 2003). These traits would obviously be maladaptive in confronting the stressful life events with which refugees are faced. Particularly problematic would be the detrimental effects of neuroticism/negative emotionality on the establishment of meaningful social relationships. Interpersonal variables, particularly social support, mitigate the impact of stressful life events for refugees (Pumariega, Rothe & Pumariega, 2005). Hunt and Gakenyi (2005) compared the mental health of 69 refugees from Bosnia living in the United Kingdom with 121 internally displaced persons who continued to reside in Bosnia after the war. Participants completed questionnaires which gathered information about wartime experiences, traumatic symptoms and personality. Neuroticism was found to be significantly related to symptoms of PTSD.

Studies examining the impact of personality variables on the psychological functioning of refugees are scant, however the author is aware of two studies which address this issue. Karam and Bou Ghosn (2003) conducted a review of literature

regarding the psychosocial consequences of war among civilian populations. As many studies of trauma have shown, greater exposure to trauma is a risk factor for developing PTSD. Wartime combat is obviously a potentially traumatic experience, and researchers also identified that antisocial personality increases the risk that an individual will be exposed to combat. Hunt and Gakenyi (2005), in the study described earlier, found a link between traumatic symptoms and harm-avoidant personality traits (e.g. pessimistic worry, shyness, fearfulness). Individuals with these traits were more likely to develop PTSD than those who were not harm avoidant.

Several studies of refugees have found links between certain demographic characteristics and psychological distress (Michultka, Blanchard & Kalous, 1998; Mollica, McInnes, Sarajlic, Lavelle, Sarajlic & Massagli, 1999). The most significant demographic predictor of poor adjustment for refugees is age (Westermeyer, 1989). Older individuals respond least adaptively to the relocation process. Other demographic characteristics such as lack of education, lack of employment, poverty and poor physical health also serve as risk factors for psychological distress (Pumariega, et. al, 2005).

Gender likely also impacts the psychological functioning of refugees. Some of the predictor and outcome variables included in the current study are known to be affected by gender, which could constitute a confounding variable in several of the analyses. Both depression and PTSD are more prevalent in women than in men (Prior, 1999; Shaw, Kennedy & Jaffe, 1995). Epidemiological studies show that depression is the most frequent mental disorder diagnosed in women, and this finding occurs across cultures. In addition, women are twice as likely as men to experience at least one

depressive episode over the lifetime (Prior, 1999; Shaw, et. al, 1995). Several researchers have suggested that greater prevalence of depression among women is the result of differences in stress appraisals between the sexes. Women often report coping with multiple demands, such as family and work and feel overloaded as a result (Walters, 1993; Rogler & Cortes 1993; Leibenluft, 1996; Prior, 1999). It has been suggested that higher rates of depression in women may be due to greater willingness to express distress and seek professional help (Shaw, et. al, 1995).

Similarly, PTSD occurs twice as often in women than in men, despite of the type of trauma experienced (Gavranidou & Rosner, 2003). While men experience traumatic events more often and experience different types of trauma, women more often develop PTSD after a traumatic event (Gavranidou & Rosner, 2003). Frans, Rimmo and Aberg (2005) replicated this finding in a sample of 1,824 randomly selected men and women. They also found that the frequency and impact of the traumatic events along with greater perceived distress during the traumatic event accounted for the relationship found between gender and PTSD. The authors suggested that women exhibit a greater susceptibility to stress, and thus develop PTSD more often than men after traumatic experiences. Similarly, Ai (2004) examined PTSD in Kosovar refugees living in the United States and found that women reported more severe symptoms of PTSD and that female gender predicted PTSD.

There has been little research regarding gender differences in perceptions of discrimination or ethnic identity, and to date the author is not aware of any studies showing gender differences in perceived discrimination or ethnic identity.

Help-seeking behavior is also influenced by gender. A higher proportion of women than men seek help for mental problems (Prior, 1999). While the lifetime prevalence of mental disorders is equivalent among the sexes, women more frequently utilize mental health services and are prescribed twice as many psychotropic drugs as men. Women are also more likely to present with psychological distress, while men are more often referred to mental health services by a primary care physician, and are also experiencing more severe symptoms when they finally do access mental health services (Prior, 1999).

Contextual characteristics of both the native and host societies also come to bear on the adjustment process of refugees. The degree of similarity between the two cultures will impact the relative ease or difficulty with which a refugee negotiates a place in the new society. If the two cultures are highly dissimilar, the relocation process can be expected to be more difficult, whereas if the two cultures are highly similar, relocation may be accomplished with relatively less stress. The attitude of the receiving culture will also impact the relocation process. The host culture may be congenial toward outsiders, indifferent, or actively antagonistic to new members of society (Westermeyer, 1989).

Several post-migration factors impact the psychological functioning of refugees which are the focus of the current study. First, refugees must navigate the process of adjusting to a new culture. Berry (2005) suggests that various strategies to acculturation exist, and that these strategies have differential effects on psychological functioning. When two cultures meet, both groups make accommodations and experience changes in behaviors and attitudes. Individual and group level variables, such as pre-migration

trauma or societal attitudes toward immigration, contribute to the manner in which this process of change occurs. In some instances, refugees may only maintain their native culture; in others they may adopt the host culture. Some refugees may find themselves alienated from both cultures. Most psychological research suggests that the most positive outcomes are associated with a strategy which strikes a balance between maintaining native values, beliefs and customs and adopting others belonging to the host culture (Sundquist, et. al, 2000; Oppedal, Roysamb & Heyerdahl, 2005; Tata & Leong, 1994; Werkiyten & Nekuee, 1999; Kosic, Kruglanski, Pierro & Manetti, 2004; Knipscheer, de Jong, Kleber & Lamprey, 2000).

Second, social variables, such as connections to others, also impact the psychological functioning of refugees. The process of acculturation implies a process of connecting to others, both in the native ethnic group as well as with members of the host country. Preliminary research has suggested that being connected to two, opposing communities, while possible, may not be universally beneficial (Mashek, Stuewig, Furukawa & Tangney, 2006).

Third, migrants arrive to find themselves suddenly in the minority. As such, they often face prejudice and discrimination (Werkuyten & Nekuee, 1999). The experience of perceiving that one is discriminated against has been shown to increase symptoms of depression (Lee, 2005; Cassidy, O'Connor, Howe & Warden, 2004; Werkuyten & Nekuee, 1999), anxiety (Cassidy, et. al, 2004) and stress (Sellers & Shelton, 2003; Dion, 2002). Furthermore, one of the most commonly studied variables with respect to the functioning of refugees is ethnic identity. Ethnic identity is an important factor in how a

refugee copes with perceived discrimination, though research is not in unanimous agreement as to the nature of this relationship. Some research has suggested that strong ethnic identification serves as a risk factor for distress associated with perceived discrimination (Dion, 2002; McCoy & Major, 2003; Cassidy, O'Connor, Howe & Warden, 2004), whereas others have found that ethnic identity serves as a protective factor against perceived discrimination (Jetten, Branscombe, Schmitt, & Spears, 2001; Romero & Roberts, 2003; Mossakowski, 2003; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003).

Thus, it is clear that immigrants in general face considerable burden in relocating to a new country which can negatively impact psychological health. Refugees in particular, seem to be at the most risk for poor functioning. Do these individuals seek help? Research has consistently identified underutilization by minorities of mental health services (Ayalon & Young, 2005) and has identified various barriers to seeking help for minority groups (Tata & Leong, 1994). However, very little research has examined the help-seeking attitudes and behaviors of refugees, despite the fact that they are known to be at increased risk for psychological distress.

The current study examined relationships among the variables described above in a sample of Bosnian refugees residing in the United States. The Bosnian conflict which lasted nearly four years (1992-1995) left more than 200,000 persons dead and many more wounded. Bosnian citizens experienced many war crimes against civilians, including organized rape and torture in various concentration camps and prisons (Ullman, 1996). Nearly three million people--over half of Bosnia's prewar population--were forced to

leave their homes and become refugees (Mertus, Tesanovic, Metikos & Boric, 1997). Some were forced to leave for "ethnic purity," while others fled to escape the war. Many of these refugees were severely traumatized, and despite the signing of the Dayton Peace Accord in 1995, which ended hostilities, ethnonationalistic animosities, bitterness and destruction has prevented most of these refugees from returning home (Mertus et al., 1997). The Bosnian refugees living in the Untied States now face the difficulties of starting a new life in a new country, and must continue to deal with not only the effects of war trauma, but also the aforementioned post-migration challenges.

2. Effects of Trauma

In addition to being subject to the sudden disruption of forced relocation, refugees have often experienced several other forms of trauma, such as deprivation of food and shelter, physical injury and torture, incarceration, or witnessing torture or killing (Bemak & Chung, 2002). In 2004, the United Nations High Commissioner on Refugees estimated that the worldwide population of refugees had reached 19.2 million individuals, and confirmed that these individuals have a high rate of exposure to war trauma and subsequent mental health problems, the most common of which are depression and posttraumatic stress disorder (PTSD) (United Nations High Commissioner on Refugees [UNHCR], 2004). This is congruent with the fact that the likelihood that any individual will develop symptoms of PTSD is increased by the intensity of the trauma and the number of prior traumas (Hansell & Damour, 2005).

Psychological research has confirmed that traumatic premigration experiences negatively impact psychological health and postmigration functioning (Bemak & Chung, 2002). Several studies have found that the experience of trauma is related to physical and psychological distress in a variety of refugee populations, such as Cambodian and Southeast Asian refugees living in the United States (Mollica, Wyshak & Lavelle, 1987; Uba & Chung, 1991; Marshall, Schell, Elliott, Berthold, & Chun, 2005); Bosnian refugees living in Croatia (Mollica, et. al, 1999), throughout former Yugoslavia (Basoglu,

et. al, 2005), and in the United States (Corvo & Peterson, 2005); Iraqi refugees living in the Netherlands (Laban, Gernaat, Komproe, vander Tweel & de Jong, 2005); and Burmese refugees living in Thai border camps (Cardozo, Talley & Crawford, 2004). These studies have identified several consequences of trauma, including poor physical health (Mollica, et. al, 1987; Uba & Chung, 1991; Mollica, et. al, 1999), PTSD and depression (Mollica, et. al, 1987; Michultka, et. al, 1998; Mollica, et. al, 1999; Cardozo, et. al, 2004; Marshall, et. al, 2005; Basoglu, et. al, 2005; Corvo & Peterson, 2005), anxiety (Cardozo, et. al 2004), and impaired social and occupational functioning (Mollica, et. al, 1987; Uba & Chung, 1991; Cardozo, et. al, 2004).

It appears that the experience of trauma makes unique contributions to poor psychological functioning. For example, in a study examining the relationship between trauma and demographic characteristics (e.g. employment status, experience of the legalization process, education, marital status, family make-up) with the presence and severity of posttraumatic stress symptoms in a sample of refugees from Central America, Michultka and colleagues (1998) found that the number of war experiences was a significant predictor of all PTSD symptom clusters, even when controlling for the above stated demographic characteristics.

Similarly, Mollica and colleagues (1999) examined risk factors contributing to disability in a sample of Bosnian refugees living in Croatia. The study included both pre-migration factors (e.g. prior trauma) and post-migration factors (e.g. age, economic and social resources, work status, family size, length of time in the new country) as potential predictors of disability. Disability was operationalized in terms of physical functioning,

self-perceived energy level and physical health. Even when controlling for all of the post-migration factors, cumulative trauma was a significant predictor of disability.

The same association between the experience of trauma and risk for mental illness was found in a sample of Vietnamese individuals residing in Austrailia (Steel, Silove, Phan & Bauman, 2002). In addition to gathering information regarding past trauma, several social variables were examined as well, such as marital status, employment, social support and housing. Of these variables, trauma exposure emerged as the best predictor of the presence of a mental disorder (according to the ICD-10). In addition, the amount of trauma increased risk for mental illness. Participants who had experienced three or more traumatic events had a heightened risk for poor psychological functioning.

Finally, Marshall et. al (2005) examined the long-term effects of trauma, as well as several demographic characteristics including age, marital status, education, employment, self-assessed proficiency with English (not at all, poor, fair, or good), household size and household income on the mental health of Cambodian refugees who had been resettled in the United States for two decades. The study found that both PTSD and depression were highly comorbid in the sample, and that each showed a significant positive relationship with prior trauma. Multivariate analyses revealed that prior trauma was associated with depression and PTSD, even after accounting for post-migration factors which contributed to psychopathology.

Refugees are highly likely to have experienced trauma prior to migration which negatively impacts their psychosocial adjustment in the new country. Relocation to a new country entails economic, social and cultural struggles which all represent significant

stressors which could negatively impact psychological functioning. However, even after controlling for post-migration factors, trauma remains a significant predictor of psychological distress.

3. Acculturation

After arriving in the host country, refugees next confront a period of adjustment and adaptation to a new culture. This process is known as acculturation (Flannery, Reise & Yu, 2001). Berry (2005) defines acculturation as "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p. 698). The process results in several group and individual changes. When two cultures come into contact, social structures and institutions and cultural practices change. At the individual level, one experiences changes in behavior. This process of change can be a lengthy process, and involves accommodations among the two cultures which eventually result in psychological and sociocultural changes in both groups (Berry, 2005).

Acculturation has been conceptualized in many different ways over the years. Many of the early studies used demographic variables (for example, age at immigration, generation status, or length of residence in the host country) as proxy measures of acculturation. Since then, acculturation has most often operationalized as proficiency with the host language (Sundquist, et. al, 2000; Liebkind & Jasinskaja-Lahti, 2000), but has also been measured as proficiency in various life roles, such as work or school (Knipscheer, et. al 2000). However, when one or only a few of these variables is considered to be representative of acculturation, there is a concern that the complex

picture of acculturation, including an individual's internalization of the host culture and the integration of new cultural values and practices with the native culture, is not captured adequately. Self-report measures which attempt to measure psychological indicators of acculturation, as opposed to simply demographic indicators, were developed to address this problem. The resulting individual-differences measures assess various components of cultural identification, including language, preferences in terms of food, music, and customs, willingness to socialize or marry members of the culture, etc. These assessment instruments typically capture acculturation in terms of a continuum at which one end are those who consider themselves to be highly traditional and at the other those who consider themselves to be highly assimilated to the host culture.

Examining the concept of acculturation more closely, the process of acculturation is akin to living between two cultures, and immigrants face the pressure to assimilate to new cultural values while at the same time struggling to maintain their native belief and value system. This process can negatively impact psychological health. Various acculturative strategies have been identified. It appears that individual process and outcome of acculturation (e.g. strategy used) affect the subsequent degree of stress experienced (Berry, 2005). There is a significant body of literature examining the acculturation process and the stress associated with adapting to a new culture.

Acculturation can be conceptualized as a unidimensional or bidimensional construct. The two models differ in how each accounts for the relationship between the host culture and native culture (Ryder, Alden & Paulhus, 2000). According to the unidimensional model of acculturation, the process of acculturation exists as a continuum

on which the individual moves unidirectionally from orientation to the native culture to orientation to the host culture. The individual's culture is conceptualized as evolving over time during the process of acculturation; as the individual moves along the continuum, they accept more aspects of the host culture as they lose aspects of their native culture. The native cultural values, attitudes and practices are relinquished as the individual adopts the cultural values, attitudes and practices of the host country (Gans, 1979; Gordon, 1964).

Research has shown that degree of acculturation, conceptualized unidimensionally, is related to several outcomes. For example, Sundquist and colleagues (2000) used data collected by a national survey conducted in 1996 by the Swedish National Board of Health and Welfare to examine the impact of various post-migration factors, including degree of acculturation (assessed as knowledge of Swedish), on psychological distress (presence of a psychiatric disorder). The random sample selected from the entire population of migrants included individuals born in Iran, Chile, Turkey and Poland. Analysis of the data revealed that for the men in the sample, poor acculturation was found to be a strong predictor of psychological distress. Oppedal et. al (2005) found this to also be the case for a sample of Norwegian adolescents. Questionnaire data from 1275 10^{th} grade immigrants included psychological distress, conceptualized as emotion, conduct, hyperactivity, and peer problems. Responses were dichotomized into low and high levels of distress, split at the median. Acculturation was measured by migrants' interpersonal skills and attitudes about the host culture. Acculturation was negatively associated with psychological distress. First generation

girls were at risk for emotional, hyperactivity and peer problems. Second generation boys were at risk for internalizing and externalizing disorders.

Acculturation can also be conceptualized as a bidimensional process, in which attachment to the native and host cultures are independent of one another. According to the bidimensional model, acculturation is not merely the process of becoming less 'ethnic' and more 'American', but rather represents a bidirectional process of change in both cultural identities resulting in the emergence of a new cultural identity that is some combination of the native and host culture (Berry, 1997; Ramirez, 1984; Flannery et. al, 2001). A bidimensional conceptualization of acculturation implies that an individual can maintain a sense of identification with both the native and host culture, and there are individual differences in the manner in which people go about the acculturation process and adapt to cultural change. Berry (2001) has put forth the most widely used bidimensional model of acculturation, and defines four strategies of acculturation. Assimilation occurs when the individual abandons his or her own cultural heritage and seeks regular contact with the host culture, eventually adopting the host culture. Separation occurs when the individual instead chooses to maintain his or her original culture. Contact with the host culture is avoided, and cultural practices of the host culture are not assumed by the individual. Still, other individuals demonstrate a desire to maintain the original culture and to have contact with the host culture as well. This is the strategy of integration. The original culture is maintained despite adoption of the host culture. Finally, the strategy of marginalization occurs when the individual has little interest in engaging in the host culture, generally because of the perception of

discrimination, and also becomes disconnected with the host culture. These acculturative strategies are theorized to have differential outcomes in terms of psychological adaptation.

Several studies have examined acculturative processes and outcomes using various approximations to one of more acculturative strategies postulated in Berry's model. For example, Werkuyten & Nekuee (1999) examined factors which contributed to psychological well-being (measured as subjective satisfaction with life) in a sample of Iranian refugees residing in the Netherlands. Acculturation was conceptualized as degree of cultural conflict, which assessed the extent to which the Iranian refugees felt conflicted between their native and host culture (e.g. ability to show consideration for both cultures, ability to relate to others of both cultures). This operationalization was meant to approximate a marginalization style of acculturation, which has been shown to be the least adaptive method of acculturation (Phinney, et. al, 2001; Berry, 2005). The authors found that greater cultural conflict had a direct, negative impact on life satisfaction. Liebkind and Jasinskaja-Lahti (2000) examined the relationship between acculturation (measured as adherence to Western versus traditional family values and language proficiency) and psychological well-being in a sample of immigrant adolescents in Finland. Well being was measured using five different measures, including absence of psychiatric symptoms and behavior problems, self-esteem, life satisfaction and sense of mastery over life. In general, it was found that adherence to traditional family values and host (Finnish) language proficiency was related to lower stress and behavior problems. This mimics the integrative style of acculturation in that participants who showed aspects

of both their native (traditional family values) and host (language proficiency) cultures experience greater well-being than those who did not.

Recently, empirical comparisons of the two models have attempted to determine which model is a more valid operationalization of acculturation. Ryder and colleagues (2000) conducted a series of studies to shed light on this issue. The authors argued that certain conditions must exist if the bidimensional model were to be upheld. First the two cultural dimensions (native and host) must be able to be measured reliably. Second, the two dimensions must show distinct pattern of correlations with key third variables, such as personality traits. Third, the two dimensions must either be orthogonal or only weakly inversely related. The authors utilized a diverse college sample, including participants of East- and Southeast Asian, Indian, Italian and Arabic decent. The authors concluded that the bidimensional model of acculturation is a more valid operationalization of acculturation. All of the conditions described above were met. In particular, the two dimensions were independent of one another, suggesting an orthogonal relationship. In addition, the two dimensions correlated with similar patterns or personality characteristics, suggesting that the two identities do not exist at separate ends of one spectrum.

Similarly, Lee, Sobal and Frongillo (2003) compared the unidimensional model and the bidimensional model in order to determine which model best described the acculturation of Korean Americans. Subjects were recruited through a national cross-sectional mail survey, resulting in the participation of 356 individuals. The bidimensional model was measured via questions tapping seven domains considered

pertinent to acculturation (cultural patterns of native and host society, involvement in social groups, marriage status, identification, degree to which host society is prejudiced against the ethnic group, degree of discrimination of the ethnic group by the host society and value or power conflicts among the two cultures). For each domain, there were two sets of questions, one set related to American culture, the other to Korean culture. An overall acculturation score was also generated. Because the unidimensional model implies that an individual must be of one culture or another, then the model could be rejected if the Korean and American domains demonstrated a strong inverse relationship. The bidimensional model would be supported if the two dimensions (Korean, American) were independent of one another, or only weakly related, either in the positive or negative direction. Results identified three distinct forms of acculturation among the sample: assimilated, integrated and segregated. The authors conclude that the presence of the integrated style indicates that a bidimensional model is the best descriptor of Korean American acculturation, because a unidimensional model does not allow for this outcome.

However, there have been other findings which have been less conclusive, suggesting that the two models are differentially useful. Flannery and colleagues (2001) also conducted an empirical comparison of the two models of acculturation on each model's internal, psychometric properties as well as on their external, criterion validity. In order to do so, two measures of acculturation which were topically similar were administered to a sample of Asian-American college students. One measure emphasized a unidimensional model of acculturation. It covered various domains of acculturation

including language, peer relations, food and media preferences, preferred ethnic label and generational status. While this measure included many facets of culture, it does not consider each cultural orientation separately, but rather response categories are such that they imply a trade-off between the native and host culture. The measure representing the bidimensional model is comprised of nine subscales covering the areas of language, social relationships, knowledge of customs and heritage and behavioral markers of culture (e.g. food and media preferences). These subscales are measured bidimensionally by presenting the same set of questions twice, one set addressing orientation to the native culture and one set addressing orientation to the host culture. Participants also completed several other external measures in order to assess the validity of the measures of acculturation. These measures included three personality inventories, measures of personal preferences (e.g. music, food, friends), demographic self-reports (e.g. age, gender, academic achievement), and measures of cultural knowledge (e.g. with respect to native and host cultures, knowledge of geography, traditions, politics and languages). Results did not suggest that one model demonstrated better criterion validity than the other. The authors found a moderate correlation between home and host orientation measures, which can be interpreted as lack of orthogonality between the two dimensions. However, both models were found to be adequate predictors of the external criterion variables measured, when individual variables were considered. When examining the unique proportions of the variance explained by each model, neither was consistently superior to the other. Each model was superior in specific domains. The authors conclude that these findings have different implications for each model. Since both

models adequately predicted external criterion, some may favor the unidimensional model for its parsimony. However, the bidimensional model was found to produce slightly larger incremental validities for domains such as Asian preferences, cultural knowledge, ethnic identification and openness to experience. Thus, the authors suggest that the model chosen to conceptualize acculturation should be based upon the particular context of the study.

For the purpose of the current study, acculturation will be measured bidimensionally. There appears to be more support for this model, despite some conflicting evidence regarding the validity of each model. In addition, Ryder and colleagues (2000) suggest that the bidimensional measurement of acculturation should be used in samples beyond that of college students, which the current study was able to accommodate. The majority of work in this area has focused on immigrants, whereas fewer studies have focused on the process of acculturation for refugees. Because refugees have unique pre-migration experiences than do migrants who chose to relocate, it will be useful to understand how the process of acculturation may be different among this particular population.

4. Community Connectedness

As we have seen, past trauma and acculturative strategy both contribute to the psychological functioning of refugees. Social variables (e.g. social support, family values) in particular may serve as buffers against psychological dysfunction. For example, Mollica and colleagues (1999) found that social isolation was the strongest predictor of post-migration variables of mental illness. Other research has supported the positive influence of social variables on the adjustment process of immigrants and refugees in terms of reducing severity of depression (Noh & Kasper, 2003) and anxiety (Oppedal, et. al, 2005). In adolescents, Liebkind, Jasinskaja and Solheim (2004) found that the presence of ethnic parental support was associated with greater school adjustment.

The presence of social support suggests a subjective feeling on the part of the individual, that he or she is connected to and cared for by a group of individuals. Sociological and psychological theories are increasingly interested in understanding the manner in which an individual relates and feels connected to others, and what occurs when an individual belongs to multiple social groups (Roccas & Brewer, 2002). Social identity theory defines the identification of an individual with a group as self-identified membership in a particular group and the corresponding valuing and emotional significance of the group for the individual (Hogg & Abrams, 1988). Conceptualizations

of ingroup identification are based upon knowledge of interpersonal closeness. Aron, Aron and Smollen (1992) introduced the term "inclusion of other in the self" to describe the connectedness of two individuals in a close personal relationship. Closeness can be understood as overlapping selves. Aron and colleagues based this approach to conceptualizing closeness on several social and psychological theories of closeness. For instance, concepts of intimacy hold that as individuals become closer in a relationship and increasingly engage in self-disclosure, the result is that each feels that his or her innermost self is being validated, understood and cared for by the other (Reis & Shaver, 1988). Social cognitive conceptualizations of interpersonal closeness describe the phenomena as the collective aspect of the self (Greenwald & Pratkanis, 1984).

Moving from the individual to the group level, the interconnectedness of group members and the closeness group members feel on an individual level reflect a sense of community at the group level. Sarason (1977) defined sense of community as "the perception of similarity with others, an acknowledged interdependence with others, a willingness to maintain this interdependence by giving to or doing for others what one expects from them, the feeling that one is part of a larger dependable and stable structure" (p. 157). Later, McMillan and Chavis (1986) enumerated four dimensions of sense of community: belonging, fulfillment of needs, influence and shared connections. Belonging entails the sense of being a part of a collective. A cohesive and attractive group for individuals is able to influence the individual's behavior while at the same time allowing the individual to feel he or she maintains control of decisions. A community also provides a sense of togetherness and can be rewarding for individuals by fulfilling

various needs. Shared emotional connection constitutes the bond that the individuals in the group feel toward one another.

Theory and research have identified the mechanisms by which individuals are close to one another, and the manner in which a group of individuals feel a sense of community. Interpersonal and group connectedness comes to bear on the acculturation process. The integration strategy of acculturation suggests that an individual has maintained connections to both the ethnic and host community. Research has established that this strategy of acculturation leads to the most desirable acculturative outcomes. Thus, examining the connections of individuals to the native and ethnic communities may shed new light on the role of community in acculturation, and constitute another method of measuring acculturation. Consider that trauma research has identified several pre- and post-trauma factors which predict posttraumatic stress disorder in adults, and meta-analyses of this body of literature show that perceived social support is the strongest predictor above and beyond predictors such as prior trauma and psychological adjustment and perceived life threat (Ozer, Best, Lipsey & Weiss, 2003; Brewin, Andrews & Valentine, 2000). Perceiving that one has social support suggests a sense of being connected to others and feeling a sense of belonging to a group of individuals. Traditionally, measures of acculturation have focused on external indicators of connectedness to the native and host communities, such as preference for food and music or adherence to traditions and customs. The social identification with a particular community has not been used as an operationalization of acculturation. This aspect of acculturation draws the distinction between categorization into a group (i.e. I am

American because I eat American food) and feeling a subjective sense of belonging to a group (i.e. I am an American because the American community has embraced me as one of its own).

A relatively new body of literature has begun to explore the construct of community connectedness. Mashek, Cannaday and Tangney (2005) developed the concept of community connectedness based upon the work of Aron and colleagues (1992). Rather than representing closeness between individuals, Mashek, et. al (2005) suggest that an individual can also experience closeness to a group. Psychological theories of sense of community support this notion. Community connectedness is conceptualized as "the inclusion of the community in self" (Mashek, et. al, 2005) versus inclusion of the other in self. Preliminary research on community connectedness in a prison population (Mashek, et. al, 2005) found that prisoners did possess feelings of closeness and belonging to both the prison population and the outside community-at-large. However, being connected to two, opposing communities did not appear to be universally beneficial. Results showed that connectedness to the community-at-large moderated the relationship between connectedness to the criminal community and psychological distress. That is, feeling connected to two, opposing communities, while possible, contributed to greater psychological distress in the inmates. Acculturation research has suggested that possessing cultural identification with two groups (native and host) is positive and leads to more positive outcomes. Thus, examining community connectedness in the context of acculturation may help to clarify the process of

acculturation and what factors influence positive and negative outcomes for the process. The current study included measures of community connectedness.

Berry (2001) suggests that on the individual level, the process of acculturation includes individual attitudes about the acculturation process, overt behaviors and internal cultural identities. On a broader level, two major aspects of intercultural contact impact the acculturation process: the degree of contact and interaction between two cultural groups and the extent to which each group attempts to maintain their own culture. These individual and group variables for both the native and host culture to a large extent determine how intercultural relations manifest. One may assume that if the native and host cultures are significantly dissimilar in cultural values and practices, then intercultural relations would be more difficult and stressful for the acculturating group. In this case, as Mashek and colleagues (2006) have found, being connected to these two opposing communities may be detrimental. However, if the native and host cultures are more similar, forming connections among different communities may not have negative consequences for psychological functioning.

Thus, the connections that a refugee has to his or her ethnic culture and to the host culture may have implications for psychological distress and well-being. The relatively new concept of community connectedness may represent an alternative operationalization of the acculturation strategies identified by Berry (2001). Recent empirical work surrounding this concept however, has suggested that connectedness to opposing communities may not always be beneficial. This is somewhat contradictory to

acculturation research which has found positive outcomes associated with the integration style of acculturation.

5. Perceived Discrimination

To this point, we have focused on the effects of trauma and the acculturation process on the psychological functioning of refugees. Another significant experience of relocation for refugees is that they are often members of a minority group in the host culture, and are no longer a part of a dominant group to which they may have belonged in their native country. This creates the possibility for refugees to experience prejudice and discrimination by members of the host society. Dion (2002) defines prejudice as the "negative attitudes toward disfavored groups and their members" (p. 2) and discrimination as the "unfair behavior or unequal treatment accorded others on the basis of their group membership or possession of some arbitrary trait" (p. 2).

There are several possible outcomes of perceived discrimination with respect to psychological functioning and self-concept. Dion (2002) in his review of the psychology of prejudice and discrimination enumerates the major theories regarding these topics. The attribution viewpoint emphasizes the role of the meanings assigned to given events in prejudice and discrimination. When a member of a disvalued group encounters a negative situation, the individual must determine whether that event was due to prejudice or discrimination, or whether the event is the result of a personal failing on the part of the individual. These attributions in turn affect an individual's self-evaluation. Some studies based on this theory have shown that attributing negative events to prejudice or

discrimination can sometimes serve a protective role for the self-concept, because the negative event is attributed externally (e.g. Dion, 1975; Crocker & Major, 1989).

In other cases, perceiving that one is discriminated against has deleterious effects on the individual. Dion (2001) theorizes a stress model of discrimination, in which the experience of discrimination is a psychological stressor which elicits cognitive appraisals of threat. The individual perceives the experience of discrimination to be a stable event, and the intentions of the discriminating individuals malevolent. When this is the case, the outcomes are hypothesized to be negative with respect to psychological distress, because stressful life events are known to result in such consequences as negative affect and psychological or psychiatric symptoms (Dion, 2001). Subsequent research has supported the hypothesis that experiences of prejudice and discrimination are stressful (Dion & Earn, 1975; Pak, Dion & Dion, 1991; Liebkind, 1996). Several studies of minority groups in the United States have confirmed that the perception of discrimination is associated with negative outcomes. For example, Cassidy and colleagues (2004) found that for individuals of Chinese, Pakistani, and Indian decent residing in Scotland, perceived discrimination was associated with symptoms of depression and anxiety. Similarly, Sellers, Caldwell, Schmeelk-Cone, and Zimmerman (2003) found that in a sample of 555 African American young adults, the experience of discrimination led to the experience of more stress, and symptoms of depression and anxiety. Likewise, Moradi and Hasan (2004) similarly found that perceptions of discrimination were directly linked to increased scores on a broad measure of psychological distress in a sample of Arab American adults. Perceptions of discrimination have also been found to be related to

increased symptoms of depression for Korean Americans as well (Lee, 2005). Other studies have linked perceived discrimination to lower subjective perceptions of quality of life and life satisfaction. For example, Ryff, Keyes and Hughes (2003) identified an inverse relationship between perceived discrimination and well-being (e.g. autonomy, purpose in life, self-acceptance) in a sample of African- and Mexican-American residents of Chicago, Illinois.

Despite the fact that perceptions of discrimination have direct, negative effects on psychological distress (such as depression, low self-esteem and decreased well-being), this relationship is often complicated by a number of moderating and mediating factors. Studies have identified the role of acculturation and interpersonal variables in the relationship between perceived discrimination and psychological distress and well-being. Werkuyten and Nekuee (1999) examined the relationship between perceived discrimination and life satisfaction in a sample of Iranian refugees residing in the Netherlands. The authors found that indicators of acculturation, such as length of residence and legal status moderated the discrimination-distress relationship. In addition, participants with low mastery (sense of causal agency and being in control of one's life) experienced greater negative affect than other participants. For immigrants from China, India and Pakistan residing in Scotland, Cassidy and colleagues (2004) found that both personal and ethnic self-esteem mediated the relationship between discrimination and the experience of anxiety and depression. Interestingly, this was true only for the males in the sample, but perceptions of discrimination negatively impacted self-esteem which led to more psychological distress. Noh and Kasper (2003) found that coping style affected

the outcomes for perceived discrimination for Korean immigrants living in Canada. Problem-focused coping (e.g. personal confrontation) moderated the relationship between perceived discrimination and depression such that the positive relationship between discrimination and depressive symptoms was stronger among individuals who engaged in problem-focused coping than in those who utilized emotion-focused coping.

The literature is in almost unanimous agreement that the experience of discrimination has significant negative effects on psychological functioning, whether directly or indirectly through other variables, such as those described above. To this point, research has focused on immigrant populations in general, or on minority groups in the United States (e.g. African American, Hispanic American, Asian American). Interestingly, very few studies have examined the effects of perceived discrimination for refugees. What is more, when these studies examine the negative effects of discrimination, most all operationalize distress in terms of depressive symptoms, low self-esteem or a global indicator of psychological functioning. However, depression may not be the only outcome given different circumstances. Refugees, by very definition, have a high potential to have been exposed to pre-migration trauma, and may respond to the acculturative process differently. Therefore, the current study included measures of posttraumatic stress symptoms to assess the role of perceived discrimination in exacerbation of posttraumatic stress symptoms which may already be present due to pre-migration trauma.

6. Ethnic Identity

To this point, the discussion has focused on the impact of acculturation and discrimination on the psychological adjustment of refugees and immigrants. However, interest in these constructs has grown more recently. Historically, one of the most commonly studied individual variables which impacts refugees during the migration process is ethnic identity. Ethnic group identity has been defined as "an individual's sense of self in terms of membership in a particular ethnic group" (Phinney, et. al, 2001, p. 496). Ethnic identity is often used to refer to an individual's self-categorization as a member of a particular ethnic group. However, ethnic identity is a multidimensional construct, encompassing various aspects such as the salience of the ethnic identity to the individual's self-concept; feelings of belongingness to the group; behavioral involvement with the ethnic group; a sense of shared values; and attitudes towards one's own ethnic group, such as private and public regard (i.e. individual attitudes toward one's own ethnic group and perceptions of attitudes of out-group members toward the in-group, respectively (Phinney, et. al, 2001; Ashmore, Deaux & McLaughlin-Volpe, 2004; Sellers & Shelton, 2003).

Ethnic identity needs to be differentiated from ethnicity. While ethnicity denotes a biological characteristic, one's race, ethnic identity refers to the behaviors, beliefs, values and norms that characterize the group. Older conceptualizations of acculturation

which emphasized the subsuming of the ethnic identity with the host identity treated ethnic and national identities akin to labels (Phinney, et. al, 2001). An individual was either one or the other. More recently, two-dimensional models of ethnic and national identities have arisen. This model conceptualizes the two identities as being independent (Phinney, et. al, 2001), such that an individual could be high or low on both, or high on one and low in the other, mirroring Berry's (2001) model of acculturation.

It has been debated whether ethnic identity serves as a risk or protective factor for negative psychological outcomes. Some research has suggested that the experience of discrimination in the face of a strong sense of ethnic identification results in negative psychological outcomes, such as low self-esteem (McCoy & Major, 2003; Cassidy, et. al, 2004; Dion, 2002) and depression (Lee, 2005). Theoretically, the negative views of the out-group threaten the individual's self-concept, and in the face of continued discrimination may be internalized. McCoy and Major (2003) explored the hypothesis that strong ethnic identity moderated the impact of perceived discrimination on self-evaluative emotions, including depression and self-esteem, for Latino-Americans. The study required participants to read vignettes about acts of prejudice against Latinos. The authors found that strong ethnic identity was positively related to symptoms of depression when participants read about prejudice against the ingroup. The authors concluded that strong ethnic identity was a liability in light of prejudice against Latinos.

Lee (2005) investigated the moderating role of ethnic identity in the relationship between perceived discrimination and self-esteem and symptoms of depression among Korean American college students. Similar to the studies described above, the author

found that for individuals demonstrating a strong identification with the ethnic group, the effects of discrimination on depressive symptoms were stronger among people with weak ethnic identification.

Somewhat more support has been found for the role of ethnic identity as a protective factor. A strong sense of ethnic identity can buffer the effects of perceived discrimination and actually enhance self-esteem (Romero & Roberts, 2003) and lower psychological distress (Mossakowski, 2003; Sellers, et. al, 2003). This pathway suggests that a strong sense of ethnic identification may lead an individual to attribute incidents of discrimination externally (e.g. to the negative qualities of the out-group), thus reducing stress, buffering self-esteem and protecting the individual from experiencing negative affect as a result of discrimination. For example, Mossakowski (2003) utilized data gathered from the Filipino American Community Epidemiological Study conducted between 1998 and 1999 for Filipino immigrants residing in San Francisco, California and Honolulu, Hawaii. The author was interested in how ethnic identity related to depressive symptoms when perceived discrimination was present. Not only did the author find a direct relationship between ethnic identity and depressive symptoms in that generally, participants who demonstrated strong identification with an ethnic group experienced fewer symptoms of depression, but strong ethnic identification buffered the effects of perceived discrimination such that participants with strong ethnic identification experienced less distress as the result of discrimination than did those who did not have a strong ethnic identification. Similarly, when examining the interaction of ethnic identity and perceived discrimination in a sample of Mexican American adolescents, Romero and

Roberts (2003) found that individuals who reported strong ethnic identity and high amounts of perceived discrimination still exhibited high self-esteem, supporting the protective role of ethnic identity against perceptions of discrimination.

Similarly, Cassidy and colleagues (2004) were interested in examining the self-esteem theory of depression in the context of perceived discrimination. The self-esteem theory of depression holds that self-esteem serves a moderating role between negative life events and the experience of depression such that low-self esteem is a risk factor for the experience of depression and high-self esteem is a protective factor against the experience of depression. The authors expanded this theory to test not only personal self-esteem, but ethnic group self-esteem, basically equivalent to the notion that individuals can have ethnic identities of differing strengths. A sample of young people, aged 14-21, and comprised of individuals of Chinese, Indian and Pakistani decent residing in Scotland, was used for this study. The authors failed to find evidence of the self-esteem theory of depression for women, however for the men in the sample, low ethnic self-esteem predicted higher levels of depression in men who had experiences of perceived discrimination. The authors note that women in the sample reported low levels of perceived discrimination, which may have accounted for the lack of findings in this group.

The relationship between ethnic identity and perceived discrimination remains unclear. Some studies have found support for the theory that individuals who possess a strong sense of ethnic identity are at greater risk for negative outcomes as the result of perceived discrimination. Other studies have found that strong ethnic identity can serve

as a buffer between perceived discrimination and psychological distress. It is possible that yet unidentified moderating and mediating factors are present which impact the effects of ethnic identity on individual responses to perceived discrimination.

7. Help-Seeking

Refugees seem to be at high risk for poor functioning. Research has already concluded that minorities in general underutilize mental health services (Ayalon & Young, 2005) due to a number of barriers to seeking help (Tata & Leong, 1994). Generally speaking, demographic characteristics such as cost of care, lack of insurance, inconvenient office hours, unavailability of care, lack of knowledge about where to go for help, or lack of perceived need for help have all been identified as barriers to seeking professional help for psychological problems (Fox, Blank, Rounyak & Barnett, 2001). Gender differences in help-seeking are well-documented. Men, in general, are less likely to seek psychological help than women (Tata & Leong, 1994; Moller-Leimkuhler, 2002).

Other studies have identified factors which promote help-seeking. For example, Sheffield, Fiorenza and Sofronoff (2004) found that greater adaptive functioning, fewer perceived barriers to help seeking, and higher psychological distress predicted adolescents' willingness to seek help from both formal and informal sources. Chung and Lin (1994) identified a similar link between acculturation and help-seeking behavior in a sample of Southeast Asian refugees. Indicators of acculturation measured, such as language proficiency and being employed, predicted preference for use of Western medicine for psychological problems over traditional forms of medicine.

Leong, Wagner and Tata (1995) add that disadvantaged social groups, such as minorities, have a greater vulnerability to experience psychological distress and have a higher incidence of psychological problems than the general population. Despite this fact, these individuals seek help less and when they do, use the mental health system differently than non-minorities. African Americans tend to over-utilize mental health services for social, occupational and economic stress, yet they seek help for practical rather than emotional problems. Hispanic Americans, while they are often thought to be at great need for services due to the stress of coping with lack of English, poverty, unemployment, and poor housing encounter barriers which prevent them from seeing help. These include lack of finances, cultural barriers (e.g. cultural conceptualization of mental illness, low acculturation, role of family in healing) and institutional barriers (e.g. language). Asian Americans tend to underutilize mental health services due to conflicts between Asian and Western beliefs and values, including belief in the collective, belief in an open communication between therapist and client, and preferences for the ethnicity and credibility of the therapist (Leong, et. al, 1995).

Despite what is currently known there remains a dearth of information regarding how the complex picture of migration including pre-migration trauma, acculturation and perceived discrimination affects the attitudes toward and help seeking behaviors of refugees. Rogler and Cortes (1993) point out that the serious nature of the distress experienced by immigrants indicates that a need for help exists, but that actual help seeking behavior is influenced by psychosocial and cultural factors. For example, Knipscheer et. al (2000) found that in a sample of Ghanian immigrants residing in the

Netherlands, individuals did seek professional help for acute psychological distress, however less acculturated individuals evidenced difficulty in disclosing mental health problems and asking for help. In addition, many Ghanians demonstrated a preference for seeking help from religious or community groups. Similarly, Tata and Leong (1994) examined the attitudes of a group of Chinese-American college students toward seeking professional psychological help. In this study, acculturation was measured via language familiarity, usage and preference; ethnic identity; cultural behaviors and ethnic interactions. Scores ranged from 1 to 5, with low scores indicating Asian identification and low level of acculturation. Acculturation was found to be a significant predictor of attitudes toward seeking professional psychological help. More acculturated individuals demonstrated more willingness to seek professional help for psychological problems. Interestingly, even when immigrants and refugees utilize Western mental health service, there remains a heavy reliance on traditional forms of care. In a sample of Southeast Asian refugees from Vietnam and Cambodia, Chung and Lin (1994) found that there was a significant increase in the use of Western medicine after relocation to the United States, which was predicted by English proficiency and youth, such that these individuals were relying more heavily on Western rather than traditional treatment methods. Despite this fact, however, the refugees continued to value and utilize traditional forms of treatment. This implies that even when an individual is fairly well acculturated to the United States, cultural values still heavily influence the selection of treatments. Research has supported this proclivity for the use of traditional versus Western medicine in other immigrant

groups residing in the United States, for example, Mexican and Asian immigrants (Chung & Lin, 1994; Higginbotham, Trevino & Ray, 1990).

Immigrants, and refugees to a greater degree, experience significant levels of psychological distress. Whether or not they seek help is complicated by a number of cultural and psychosocial factors. Due to the dearth of research which focuses specifically on the factors which contribute to poor psychological functioning in refugees and to the barriers to seeking help by these individuals, it is pertinent to gain a better understanding of the causes of psychological distress in refugees and why or why not they seek help for their problems. However, studying the psychological functioning of refugees is confounded by the effects of past traumatic experiences. In addition to being subject to a sudden disruption in one's life and forced relocation, refugees have often experienced one or several forms of trauma such as deprivation of food and shelter, physical injury and torture, incarceration, or witnessing torture or killing (Bemak & Chung, 2002).

8. Hypotheses of the Current Study

Hypothesis 1. The current study explored whether a relationship exists between prior trauma and psychological distress (symptoms of depression and PTSD) and well-being (life satisfaction). It is predicted that prior trauma will be positively related to symptoms of psychological distress and inversely related to well-being. If this is found to be the case, the present study will control for trauma in all subsequent analyses.

Hypothesis 2. It is predicted that participants who have chosen the integration style of acculturation will experience less psychological distress and greater well-being than participants who have chosen the strategies of assimilation, separation or marginalization.

> Hypothesis 2A. Because the current study is also interested in the emerging concept of community connectedness as an alternative operationalization of acculturation, it is also hypothesized that strong connection to the American community and the Bosnian community (integration strategy) will be negatively associated with psychological distress and positively associated with well-being. In contrast, it is predicted that strong connection to the Bosnian community and weak connection to the American community (separation strategy), or weak connection to both communities (marginalization strategy) will be negatively related to psychological distress and well-being.

Hypothesis 3. It is predicted that greater perception of discrimination will be positively related to psychological distress and negatively related to well-being.

Hypothesis 4. In order to clarify the nature of the interaction of ethnic identity salience and perceived discrimination and psychological outcomes, the current study will explore the interaction of ethnic identity and perceived discrimination and the impact on psychological distress and well-being. It may be that the experience of discrimination for individuals whose ethnic identity is highly salient leads to more psychological distress and lower well-being because discrimination targets a central aspect of the self-concept. And yet still, ethnic identity may serve as a protective buffer against discrimination, because the discrimination is attributed to external factors. Given that prior literature is inconclusive regarding the direction of the moderating effect of ethnic identity in predicting psychological distress and well-being, no a priori hypothesis will be predicted.

Hypothesis 5. The current study will examine the relationship between all the aforementioned predictors and help-seeking. Three indicators of help-seeking will be explored, including instances of help-seeking, the type of help sought (e.g. professional, non-professional), and attitudes toward seeking professional psychological help.

Hypothesis 5A. It is predicted that prior trauma will have an inverse relationship with help-seeking behaviors and attitudes. If a relationship is found, then past trauma will be controlled in the rest of analyses regarding help-seeking.

Hypothesis 5B. It is predicted that the integration strategy of acculturation will be positively associated with instances of help-seeking in general, instances of

seeking help from a professional, and positive attitudes toward seeking professional psychological help.

Hypothesis 5C. It is predicted that strong connections to the American community will be positively associated with all indicators of help-seeking, and that strong connections to the Bosnian community will be negatively associated with all indicators of help-seeking.

Hypothesis 5D. It is predicted that greater perception of discrimination will be negatively associated with all indicators of help-seeking.

9. Method

Participants

Bosnian refugees residing in the United States participated in the current study. A total of 160 Bosnian refugees were approached to participate in the current study. The final sample of participants was comprised of 52 males and 73 females for a total of 125 participants. On average, participants had been residing in the U.S. for 9.6 years, with a range from 4 to 14 years in the U.S (SD = 2.23). The average participant was 44 years of age. Participants' age ranged from 25 to 79 (SD = 13.99). Sixty percent of participants were married, 20% were single, 12% were divorced, and 7.2% were widowed.

Given that gaining access to and recruiting research participants from disadvantaged, diverse or minority populations is difficult using typical recruiting methods, participants were recruited from the greater Washington, D.C. area using a "snow-ball" method (Spasojevic, Heffer & Snyder, 2000). This entailed utilizing researchers' personal connections in the refugee/immigrant communities as a point of contact and departure in terms of referrals of potential research participants. It should be noted that no individuals known personally by the researchers were asked to participate. Only their referrals, referrals of referrals and so on were approached to participate in the research. Participants received a small gift (a piece of candy) not exceeding $3 in monetary value for their participation.

Measures

Demographic questions (developed for this study). Information was collected regarding participants' age, gender, marital status, socioeconomic status and time in the United States.

Trauma. The War Trauma Questionnaire (WTQ) (Dapic & Stuvland, 1993, as cited in Dapic, Stuvland, Sultanovic, Mavrak, Durakovic & Kulenovic, 1995) was used to assess the level of exposure to different types of war trauma. The measure includes 28 items describing different war traumas and requires respondents to answer "yes" or "no" according to whether or not they experienced the particular war trauma. Seven different types of war traumas are assessed, including displacement, general war events, separation, loss, personal life threat, life threat to significant others and witnessing violence. Scores are based on the number of "yes" responses and scores range from 0 to 28 with higher scores indicating greater experience of war trauma. In another study focusing on Bosnians residing in Sarajevo who had experienced war, Durakovic-Belko, Kulenovic and Dapic (2003) found an alpha of 0.72 for the entire scale.

Posttraumatic Symptomotology. The PTSD Checklist-Civilian (PCL-C) (Weathers, Litz, Herman, Huska & Keane, 1993) was used to assess symptoms of posttraumatic stress disorder. This measure is a brief, 17-item self-report inventory that comprises items reflecting PTSD symptomotology according to the DSM-IV. The PCL-C was designed specifically to assess responses to traumatic experiences encountered in the course of civilian living (Weathers, et. al, 1993). The PCL-C provides a continuous score based on a number of severity symptoms, enabling it to capture gradations in PTSD

symptomotology. Specifically, the PCL-C measures re-experiencing symptoms, avoidance-numbing symptoms, and hyperarousal symptoms. Respondents rate the extent to which they have been bothered by symptoms over the past month on a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely). In this way, the scale assesses symptom presence as well as anxiety. Ruggiero, Del Ben, Scotti & Rabalais (2003) found that the full scale and subscales had good internal consistency (Total: alpha = .94; Re-experiencing: alpha = .85; Avoidance-numbing: alpha = .85; Hyperarousal: alpha = .87) and retest reliability (r = .92, $p < .001$). A study with 27 motor vehicle accident victims and 13 sexual assault victims (Blanchard, Jones-Alexander & Buckley, 1996) yielded high correlations (overall r = .93) between symptom ratings derived from the PCL-C and the CAPS, indicating good concurrent validity.

Depressive Symptomotology. The Beck Depression Inventory (BDI-II; Beck, Steer & Brown, 1996) was used to assess cognitive, affective and behavioral symptoms of depression. This measure has well established reliability and validity (alpha = .91), and is widely used in clinical and research settings to measure the severity of depressive symptoms.

Life Satisfaction. The Satisfaction with Life Scale (SWLS) (Diener, Emmons, Larsen & Griffin, 1985) was used to assess participants' subjective satisfaction with life. The SWLS is the most widely used brief measure of life satisfaction. The measure assesses an individual's global judgment of life satisfaction via five items including "In most ways my life is close to my ideal," "The conditions of my life are excellent," "I am satisfied with my life," "So far I have gotten the important things I want in life," and "If I could

live my life over, I would change almost nothing." Responses are given on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). The measure demonstrated good internal consistency (alpha = .87) and retest reliability (Diener, et. al, 1985). It has also been shown to be negatively correlated with measures of psychological distress such as the Beck Depression inventory (r = -.72, p = .001) (Blais, Vallerand, Pelletier & Briere, 1989) and anxiety (r = -.54) and depression (r = -.55) as measured by the Symptom Checklist-90 (SCL-90-R; Derogatis, 1977) (Arrindell, Meeuwesen & Huyse, 1991). In contrast, the SWLS is positively correlated with measures of positive affect (e.g. r = .44 for positive affect on the PANAS scales; Watson, Clark & Tellegen, 1988).

Acculturation. The Vancouver Index of Acculturation (VIA) (Ryder, Alden & Paulhus, 2000) was used to measure acculturation. The VIA is a 12-item measure of heritage and mainstream dimensions of acculturation. Each item is duplicated such that one refers to ethnic culture and the other to American culture. Items pertaining to each culture are grouped together to form two subscales. Items are rated on a 5-point Likert scale ranging from 1 (not at all) to 5 (very much so). For example, "I am interested in maintaining or developing Bosnian traditions" and "I would be willing to marry an American person." Higher scores on each subscale represent higher levels of identification with the respective culture. The VIA has good reliability (Heritage subscale: alpha = .79; Mainstream subscale: alpha = .75), good concurrent validity (Heritage subscale: rs = -.30; Mainstream subscale: rs = .54, ps < .001) and good factorial validity (k = 4) (Ryder, Alden & Paulhus, 2000).

Community connectedness. The Inclusion of Community in Self (ICS) Scale (Mashek, Cannaday & Tangney, 2005) was used to measure participants' level of connectedness to their ethnic community and to the American community at large. The ICS is a single item pictorial measure consisting of six pairs of overlapping circles. Each pair contains same sized circles, and the pairs differ in the degree to which the two circles overlap. From right to left, each pair overlaps slightly more than the preceding pair. Each pair of circles is assigned a numerical value, ranging from 1 (no connectedness to community) to 6 (strong connectedness to community). Each participant is instructed that the circle on the left represents him- or herself while the circle on the right represents the community (e.g. Bosnian community, American community at large). Participants are then asked to circle the picture that best describes their relationship to their ethnic community. This procedure will then be repeated, asking participants to circle the picture that best describes their relationship to the American community at large. This scale is an explicit derivative of Aron, Aron and Smollan's (1992) Inclusion of Other in Self (IOS) Scale which has a good test-retest reliability (r = .83 over two weeks) and convergent validity (correlating r = .25 with "behaving close" and r = .26 with "feeling close").

Perceived discrimination. The Perceived Ethnic Discrimination Questionnaire (PEDQ) (Contrada, Ashmore, Gary, Coups, Egeth & Sewell, et. al, 2001) was used to assess participants' perceptions of ethnic-related discrimination. The PEDQ is comprised of 22 items tapping four forms of discrimination including *disvaluation* (e.g. How often have others had low expectations of you because you are a refugee?), *threat/aggression* (e.g. How often have others threatened to hurt you because you are a refugee; How often have

others physically hurt you or intended to physically hurt you because you are a refugee?), *verbal rejection* (e.g. How often have you been subjected to offensive comments aimed directly at you, spoken either in your presence or behind your back because you are a refugee?) and *avoidance* (e.g. How often have others avoided social contact with you because you are a refugee?). Participants respond based on how frequently over the past three months each form of discrimination has been directed at them. Responses range from 1 (never) to 4 (sometimes) to 7 (very often). This measure has good reliability and validity (Contrada, et. al, 2001). For each of the four factors, the full sample (comprised of White and Non-White participants) alpha coefficients are as follows: disvaluation, alpha = .89; threat/aggression, alpha = .84; verbal rejection, alpha = .78; avoidance, alpha = .74. The author revised the wording of the original measure slightly. The original measure referred to "ethnic group" and "ethnicity." Because the focus of the current study is on participants' refugee status rather than their ethnicity, the phrase "because you are a refugee" was substituted for "ethnic group" and "ethnicity" to ensure that participants considered their refugee status when responding to the items. This should not affect the statistical properties of the measure, as the content of the items has not been altered.

Ethnic identity. The Identity Centrality subscale of the Group Membership Questionnaire (GMQ) (Contrada, Ashmore, Gary, Coups, Egeth & Sewell, et. al, 2001) was used to measure assess ethnic group identity. This measure has good reliability and validity (Identity Centrality subscale: alpha = .86). Four items comprise the Identity Centrality subscale, including "Overall, my ethnic group has very little to do with how I feel about

myself," "The ethnic group that I belong to is an important reflection of who I am," "The ethnic group that I belong to is unimportant to my sense of what kind of person I am," and "In general, belonging to my ethnic group is an important part of my self-image." Participants are asked to consider their membership in their ethnic group and respond to each statement on the basis of how they feel about their ethnic group and their membership in it. Responses range from 1 (strongly disagree) to 4 (neutral) to 7 (strongly agree).

Attitudes toward professional counseling. Attitudes toward professional counseling were measured via the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) – Short Form (Fischer & Turner, 1970; Elhai, Schweinle, Patrick & Anderson, in press). The full measure contains 29 items, and assesses participants' attitudes towards traditional counseling services. Fischer and Farina (1995) developed a shorted version, containing 10 items. Examples of the items include, "If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy," "There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help," and "A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help." Participants respond using a 4-point Likert-type scale ranging from 0 (disagree) to 3 (agree). Responses are then summed, with higher scores indicating more positive attitudes towards receiving help from a professional counselor. The shortened version was demonstrated to be internally consistent (alpha = .84), to have adequate retest reliability over one month (r = .80) and

correlated highly with the original measure (r = .87) (Fischer & Farina, 1995). A recent study by Elhai, Schweinle, Patrick and Anderson (2006) replicated the reliability and validity of the measure among college students as well as adult medical patients, aged 18-85, recruited from a university primary mental health clinic.

Help-seeking. We assessed whether participants have sought help for emotional problems and what type of help they sought. Following the methodology of Adams, Ford and Dailey (2004) and Mojtabai, Olfson and Mechanic (2002) help-seeking behavior was measured by asking participants, "Have you ever sought help for an emotional problem?" If the response was affirmative, participants were then asked to specify the type of help. Choices included formal support services (general medical doctor, psychiatrist, psychologist, social worker, religious clergy/counselor, other: please specify), informal support services (family member, friend, neighbor, other: please specify). Participants were asked to check all that apply.

Measure translation. A Bosnian language version of the PTSD Symptom Scale - Self-Report was obtained from another investigator with previous experience conducting research with Bosnian refugees (Weine, Becker, McGlashan, Laub et al., 1995; Weine, Becker, McGlashan, Vojvoda et al., 1995). All other instruments were translated to the Bosnian language by a US Clinical Psychologist who is a Bosnian. A blind back-translation by university students of Bosnian origin (10-15 years in the U.S.) was used to check for accuracy, sensitivity and validity of the translation. This method has been used in previous work with refugees in order to maximize ethnocultural relevance of the

measures (Weine, et. al, 1995a, 1995b; Carlson & Rosser-Hogan, 1991; Kinzie, Tran, Breckenridge, & Bloom, 1980; Mollica et al., 1987).

Procedure

After obtaining a referral (including name and phone number), a research team member contacted potential participants, briefly described the study to them and solicited their participation. After obtaining informed consent, a research team member met with participants, depending on their preference, either in their home or at the research laboratory located on George Mason University's Fairfax campus to complete the battery of psychological measures. Upon completion of participation, participants were compensated with a small gift for their participation.

10. Results

Preliminary Analyses

Before analyses proceeded, independent variables were assessed for multicollinearity. In particular, community connectedness was being explored as a possible alternative conceptualization of acculturation. The VIA scale assessing level of identification with the American culture was positively correlated to the measure of connectedness to the American community ($r = .712$, $\underline{p} < 0.01$). The VIA scale assessing level of identification with the Bosnian culture was positively correlated to the measure of connectedness to the Bosnian community ($r = .476$, $\underline{p} < 0.01$). Despite the statistical similarity of the constructs of acculturation and community connectedness, subsequent analyses proceeded without collapsing the variables due to the exploratory nature of the investigation of the construct of community connectedness.

A preliminary set of hierarchical regression analyses was performed to test for the possible moderation effects of gender. Gender was not found to moderate any of the predicted relationships among variables included in the study. Therefore, subsequent analyses proceeded with both genders included in the same sample.

Descriptive Statistics

Table 1 shows descriptive statistics for demographic characteristics of the sample, as well as for predictor and outcome variables.

Table 1.

Means and standard deviations (n = 125)

	Mean	SD
Age	44.88	13.99
Years in US	9.63	2.23
Marital Status	1.66	.95
Prior trauma	5.30	2.08
Acculturation – Bosnian	63.91	12.48
Acculturation – American	53.25	17.11
Ethnic Identity	15.57	2.68
Perceived Discrimination	38.17	9.78
Community Connectedness – Bosnian	4.42	1.14
Community Connectedness – American	3.50	1.61
Posttraumatic Symptomotology	26.36	9.06
Depressive Symptomotology	5.97	4.74
Life Satisfaction	18.74	6.50
Attitudes toward Counseling	17.38	7.48
Help-Seeking	1.18	.317

Hypothesis 1

Prior trauma was not related to symptoms of posttraumatic stress ($t(122) = 1.51$, $p = .13$, $\beta = .13$) but did positively predict symptoms of depression ($t(122) = 2.86$, $p < .01$, $\beta = .25$). Prior trauma also negatively predicted poor life satisfaction ($t(122) = -2.57$, $p < .01$, $\beta = -.23$). As a result, subsequent analyses involving depression and life satisfaction as outcome variables controlled for prior trauma.

Hypothesis 2

As hypothesized, participants exhibiting the integration style of acculturation experienced less psychological distress and greater quality of life. Acculturation to the Bosnian

culture was negatively related to posttraumatic stress symptoms (t(123) = -3.26, p < .001, β = -.28) as was acculturation to the American culture (t(123) = -3.85, p < .001, β = -.33). Controlling for trauma, acculturation to the Bosnian culture negatively predicted symptoms of depression (t(123) = -2.31, p < .05, β = -.20) as did acculturation to the American culture (t(123) = -3.77, p < .001, β = -.34). Controlling for trauma, acculturation to the Bosnian culture was positively associated with life satisfaction (t(123) = 2.77, p < .01, β = .24) as was acculturation to the American culture (t(123) = 6.09, p < .001, β = .51).

Hypothesis 2A.

As predicted, when examining the construct of community connectedness, strong connections to the Bosnian and American communities were related to less posttraumatic stress symptomotology and greater life satisfaction. Connection to the Bosnian community negatively predicted posttraumatic stress symptomotology (t(123) = -1.98, p < .05, β = -.18) as did connection to the American community (t(123) = -1.99, p < .05, β = -.18). Controlling for trauma, neither connection to the Bosnian community (t(123) = -.97, p = .33, β = -.09), nor connection to the American community (t(123) = -1.91, p = .06, β = -.18) was related to symptoms of depression. Participants exhibiting connections to both the native and host communities also experienced greater satisfaction in their lives. Controlling for trauma, connection to the Bosnian community was positively associated with life satisfaction (t(123) = 3.77, p < .001, β = .32) as was connection to the American community (t(123) = 4.34, p < .001, β = .38). Table 2 shows the

correlations between Bosnian and American acculturation and community connectedness and the outcome measures.

Table 2.

Correlations of Bosnian and American acculturation and community connectedness with posttraumatic stress, depressive symptoms and life satisfaction (n = 125)

	PTS	DEPS	LSAT	AccBos	AccAm	CCBos	CCAm
PTS	----						
DEPS	.67***	----					
LSAT	-.44***	-.53***	----				
AccBos	-.28**	-.16	.20*	----			
AccAm	-.33***	-.38***	.52***	-.19*	----		
CCBos	-.18*	-.11	.34***	.48***	.03	----	
CCAm	-.18*	-.24**	.41***	-.19*	.71***	.03	----

Note. PTS = posttraumatic stress symptoms; DEPS = depressive symptoms; LSAT = life satisfaction; AccBos = acculturation – Bosnian; AccAm = acculturation – American; CCBos = community connectedness – Bosnian; CCAm = community connectedness – American.
* $p < .05$; ** $p < .01$; *** $p < .001$.

Hypothesis 3

Perceived discrimination did not predict posttraumatic stress symptomotology ($t(123) = -.09$, $p = .93$, $\beta = -.01$). Controlling for trauma, perceived discrimination was not related to symptoms of depression ($t(123) = 1.50$, $p = .14$, $\beta = .13$), but it did negatively predict life satisfaction ($t(123) = -5.36$, $p < .001$, $\beta = -.43$). Given that discrimination, conceptualized and assessed as a unitary construct, was not significantly related to the indices of psychological distress and life satisfaction, post-hoc analyses were conducted

relating each of the PEDQ subscales (disvaluation, threat/aggression, verbal rejection, avoidance) to the outcome variables to determine whether specific types of discriminatory experiences were related to the hypothesized outcomes. However, these results were also insignificant.

Hypothesis 4

In order to clarify the nature of the interaction of ethnic identity salience and perceived discrimination, three sets of analyses were conducted using symptomotology of posttraumatic stress and depression, and life satisfaction as outcome variables. When analyzing symptoms of depression and life satisfaction, to control for trauma, it was entered in the first step of the model. Ethnic identity and perceived discrimination were entered individually in the second step. In the third step, the interaction term of ethnic identity and discrimination was entered into the model. The interaction of ethnic identity and perceived discrimination did not predict symptoms of posttraumatic stress ($\underline{t}(121) = .02$, $\underline{p} = .99$, $\beta = .01$). Controlling for trauma, the interaction of ethnic identity and perceived discrimination did not predict depression symptomotology ($\underline{t}(120) = 1.49$, $\underline{p} = .14$, $\beta = 1.02$). Controlling for trauma, the interaction of ethnic identiy and perceived discrimination did not predict life satisfaction ($\underline{t}(120) = .32$, $\underline{p} = .75$, $\beta = .20$).

Hypothesis 5

Hypothesis 5A. Prior trauma was a negative predictor of attitudes toward counseling ($\underline{t}(123) = -2.43$, $\underline{p} < .05$, $\beta = -.21$), but was not related to instances of help-seeking ($\underline{t}(123) = .99$, $\underline{p} = .32$, $\beta = .09$) or to asking for help from a professional ($\underline{t}(12) = -.40$, $\underline{p} =$

.70, β = -.12). Prior trauma was controlled for in subsequent analyses involving attitudes toward counseling.

Hypotheses 5B & 5C.

Controlling for trauma, acculturation to Bosnian culture was not related to attitudes toward counseling (t(122) = .28, p = .78, β = .03). Controlling for trauma, connection to the Bosnian community was positively related to attitudes toward counseling (t(122) = 2.36, p < .05, β = .21). Controlling for trauma, both acculturation to American culture (t(122) = 4.84, p < .001, β = .43) and connection to the American community (t(122) = 3.09, p < .01, β = .28) positively predicted attitude toward counseling. The regression coefficients between the two regression analyses predicting attitudes toward counseling with Bosnian acculturation and American acculturation, respectively, as independent variables were significantly different. Acculturation to the Bosnian community was not related to instances of help-seeking (t(122) = 1.13, p = .26, β = .10) or to seeking help from a professional (t(12) = -.41, p = .69, β = -.12). Similarly, connection to the Bosnian community did not predict instances of help-seeking (t(123) = -.51, p = .61, β = -.05) or seeking help from a professional (t(12) = 1.16, p = .28, β = .32). Acculturation to the American community was also not related to instances of help-seeking (t(122) = 1.29, p = .20, β = .12) or to seeking help from a professional (t(12) = -.87, p = .40, β = -.24). Connection to the American community did not predict asking for help (t(123) = 1.25, p = .22, β = .11) or seeking help from a professional (t(12) = -1.15, p = .28, β = -.31).

Table 3 shows the correlations of Bosnian and American acculturation and community connectedness and the outcome variables related to help-seeking.

Table 3.

Correlations of Bosnian and American acculturation and community connectedness with attitudes toward counseling and help-seeking (n = 125)

	Att	Help	Prof	AccBos	AccAm	CCBos	CCAm
Att	-----						
Help	.025	-----					
Prof	-.21	.00	-----				
AccBos	-.01	.10	.10	-----			
AccAm	.45***	.12	.12	-.19*	-----		
CCBos	.23**	-.05	-.05	.48***	.03	-----	
CCAm	.32***	.11	.11	-.19*	.71***	.03	-----

Note. Att = attitudes toward counseling; Help = instances of help-seeking; Prof = professional help-seeking; AccBos = acculturation – Bosnian; AccAmm = acculturation – American; CCBos = community connectedness – Bosnian; CCAm = community connectedness – American.
* $p < .05$; ** $p < .01$; *** $p < .001$.

Hypothesis 5D. Controlling for trauma, perceived discrimination predicted poorer attitudes toward counseling ($t(122) = -4.91$, $p < .001$, $\beta = -.40$). Perceived discrimination was not related to asking for help ($t(123) = -1.83$, $p = .07$, $\beta = -.16$) or seeking help from a professional ($t(12) = -.40$, $p = .70$, $\beta = -.11$).

11. Discussion

Prior Trauma

Consistent with past research regarding predictors of psychological functioning in refugees, the current study, comprised of Bosnian refugees living in the United States, found prior trauma predicted their psychological distress (when measuring depressive symptomotology) and poor life satisfaction. Mollica and colleagues (1999) also identified a relationship between trauma and disability in Bosnian refugees, even controlling for demographic variables.

In contrast to most, but not all prior research (see Johnson & Thompson, 2008 for a review), prior trauma did not predict posttraumatic stress disorder. This may be explained by various factors. Current methods for identifying posttraumatic stress symptoms in refugee populations rely on identifying the clinical presentation of psychological trauma as it has been identified and measured in Western society. As Charney and Keane (2007) suggest, cross-cultural assessment of posttraumatic stress is complicated by the lack of knowledge about the psychometric properties of instruments which are originally developed and validated for another culture. This could affect the accuracy of identifying symptoms of posttraumatic stress. The current study relied on a Bosnian translation of a measure developed and standardized in America, and thus may not adequately capture the culturally specific picture of posttraumatic stress for Bosnian

refugees. Furthermore, the measure of trauma severity used in this study is a relatively new one lacking well-established psychometric properties.

Acculturation and Community Connectedness

Past research has identified many post-migration factors which impact the functioning of refugees. The current study aimed to elucidate the nature of the effects of the acculturation process, cultural identity, and experience of discrimination on the psychological functioning of refugees. Two lines of inquiry are predominant in studies examining the acculturation process in immigrants and refugees. First is the question of how to operationalize acculturation. Second is the question of which acculturative state results in optimal psychological functioning.

Much past research has investigated acculturation using a unidimensional model. According to this model, acculturation is a terminal process that occurs over a continuum during which individuals move from an orientation to the native culture at one pole, to an orientation to the host culture on the opposite pole. Research utilizing the unidimensional model seems to support the link between poor acculturation and psychological distress. For individuals who do not acquire certain culture-relevant skills essential for day to day functioning (e.g. language proficiency), it is more likely that they will develop psychological problems.

Other research has conceptualized acculturation bidimensionally. In this conceptualization, attachments to the native and host cultures exist independent of one another. When two cultures come into contact, change occurs in both cultural identities of the individual such that at the end of the process, a new cultural identity emerges that

is some combination of the two original cultures. The most predominant bidimensional conceptualization defines four strategies of acculturation (Berry, 2001), which have been discussed previously. Several studies have identified the integration style as having the most positive outcomes of acculturation. When individuals are able to maintain their original cultural identity while also adopting key attributes of the host culture, they seem to experience less psychological distress and more life satisfaction. Werkuyten and Nekuee (1999) found that individuals who were marginalized in the acculturative process experienced less life satisfaction. Similarly, Liebkind and Jasinskaja-Lahti (2000) found integration style led to lower stress and less behavior problems.

The current study predicted that participants who have utilized the integration style of acculturation will experience less psychological distress and greater life satisfaction than participants who have utilized other acculturative strategies. Consistent with past research using a bidimensional conceptualization, the current study found that acculturation to the Bosnian as well as American culture predicted less psychological distress (both posttraumatic stress and depressive symptomotology) and more life satisfaction. These findings support previous evidence that individuals who maintain aspects of their native cultural identity while also internalizing American cultural values and practices experience the best outcomes. It also adds evidence to the notion that the process and outcome of acculturation (e.g. strategy used) affect subsequent degree of stress experienced (Berry, 2005).

The present study was helpful to the end of expanding research examining the feasibility of a bidimensional operationalization to predict such outcome measures.

Acculturation was measured on two separate but duplicate scales. One refers to the native culture and the other to the American culture. The scales measure aspects of acculturation beyond demographic statistics, such maintaining ethnic cultural values and practices and adopting host cultural values and practices. The current study identified that participants scores on both subscales predicted key outcome variables, indicating that individuals who have incorporated aspects of both cultures experience more positive outcomes than individuals who only maintain the native culture or who become disconnected from both cultures. In addition, the current findings regarding the acculturation process and psychological outcomes expands previous research utilizing these models beyond samples comprised mainly of college students who are immigrants in order to understand the acculturative process for refugees. Refugees are a unique group of migrants who have unique pre-migration experiences and do not have a choice in relocating (Ryder, 2000).

The current study also attempted to shed more light on community connectedness, an emerging concept from interpersonal theory and research, as an alternative operationalzation of acculturation. Developing and maintaining connection to a community, whether the native community or the American community, is conceptually similar to the concept of acculturating to the host culture while also remaining acculturated to the native culture. In the current study, the measure of Bosnian acculturation was positively correlated with the measure of connectedness to the Bosnian community, and similarly, American acculturation was positively correlated with connectedness to the American community. This suggests the conceptual similarity of

acculturation and connection to community. Results also indicated that connection to the Bosnian and American communities had similar, albeit not identical, relationships to key outcome variables as acculturation did. In the current study, connection to the Bosnian community as well as connection to the American community was negatively related to symptoms of posttraumatic stress and positively related to life satisfaction. This relationship was not found when examining community connectedness and depressive symptoms.

Social variables (e.g. social support, family values) have been shown to protect the functioning of refugees; and social isolation is the strongest predictor of post-migration variables of mental illness (Mollica, et. al, 1999). Recent studies have continued to identify social support as a protective factor against psychological distress (Ryan, Benson & Dooley, 2008). Past studies have also shown that social support also reduces depression (Noh & Kasper, 2003) and anxiety (Oppedal, et. al, 2005), and contributes to greater school adjustment in adolescents (Liebkind, Jasinskaja & Solheim, 2003). One might suspect that community connectedness would implicate a good social support structure, and thus would protect against psychological problems.

It is somewhat perplexing why community connectedness failed to predict depression. The lack of significant finding may be attributed to the emerging nature of the construct of community connectedness. The Inclusion of Community in Self (ICS) scale (Mashek, Cannaday & Tangney, 2005) is a newly developed measure. Thus far, one study (Mashek, Cannaday & Tangney, 2005) has shown that it has good test-retest reliability, though it has not been previously utilized with refugee populations. Further

validation studies are needed to clarify the psychometric properties of the measure and its utility with various populations.

Perceived Discrimination & Ethnic Identity

Perceived discrimination predicted poor life satisfaction for Bosnian refugees. This expands prior research focused mainly on minority or immigrant populations which has also demonstrated that discrimination impacts life satisfaction (Ryff, Keyes & Hughes, 2003). However, the current study failed to find a link between perception of discrimination and symptoms of posttraumatic stress or depression. Emerging research continues to identify a link between the experience of discrimination and psychological distress among refugees (Ryan, et. al, 2008) and immigrant populations in general (for review, see Ford, 2008). It may be that the experience of discrimination for Bosnian refugees impacts their perception of quality of life, but does not result in enough cumulative stress to result in psychological problems. Depression and anxiety were the most commonly cited problems identified in previous research (i.e. Cassidy, et. al, 2004; Sellers, Caldwell, Schmeelk-Cone & Zimmerman, 2003; Moradi & Hasan, 2004; Lee, 2005). The lack of an identified relationship between discrimination and distress in the current study may implicate the manner in which discrimination was perceived by the participants.

The attribution viewpoint of the effects of perceived discrimination (Dion, 1975; Crocker & Major, 1989) suggests that the effect of discrimination is a function of the meanings assigned by individuals to given events. This theory suggests that if one attributes discrimination to an internal failing based on minority status, he or she is more

likely to experience psychological distress than one who attributes discrimination externally (e.g. ignorance of the perpetrator). The PEDQ, used to collect data regarding experiences of discrimination, is a self-report measure. If individuals in the sample had a primarily external attribution style for instances of discrimination, the experience of discrimination may not have caused a great deal of distress. However, the attributions of participants regarding perceived discrimination were not measured.

It is also possible that perceived discrimination did not predict psychological distress because, as past research suggests, moderating variables might impact the effect of discrimination on psychological distress and life satisfaction (Werkuyten & Nekuee, 1999; Cassidy, et. al, 2004). One prominent variable of interest is ethnic identity. Prior literature is inconclusive regarding the manner in which ethnic identity moderates the relationship between discrimination and psychological functioning. Some previous studies have shown that strong ethnic identity actually increases distress resulting from perceived discrimination because it increases the likelihood that individuals will make internal attributions for discrimination (Lee, 2005; McCoy & Major, 2003; Cassidy, et. al, 2004; Dion, 2002). A larger body of past research suggests the opposite: strong ethnic identity is a protective buffer against discrimination because it leads to external attributions, reducing stress and protecting against the development of psychological problems (Cassidy, et. al, 2004; Romero & Roberts, 2003; Mossakowski, 2003; Sellers, et. al, 2003).

The current study did not find that ethnic identity moderated the relationship between perceived discrimination and psychological problems. Statistically, it is quite

difficult obtain a significant moderation relationship (effect sizes need to be moderate to large). That being said, participants included in the current sample may have had varying experiences with respect to discrimination. Ethnic identity may have served as a protective factor for some and a risk factor for others (consistent with previous research), causing results to cancel each other out and yield no moderating effect for ethnic identity in the sample overall. Future research should utilize cluster analysis in attempt to identify types of individuals for whom ethnic identity might moderate the relationship between perceived discrimination and psychological distress.

Help-Seeking

There has been little research on help-seeking in refugee populations. What we do know is that help-seeking is influenced by psychosocial and cultural factors (Rogler & Cortes, 1993). Acculturation is one prominent factor has been implicated in help-seeking among immigrants (Knipscheer, et. al, 2000; Tata & Leong, 1994; Chung & Lin, 1994; Higginbotham, Trevino & Ray, 1990). It suggests that acculturation can impact whether or not refugees seek help, whether or not they benefit from help, or if they prefer to replace or supplement western forms of help with traditional and non-institutional services. The present study attempted to elaborate on help seeking in refugees given they have unique acculturative experiences due to prior trauma compared to immigrants.

The current study failed to identify a link between any predictor variables and instances of help seeking. It should be noted that only 13 out of 125 participants reported any instances of help-seeking, and thus the range of responses was highly restricted with respect to both seeking help in general and even more so with respect to seeking help

from a professional. This restriction probably contributed to the lack of significant findings in predicting help-seeking. Seven individuals sought help from a general medical doctor, two individuals sought help from a social worker, while three individuals sought help from a friend and one sought help from a neighbor. It is somewhat perplexing that a minority of participants sought help from non-professionals, like family or friends. Given that the current study utilized one item measures, not previously validated, to assess instances of help-seeking and the type of help sought, it is possible that individuals in the sample understood the questions in a manner not intended by researchers. For instance, participants were asked, "Have you ever sought help for an emotional problem?" Did Bosnian participants understand the term "emotional problem" in the same manner as it is understood in the United States? It is also possible that the lack of findings regarding help-seeking are simply due to the inherent unreliability of one-item measures.

However, as previous research suggests, minorities may use help differently (e.g. seek practical rather than emotional support) or experience barriers to accessing institutionalized forms of help (e.g. language, financial, cultural) (Tata & Leong, 1994). Most often, minorities do not utilize western forms of mental health care because of differing cultural values regarding the collectivity of the self, conceptualizations of mental illness, or role of the family/social group for healing (Leong, Wagner & Tata, 1995; Leong, et. al, 2005; Fung & Wong, 2007). It is possible that the majority of participants in this study did not seek help for one or more of these reasons, though it was beyond the scope of this project to examine barriers to help-seeking specifically. It

would be useful for future research to specifically identify barriers to help-seeking for refugees.

In order to tap into a concept which can serve as a proxy and/or predictor variable for future help-seeking, we utilized a well validated method for measuring attitudes toward counseling (Fischer & Turner, 1970; Fischer & Farina, 1995; Elhai, Schweinle, Patrick & Anderson, in press) and were able to identify several relationships among predictor variables and attitudes toward counseling.

The present study has identified prior trauma as a risk factor for poorer attitudes toward counseling. Given that prior trauma is almost unanimously identified as a risk factor for psychological distress and poor life satisfaction by previous research examining the post-migration functioning of refugees, it is important to note that refugees often also have poor attitudes toward seeking counseling to alleviate their distress. This could serve as a barrier to help-seeking, and create larger consequences in terms of burden to society in the host country.

As with prior trauma, perceived discrimination was related to poorer attitudes toward counseling. It stands to reason that if refugees experience discrimination by members of the host country, that they would look less favorably on help offered by the host society. Because of their experience of being treated negatively on the basis of their ethnicity or refugee status, they may find it unlikely that mental health professionals would understand them or their unique circumstances. Without the expectation that they will be understood, refugees (or anyone for that matter) would be skeptical about the

ability of mental health care professionals to provide adequate help to overcome the adversity they face.

As hypothesized, those acculturated to the American culture had more positive attitudes toward counseling. This is consistent with past research which sites acculturation to the host culture (Chung & Lin, 1994) as promoting seeking-help. Attitudes, on the other hand, were dependent on both connection to the Bosnian community and connection to the American community. Whereas acculturation to the American culture was identified as predictive of attitudes toward counseling, here, connectedness to both communities was linked to more positive attitudes toward counseling. This is contrary to hypotheses that connection to the Bosnian community would lead to poorer attitudes toward counseling. It is possible that connection to the Bosnian community actually operated in the opposite direction than hypothesized. Rather than making it more likely that individuals would prefer to rely on traditional healing methods, connection to the native community may indicate access to individuals who are more highly acculturated to American culture. Community leaders and other upstanding members of the community may serve as a link between American forms of care and less acculturated members of the Bosnian community, thus promoting the approval and acceptance of host culture forms of care.

Most of the predicted hypotheses regarding prediction of attitudes toward counseling were supported. Prior trauma and perceived discrimination were related to poorer attitudes toward counseling, while acculturation to the American community and connectedness to both the Bosnian and American communities were related to more

positive attitudes toward counseling. Past research has suggested that cultural variables can serve as barriers to help-seeking (Tata & Leong, 1994). Bosnian refugees' attitudes toward the American mental health system are likely influenced by cultural conceptualizations of mental illness and appropriate treatment. According to the current study, they are also influenced by post-migration factors, such as acculturation and perceived discrimination. Depending on the unique experience of each individual, some may develop poor attitudes toward mental health care as it exists in America. A person assimilated to American culture and connected to the American community may be very likely to look favorable upon American mental health care and seek help for distress. On the other hand, a person who had experienced a high amount of discrimination and had not acculturated to the American culture may not feel positively toward American forms of treatment and be very unlikely to seek help. Future studies may explore attitudes toward counseling as an antecedent or a moderating factor in what appears to be a complex relationship between contextual factors and help-seeking in refugee populations.

12. Clinical Implications

The findings of the current study are consistent with past research that suggests immigrants and refugees who maintain aspects of their native cultural identity while also internalizing American cultural values and practices experience the most positive psychological outcomes. For those who cannot assimilate to American culture, or who become disenfranchised from both the native and host cultures, psychological distress is common. Other pre- and post-migration factors complicate the picture of refugee functioning. The current study showed that cumulative trauma and the experience of discrimination were negatively related to Bosnian refugees' attitudes toward counseling. Because past research has found that refugees are at particular risk for psychological distress, it is worrisome to note that these individuals may not access available services which could restore adaptive functioning.

Clinicians who work with refugees need to be aware of the unique combination of pre- and post-migration factors which contribute to poor functioning for refugees or serve as protective buffers against distress. Because prior trauma is such a pervasive predictor of poor functioning, clinicians must make it a priority to assess for such experiences in refugees. This will allow clinicians to utilize appropriate interventions to process the effects of trauma, promote acculturation and to protect against the damaging effects of discrimination. In addition, those working in social services and community outreach

(e.g. health and human services, teachers, doctors, religious clergy) need to be aware of refugees' vulnerability to psychological problems and assist those in distress in working through negative attitudes toward receiving counseling for their problems and in accessing appropriate care.

Past research on both immigrant and refugee populations has established that these groups are generally less likely to seek help than are American citizens because of a myriad of barriers to help seeking. In addition, when immigrant and refugee populations do seek help, they often still rely on traditional forms of care in addition to Western forms of mental health care. The present study suggests that for Bosnian refugees, those acculturated to American culture had more positive attitudes toward counseling. Mental health systems and outreach agencies could also benefit the psychological functioning of refugees by assisting in the acculturation process and attending to attitudes toward counseling. The current study reinforces the notion that to become acculturated, one does not have to relinquish identification with the native culture. Clinicians and outreach agencies need not fear that to support acculturation to American society is akin to inducing loss of the native identity. Given the conceptual and statistical similarity of acculturation and community connectedness identified by the current study, it is important for health care professionals and community leaders to assist individuals in fostering connections to both the native and host communities.

Finally, and perhaps most importantly, the findings of the current study implicate the significant influence of contextual factors in the health and well-being of refugees. Western models of mental illness and treatment currently place great emphasis on

biological etiology and intervention. According to the current study, clinical work with refugees must be highly sensitive to the context under which an individual came to this country (trauma) and the unique life situation they experience post-migration (acculturation, discrimination). Conceptualizing the psychological distress of refugees as having biological origination will seriously limit the ability of clinicians to alleviate psychological distress experienced by refugees.

13. Limitations and Future Directions

The primary limitation of the current research is that it relied on cross-sectional, self-report data, which makes it difficult to establish causal links among predictor and outcome variables. Research on the psychological functioning of refugees is still in its infancy, despite existing preliminary research which has paved the way to understanding pre- and post-migration predictors of distress and well-being. Future research on Bosnian and other refugee populations should utilize longitudinal designs, ideally from the time of the experience of trauma through the time of relocation to the new country and the acculturation process in order to clarify the nature of causal agents in the health and well-being of refugees.

The difficulties associated with accessing refugee populations to participate in psychological research force researchers to make certain concessions in the interest of furthering knowledge regarding their psychological functioning. This makes self-report methods of data collection appealing, because they are parsimonious and time- and cost-efficient. However, self-report data are limited because we cannot be certain how individuals from other cultures understand and/or interpret written measures, most of which have been developed and validated in Western societies and in the English language. Further research should focus on developing culturally relevant instruments utilizing interview (for example, semi-structured interview) or clinician-rated formats so

that researchers are better able to ascertain whether participants are understanding measures in the manner intended.

What is more, the generalizability of the current findings is somewhat limited given that we examined a specific refugee population at a certain time point (on average, 10 years since relocation). That being said, the current findings can inform us regarding the psychological functioning of refugees residing in the United States, and other immigrant populations in the United States. Future research may wish to include multiple refugee populations in the same sample in order to elucidate common pre- and post-migration factors related to distress and well-being, despite country of origin.

Studies on refugees in general and the present study included, face problems with the measurement of psychological distress. Applying western diagnoses to refugee populations may fail to adequately capture distress experienced. Future research should work to validate culturally specific diagnostic tools, especially for posttraumatic stress and depression, which appear to be the most common forms of psychological distress experienced by refugees. It is possible that cultural variations in response to trauma exist, painting a unique picture of posttraumatic stress symptoms among cultures (de Silva, 1999; Wilson, 2007). In addition, despite the fact that the current study utilized established methods for translating measures, to truly establish the equivalency of western and translated measures of such concepts as acculturation, discrimination, ethnic identity and help-seeking, culture-specific validation studies would need to be conducted.

The measurement of and obtained restricted range of help-seeking data is another limitation of the current study. One-item measures have limited reliability and contribute

to poor validity. What is more, participants may have had idiosyncratic cultural interpretations or understanding of questions which were posed regarding help seeking. The limited range of help-seeking data may be due to the fact that the current study did not target individuals known to have sought help. When asking a general sample whether or not they sought help, it stands to reason that instances of help-seeking may be low.

Similar problems of measurement were evident when exploring the emerging construct of community connectedness. The ICS Scale is also a one-item measure and it is also a new measure, and is not yet well-validated. Future research including the concept of community connectedness may wish to develop additional items to measure community connectedness in order to validate a multiple item measure of the construct. Despite problems with the validity of the ICS, patterns of results using this measure were highly similar to those using measures of acculturation. The current findings suggest that connections to the community may very well be a useful factor to examine when considering the functioning of refugees and the acculturation process.

14. Conclusions

Bosnian refugees included in the current study, like their counterparts from around the world, face significant risk of psychological distress and poor life satisfaction due to the experience of war trauma. Post-migration contextual factors play a large role in exacerbating or mitigating the effects of trauma. An individual's success at acculturating to the host culture while maintaining cultural practices and values of the native culture is key in reducing psychological distress and increasing life satisfaction. Emerging knowledge about developing a sense of community adds to this notion that, it is important not only to learn cultural practices and espouse cultural values, but to also gain a subjective sense of belonging to the host community. Refugees may also face ethnic discrimination in their host country. The current study adds to inconsistent findings regarding the experience of discrimination. Past research has not reached a consensus about what moderating factors are present in the relationship between the experience of discrimination and psychological distress and well-being. Past research is also inconclusive regarding which moderating factors serve as risk or protective factors for psychological distress and well-being. This suggests that more still need to be learned about the exact mechanisms by which discrimination leads to poor psychological functioning and life satisfaction.

Further, the current study suggests that despite experiencing psychological distress and poor life satisfaction, prior trauma, acculturation to American culture, perceived discrimination and connection to both the Bosnian and American communities is related to poor attitudes toward receiving counseling among refugees. Health and human services agencies in the United States need to make it a priority when working with refugees to understand the complex picture of contextual factors which impact the functioning of refugees. Traditional methods of psychological assessment and diagnosis will fail to account for essential contextual variables that contribute to distress and well-being for refugees. The current study suggests that, for refugee populations, a diagnosis of a psychiatric disorder is not equivalent to having an understanding of the psychological functioning of a refugee. In addition, much more research is needed to fully understand factors which impact the functioning of refugees and to specify appropriate clinical interventions in order to promote and/or restore psychological health and well-being.

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