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The Relationship between Acculturation and Depression among First Generation Christian Arab American Adults

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THE RELATIONSHIP BETWEEN ACCULTURATION AND DEPRESSION AMONG FIRST GENERATION CHRISTIAN ARAB AMERICAN ADULTS

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Seton Hall University

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Abstract

The Relationship between Acculturation and Depression among First Generation Christian Arab American Adults

Contrary to the common belief that most Arab Americans are Muslim, 77% of Arab Americans are Christian (Awad, 2010). There is no research that addresses the unique experience of Christian Arab Americans with the process of acculturating to the larger American society while maintaining the values of their ethnic group. The purpose of this study is to measure levels of acculturation with its two factors; ethnic society immersion and dominant society immersion, and depression with its two factors; cognitive-affective and somatic-vegetative and examine the relationships between them. In the current study, 101 Christian Arab American participants (ages 18 and above) completed three questionnaires; The Demographic Questionnaire, The Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000), and The Beck Depression Inventory-II (BDI-II; Beck, Rush, Shaw, & Emery, 1979). Results indicated that there was no significant relationship between the two acculturation subscales and the total depression score. Also, there was a significant relationship between the two acculturation scales and the cognitive-affective symptoms of depression; higher levels of dominant society immersion were associated with lower levels of cognitive-affective symptoms of depression, and higher levels of ethnic society immersion were associated with higher levels of cognitive-affective symptoms of depression. Finally, there was no significant relationship between both acculturation scales and somatic-vegetative symptoms of depression. Clinical implications, limitations of the current study, and future directions for research are provided.

Keywords: Arab American, Christian, Acculturation, Depression, First Generation, Multiculturalism.
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Dedications

To my Godson, George, for your amazing smile that inspires me into being a better person. Also to the memory of my grandmother, Wedad, for being the strong woman whose footsteps I attempt to follow every single day. Finally, to all Arab Americans and all ethnic minorities in the United States and around the world, for your inspiring perseverance and determination.
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CHAPTER I
INTRODUCTION

Mental health problems can be directly related to daily stress and experiences of prejudice and discrimination (Clark, Anderson, Clark, & Williams, 1999). Following the September 11 attacks on the United States, Arab Americans, and especially Muslims, have suffered from multiple acts of discrimination and bias against them (Abu-Raiya, Pargament, & Mahoney, 2010). The only data available that speaks to the Arab experience is that of anti-Muslim hate crimes; however, this ignores a large proportion of Arab Americans – namely, Christian Arab Americans. Contrary to the popular belief that all Arab Americans are Muslim, 77% of the Arab American population is Christian (Awad, 2010).

Upon immigrating to the United States, individuals are confronted with the culture of majority. To some extent, they will acquire the attributes of the new dominant culture and maintain the values of their culture of origin. The acquisition of the values of the dominant culture is referred to as “acculturation,” and the retention of the values of the culture of origin is referred to as “enculturation” (Hwang, Wood, & Fujimoto, 2010). Research suggests that the acculturation/enculturation processes are directly related to mental health as well as the intergenerational gap within the immigrant family (Dinh & Nguyen, 2006). Literature also suggests that there has been sufficient support in the literature to conclude that the acculturation/enculturation gap between generations is not directly related to depression. Hwang, Wood, and Fujimoto (2010) suggested that the reason behind the uncertainty and mixed findings to be the lack of a clear definition of the process of acculturation. They suggested that further refinement of the instruments
measuring levels of acculturation among ethnic minorities and immigrant groups is essential. As a result, research findings have been contradictory and inconsistent at times (Hwang, Wood, & Fujimoto, 2010).

Furthermore, there has been an increased interest in depression among ethnic minorities (Crockett, Randall, Shen, Russell, & Driscoll, 2005). There is sufficient evidence to suggest that depression is experienced, perceived, and treated differently in different cultures. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-TR (American Psychiatric Association, 2000) states that there are certain mood disorders and other mental illnesses that are culture-specific. Minority groups in the United States are likely to experience depression as a result of discrimination or perceived discrimination against them (Meyer, 2003). This effect has been observed in Latinos (Abber, 2002) and Asian Americans (Liang, Li, & Kim, 2004). It was also concluded that the stress experienced by minority groups (i.e. Latinos, African Americans, and Asian Americans) is positively related to symptoms of depression and negatively related to their individual perceived bicultural competence (Wei, Liao, Chao, Mallinckrodt, Tsai, & Botello-Zamarron, 2010). Other research suggests that ethnic minority groups are at a higher risk of experiencing symptoms of depression than White Americans. That being said, research results remain inconsistent in revealing similarities between ethnic minority groups and White Americans experiencing depression (Plant & Sachs-Ericsson, 2004). Despite the inconclusive results, there is reason to believe that because minority groups belong to collectivistic cultures and tend to have more social and familial support than White Americans, they are more able to cope with depression (Plant & Sachs-Ericsson, 2004).

Depression became a variable of interest in the current study, especially among Christian Arab Americans. Due to inconsistencies in research addressing depression among ethnic
minorities, it will be interesting to investigate the manner in which depression manifests itself among a unique and under-researched ethnic minority, such as Christian Arab Americans. Interpreting one’s experience with depression from a cognitive theory perspective takes into account not only the individual’s behavior, but also their thinking and feeling processes. Clark, Beck, & Alford (1999) suggested that the affective or emotional state is an integral part of a person’s experience with depression. One’s affective state is likely to be impacted by messages received from the environment or vice versa. The four factors that are considered to influence one’s emotions and are basic for his or her well-being are survival, security, procreation, and sociability (Clark, Beck, & Alford, 1999). As far as cognition and depression, Clark, Beck, & Alford (1999) stated that,

In depression, the negatively oriented schemas that represent the self tend to be more rigid, absolute, and impermeable (A. Beck, 1961; Beck, & Freeman, 1990). Depressed individuals would also be expected to have negative self-referent beliefs that are more tightly interrelated and complex than the negative self-constructs of nondepressed persons. Thus, the cognitive theory recognized that structural features as well as thematic content distinguish the schemas activated in depression from schemas dominant in the nondepressed state. (Clark, Beck, & Alford, 1999, pp. 80-81)

In addition to schemas addressing cognition and emotion, there are schemas that are physiological and somatic (Clark, Beck, & Alford, 1999). Physiological schemas, according to the cognitive theory, are responsible for messages sent to and from the body that mostly involve basic emotions. Those processes are specifically evident and apparent in anxiety and panic disorders (Clark, Beck, & Alford, 1999). Further, another schema that
goes along with the physiological one is the behavioral schema. It includes voluntary and involuntary behaviors, actions, and reactions. Clark, Beck, & Alford (1999) specified four possible behavioral processes: mobilization that includes fighting back or escaping the scene, inhibiting risk-taking, avoidance, and execution of behavior. It is quite interesting to note that,

In depression, behavioral schemas representing conscious intentional strategies aimed at conserving one’s energy and resources will be prominent (e.g. social withdrawal, lack of response initiation, isolation, and passivity). (Clark, Beck, & Alford, 1999, p.86)

The Arabic culture is collectivistic in nature, which might ameliorate the perception and experience of depression through social and familial support. It is unfortunate that symptoms of depression, cognitive, affective, physiological, and environmental, have not been uniquely addressed among Christian Arab Americans as of yet. Following the previous discussion of acculturation and depression, I have felt the need to further investigate their relationship. This is true especially due to the aforementioned lack of consistency and increased uncertainty in research findings. First generation Christian Arab Americans have not been uniquely investigated in the field of mental health research. If addressed, the relationship between acculturation and depression among them might prove beneficial for Arab Americans and other ethnic minorities, and may provide a foundation for further investigation. Thus, the purpose of the present study.

Arab Americans have arrived to the United States from more than 19 countries in the Middle East. They immigrated to the United States in three significant periods of immigration (Erickson & Al-Timimi, 2001). The first wave occurred toward the end of the 19th century, when Arabs mostly arrived from Syria and Lebanon. The second wave occurred after the establishment of the State of Israel in 1948 and mostly consisted of Palestinian professionals,
students, and refugees. The aforementioned immigrants included Muslim as well as Christian Arabs. The third wave took place in 1967 after the defeat of the Arab countries in the war with Israel (Abraham, 1995; Erickson & Al-Timimi, 2001).

The Arab countries have been through multiple economic, political, and social changes (Timimi, 1995). A significant political event that took place in 1948 was the establishment of the State of Israel. Economically, the presence of oil in Arab soil has been an influential factor in Arab as well as the international business considerations. Consequently, the Arab world has suffered instability that has impacted all levels of the population and reached the family structure. War and violence have been recurrent themes in Arabic family life causing trauma to its members of varying degrees (Timimi, 1995).

The Arab American Institute (AAI; n.d.) estimates that there are approximately 3 million individuals of Arab descent in the US and most of them live in metropolitan areas. Erickson and Al-Timimi (2001) stated that “the exact number of Arab Americans is not known, because often they are reluctant to identify themselves as being of Middle Eastern descent…before 1920 Arab immigrants were classified as Turks; later they were classified as Syrian, Asian, or African; and Palestinians who have emigrated since 1948 have been classified as nationals of the country from which they came, including Israel” (Erickson & Al-Timimi, 2001, p. 309). The majority of Arab Americans have ancestry in Lebanon, Syria, Egypt, Palestine, and Iraq (Moradi & Hasan, 2004). According to the U.S. Department of Homeland Security (2010), the number of individuals who immigrated to the United States from the Arab world (i.e. Egypt, Lebanon, Syria, Libya, Jordan Iraq, Morocco, and Tunisia) between the years 1990 and 2000 was over 245,000.
Generally speaking, and within the field of mental health, there is a need to distinguish among the various Arab American groups. Despite the shared experiences between Arabs, there are numerous within-group differences. For example, Arabs differ in their Arabic dialect, education, finances, and religion (Moradi & Hasan, 2004). However, Arabs share a number of similarities that are related to the collectivistic nature of the Arabic culture. Most importantly, a great value is placed upon the family as a whole, and its needs that surmount individual desires (Abudabbeh, 1996). The Arabic culture is characterized by loyalty to figures of authority whether it is within the family, community, or larger society (Ahmad & Soenens, 2010). Dwairy (2004) described the Arabic family structure as “authoritarian, patriarchal, and interdependent” (as cited in Ahmad & Soenens, 2010, p. 758).

Country of origin is also an important contributor to the diversity among Arab Americans. Erickson and Al-Timimi (2001) reported that Arabs who arrive from Saudi Arabia are more likely to be Muslim with a conservative outlook on the world, while Arabs arriving from Lebanon or Syria are more likely to be Christian with a view of the world that is closer to the western perspective. Erickson and Al-Timimi (2001) discussed the Arab American experience as follows:

Relocating to a foreign culture can be complicated, challenging, and stressful. Among the factors that may affect Arab Americans’ acculturation experiences are country of origin, length of time in the United States, reasons for emigration, whether they have family still living abroad, their ability to return to or visit their home country, and their long-term plans to stay in the United States. Additionally, language factors such as ability to speak English or the presence of a discernible accent may affect individuals’ acculturation experiences or be a source of stress in their lives.
Another factor to consider in understanding Arab Americans’ cultural adjustment is their family’s educational and economic status in their home country and the degree to which these have changed since coming to the United States, because such differences can be dramatic and represent a significant source of stress for families. (p. 312)

It is accepted and well-known that men in Arab families are the head of the family, and women are considered to have less of an active role. Nonetheless, women hold an important position in their families and may choose to remain outwardly passive. Arab families consider relatives and extended family members as important as nuclear family members. It is not uncommon to witness families with two or three generations residing together and taking care of each other. Consequently, respecting the older generations is also an integral part of the Arab family life (Erickson & Al-Tamimi, 2001).

Ethnic minority groups in the United States are expected to increase by the year 2050 and (Camarota, 2007; Tran, Lee, & Burgess, 2010). Consequently, increased attention should be given to each ethnic group’s unique experiences, especially with discrimination and its impact on the level of emotional and mental distress. This is especially true since there is very little research addressing immigrant challenges versus those of the population at large (Tran, Lee, & Burgess, 2010; Williams, Neighbors, & Jackson, 2003). Discrimination, for example, is associated with increased mental distress specifically among first generation immigrants, those who were not born in the United States. Discrimination is present in the vocational, financial, and legal fields among others (Howertin, 2006; Quillian, 2006; Tran, Lee, & Burgess, 2010). Consequently, the population of interest in this study is first generation Christian Arab Americans. It is also
due to the lack of research addressing intergenerational differences among this specific population.

According to William and Mohamed (2009), it is evident that discrimination can also be perceived subjectively by individuals from the various ethnic minorities. Perceived ethnic discrimination (PED) can go unnoticed by others who are not necessarily familiar with discriminatory acts. Here too, discrimination, whether actual or perceived, is strongly associated with mental distress (Clark et al., 1999). In a survey conducted by Kessler, Mickelson, and Williams (1999) it was stated that:

Major lifetime discrimination (e.g., discrimination in being fired from a job, hassled by the police) is common in the entire population, affecting 33.5% of individuals. In addition, 60.9% of this national sample reported experiencing daily forms of discrimination (e.g., poor customer service, insults, name calling). They also found that the top reason ascribed to discrimination was race/ethnicity, and major lifetime discrimination was more common among non-Whites compared to Whites. Thus, discrimination appears to be pervasive in the general population, but racial/ethnic minorities in the U.S. bear a disproportionate amount of the burden. (p. 208)

A study conducted by Moradi and Hasan (2004) examined mental health experiences among Arab Americans who were subjected to acts of discrimination. Both authors were motivated by the lack of research examining the impact that discrimination has on the mental health of Arabs living in the United States. Results indicated that, among Arab Americans, discrimination and its direct impact on mental distress are perceived as similar to the perception of other minorities, such as White women and African American men and women. These
findings may allow one to generalize the distress experienced by various minority groups to Arab Americans (Moradi & Hasan, 2004).

Further, Moradi and Hasan (2004) investigated the mediating effects of self-control and self-esteem in the relationship between discrimination and distress. A strong mediating role was found for one’s sense of self-control, and a lesser impact, yet still significant, was found for the level of self-esteem. It is therefore not a surprise that acts of discrimination result in feeling a lack of control over one’s life experiences among Arab Americans.

Abu-Raiya and Pargament (2011) examined coping skills among Muslims in the United States following the September 11 attacks. The study included 138 participants who were Muslim and living in the United States after the attacks. Their results indicated that “about 86% of participants reported hearing anti-Muslim comments at least once; 68% indicated undergoing special security checks in airports at least once; 60% reported experiencing discriminatory acts at least once, and 55% indicated experiencing verbal harassment at least once” (p. 7). Moreover, “88% of the respondents found the negative events to be stressful to some degree” (Abu-Raiya & Pargament, 2011, p. 7).

The processes of transition and change that take place in one’s life upon moving to a culture that is different from their culture of origin can require the utilization of survival and coping skills. In order to practice mental health ethically, therapists ought to be aware of the various adaptation techniques their clients use during the acculturation process (Wade, Cairney & Pevalin, 2002). According to Wade, Cairney, and Pevalin (2002), intercultural contact includes the various acculturation attitudes and social interaction that individuals engage in. These interactions vary, and they influence one’s
perception of his or her culture as well as the culture he or she moved to. Furthermore, an essential part of being ethical is committing to equal treatment for all with honesty and integrity (Corey, Corey & Callahan, 2007).

As previously stated, there is a scarcity of research investigating depression as it relates to the acculturation process among Arab Americans. Further, the mental health field has failed to address the distinct experiences of first generation Christian Arab Americans, whether in research or clinical practice. It is also advisable to address the within-group differences among Christian Arab Americans upon researching their experiences of acculturation, enculturation, and depression. Acculturation to the majority culture and enculturation within the culture of origin are not necessarily two separate experiences, or two extremes of one spectrum. Therefore, there is a need to examine the relationship among acculturation, enculturation, and depression among first generation Christian Arab Americans. Evidence suggests that the physical health of ethnic minority individuals is impacted by the process of acculturation more than their mental and emotional state (Lam, Yip, and Gee, 2012; Reyes-Ortiz & Markides, 2010). Given the lack of prior research with this group, the study is exploratory in nature and no a priori hypotheses are proposed.

**Research Questions**

1. What is the overall relationship between acculturation and depression among first generation Christian Arab Americans?

2. What is the relationship between the cognitive-affective symptoms of depression and ethnic society immersion?

3. What is the relationship between cognitive-affective symptoms of depression and dominant society immersion?
4. What is the relationship between somatic-vegetative symptoms of depression and ethnic society immersion?

5. What is the relationship between somatic-vegetative symptoms of depression and dominant society immersion?

**Definitions**

*Acculturation.* According to Hwang, Wood, and Fujimoto (2010), acculturation implies the individual’s involvement in the culture of the majority including an acquisition of its cultural values and beliefs. It was also defined as the process that takes place when people from two different cultural groups come in constant contact with each other (Berry, 1986). Acculturation on the individual level reflects changes to the personality on various levels, including “behavior, language, values, and identity” (Dinh, Roosa, Teinm, & Lopez, 2002, p. 296). Acculturation is operationally defined by the SMAS (Stephenson, 2000) as the measure of ethnic society immersion and/or dominant society immersion. Ethnic Society Immersion (i.e. enculturation), refers to the retention of the attributes of one’s ethnic group or culture of origin, and Dominant Society Immersion (acculturation) refers to the extent of which a member of an ethnic minority group will acquire the attributes of the culture of majority (i.e. the host culture).

*Depression.* According to Kazarian and Taher (2010), depression is characterized with “depressed mood and feelings of guilt, worthlessness, hopelessness, and helplessness” (p. 68) in addition to somatic symptoms such as “psychomotor retardation, loss of appetite, and sleep disturbance” (Kazarian & Taher, 2010, p.68). A Major Depressive Disorder is characterized by a depressed mood that is “present for most of the day, nearly every day, for a period of at least 2 consecutive weeks” (DSM-IV-TR, 2000, p. 349). In the current study, depression is operationally defined by the BDI-II as it impacts the individual’s cognitive/affective as well as
somatic/vegetative state. The cognitive-affective symptoms of depression refer to the beliefs that one holds about him or herself or the environment and the emotions and feelings that are impacted by messages received from the environment. The somatic-vegetative symptoms of depression refer to physiological messages received to and from the body, in addition to voluntary and involuntary behaviors, actions and reactions.

Multiculturalism. According to Gallardo, Johnson, Parham, and Carter (2009), when defining culture we have to take into account race, ethnicity, religion, language, gender, and sexual orientation in addition to various environmental aspects that might be influential to one’s cultural identity formation. Culture is also defined by the interaction one has with the surroundings, whether on an individual or communal level (Gallardo, Johnson, Parham, & Carter, 2009).

Arab. According to Erickson and Al-Timimi (2001), “the word Arab refers to an ethnically mixed group of individuals and is more often used as a cultural and linguistic term than a racial one” (p.317). The American-Arab Anti-Discrimination Committee (ADC) offers two definitions of Arabs. The first is all those who speak the Arabic language and the second definition includes all Arab Americans who immigrated here from any of the 22 Arab countries (ADC, as cited in Moradi & Hasan, 2004). Nonetheless, it is important to keep in mind that despite the possible shared descent, geographically, and the language, traditions and values, Arabs remain to be an extremely diverse group (Naff, 1983). Operationally defined, an Arab is anyone who self-identifies as Arabic or an Arab.

Arab American. Operationally defined, an Arab American is anyone who self identifies as a U.S. citizen with Arabic roots.
Christian. Operationally defined, a Christian is anyone who self-identifies as Christian, Catholic, or Greek or Roman Orthodox.

First Generation. Operationally defined, first generation implies those who self-identify as immigrant (i.e. were born outside the U.S.).
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The current study investigates the unique relationship between acculturation and depression among first generation Christian Arab American adults. In this chapter, I will present information that is relevant to the research on the Christian Arab American population or the lack thereof. Stemming from demographic information about Arab Americans will be a discussion on the importance of acknowledging the uniqueness and diversity of this population. To follow, I will present an overview on acculturation, alongside studies that have addressed it among ethnic minorities and underrepresented groups in the United States. Various models of acculturation and theoretical backgrounds will be discussed in order to further investigate their implications in the field of mental health. Also, ethnic minorities are confronted with multiple challenges related to the adaptation to the culture of the majority. The discussion around challenges will be followed by an investigation of coping skills and resiliency among ethnic minorities, specifically, Arab Americans.

The other half of the chapter will begin with a review of the Arab American experience with acts of bias and discrimination. The 9/11 attacks on the United States have resulted in an increase in discrimination and hate crimes against Arabs in the US. Further, there will be a reference to historical events leading to dissatisfaction among Arab Americans with U.S. foreign policy. Consequently, there will be an examination of religious coping among other methods of addressing the aforementioned challenges. Discrimination can also increase mental distress that is related to the process of acculturation. Thus, there will be an investigation of the definition of depression in the field of mental health. Multiple theories, symptoms, and measures of
depression are presented in an attempt to assert the need for culturally sensitive definitions and
measurements. Understanding the uniqueness of depression across Arab American individuals
and communities is crucial to the development of culturally appropriate instruments. Lastly,
religion is analyzed as an important factor in a person’s decision making process, resiliency, and
survival mechanisms. These processes are especially necessary upon transitioning to a new
culture and confronting multiple stressors. Both Islam and Christianity are addressed, yet a larger
focus is placed on Christianity, the religion of participants in the current study.

The current chapter will discuss the relationship between acculturation and depression.
The aforementioned constructs will be addressed in relation to first generation Christian Arab
American adults, who have gone through the process of acculturation/enculturation at various
levels while confronting different challenges. Consequently, an argument would be made as far
as the relevance of additional research among Arab Americans and their unique psychological,
social, cultural, and religious experiences in the United States.

**Arab Americans and Within-Group Differences: Diversity and Uniqueness**

The Arab American Institute (n.d.) found that there are approximately three million
Arabs in the United States. Arabs arrived to the United States in three major waves of
immigration. The first wave was in the late 1800s and early 1900s, consisting mostly of Christian
Arabs who arrived from Syria and Lebanon in search of a better life. The second wave occurred
after World War II; more specifically, it occurred after the establishment of the State of Israel in
1948. Due to political reasons, many people had to escape Palestine and the region as a whole in
search of safety. In the second wave, Arab immigrants were mostly Muslim. As for the third
wave that took place in 1967 and most recently, the wave of immigration that has been taking
place since the 90s. These groups have consisted of mostly Muslims and individuals who were
seeking stability and safety in the midst of war and political instability in the Middle East (Abraham, 1995; Awad, 2010; Beitin, Allen & Bekheet, 2010).

To discuss within-group differences among Arab Americans, it is important to address their commonalities first. Being an Arab refers to those whose roots go back to one of the 22 Arab countries that are Egypt, Libya, Algeria, Morocco, Tunisia, Syria, Lebanon, Jordan, Palestine, Saudi Arabia, Qatar, The United Emirates, Oman, Yemen, Iraq, Sudan, Somalia, Kuwait, Mauritania, Djibouti, Comoris, and Bahrain (AAI, n.d.; Awad, 2010). The term Arab refers to the culture as well as the language. Regarding the Arabic culture, it is considered to be collectivistic. Therefore, the family needs take precedence over individual needs, and the elderly are very well-respected (Haboush, 2007). Children in Arab families are supposed to be protected and they are dependent on their family until they get married. Some families insist on maintaining that dependence even after marriage. Food is also an important element in the Arabic culture. Families gather around meals, and it is considered to be of great honor to invite a family member, a friend, or even a stranger to join a family for a meal. Generosity and hospitality are characteristics of Arabs that have been celebrated throughout the years. The head of the family would opt to feed the guest and display the best hospitality even at the expense of his children. Hospitality is also related to a family’s name and reputation in the tribe, village, or town. Maintaining a good reputation, if not an excellent one, and being known as generous, honest, and courteous is extremely important for Arab families. The extreme to which families tend to practice all that differs among Arabs from different countries, cities, and small villages. As for fashion and clothing, Arab women, both Christian and Muslim, used to wear long robes that covered the whole body, in addition to a head cover. Men, as well, used to wear big pants, long sleeve shirts, and a head cover that is called the hatta or koufiya. Nowadays, only traditional
and religiously conservative villages around the Arab world maintain the aforementioned sense of traditional fashion. Arab women and men have become increasingly westernized throughout the years and have somewhat acculturated to the western ways of living without having to be in direct contact with the west. Satellite channels, internet, and media, among others sources, have gradually turned the world into what is known as “a small village.” The Arabic culture has been exposed to the westernized and individualized life-style. This has also reflected upon romance and love. A man and a woman used to be matched in order to marry and would only see each other the day of the wedding. Nowadays, the norm became that girls and boys, women and men are able to date and socialize with minimal to no restriction in some Arab countries. Nonetheless, the Arab world remains conservative, and Islam continues to have the greater impact on the daily social, political, and interpersonal decision making processes of Muslim as well as Christians living in primarily Islamic countries. Further, religion is another commonality among Arab Americans. Among Christian Arab Americans specifically, 42% are Catholic (e.g. Syrian Catholic, Maronite, Greek Catholic), 23% are Orthodox (e.g. Coptic and Syrian Orthodox), and 12% are protestant (Samhan, 2006). Since the 1950s, Arab Muslims have been the fastest-growing segment of Arab Americans and make up approximately 23% of the Arab American population (Samhan, 2006 as cited in Awad, 2010)

Despite the fact that both religions are different in many ways, they share their lack of identification with the individualistic American culture, in addition to a few religious practices, such as fasting (Awad, 2010). Nonetheless, Muslim Arabs have a higher attachment and retention to their culture of origin than Christian Arabs (Awad, 2010). As for the Arabic language, some might argue that some Arabs do not speak the
Arabic language, yet are still considered Arabs (Awad, 2010). That being said, speaking the Arabic language is one major commonality among most Arabs.

Acculturation occurs at various rates and levels among minority and underrepresented groups in the United States. A study conducted by Faragallah, Schumm, and Webb (1997) found that Christian Arab Americans acculturate more—at a higher rate and level—than Muslim Arab Americans. The study supported the fact that the age of arrival to the United States is significant. That is, those who arrived at an early age were more likely to acculturate to the American culture; at a faster rate and a deeper level than those who arrived in later stages of adulthood. Nonetheless, very little research has addressed the uniqueness of the Arab American experience with acculturation. More specifically, no existing research has addressed the Christian Arab American experience with acculturation. The reason might be that Christian Arabs tend to blend into the American culture that is mainly Christian, and are less physically visible. Muslims are more visible due to men with beards, long robes, and special head covers, and women wearing the hijab (Awad, 2010).

Moradi and Hasan (2004) discuss the within-group differences among Arab Americans and acknowledge the uniqueness of the individual experience. Arabs do not only arrive to the United States from different Arab countries, but they also vary on community, family and individual bases. Variability arises as well from the level of education, socioeconomic status, time of immigration, age of arrival to the United States, the Arabic dialect or language spoken, religious beliefs, and many more aspects that result in a noteworthy within-group variability (Moradi & Hasan, 2004). However, it is important to keep in mind the shared experiences among Arab Americans addressed earlier. The aforementioned differences and commonalities among Arab
Americans ought to be examined upon investigating the acculturation process and its relationship with mental distress.

**Acculturation: Theory and Definition**

Researchers in the field of mental health have defined acculturation from various perspectives. One of the most popular definitions of acculturation came from Berry (1980), who described it as the contact between a person from one culture with a totally new and different culture. The result of such a process would require a certain amount of adaptability (Berry, 1980). Zamboanga (2010) encouraged his readers to define culture prior to defining acculturation. He then referred to Shore’s (2002) definition of culture as the “shared meanings, understandings, or referents held by a group of people” (Shore, 2002 as cited in Schwartz, Unger, Zamboanga, & Szapocznik, 2010, p. 240). Further, Schwartz and Zamboanga (2008) stated that acculturation is usually addressed from the experience of the immigrant as opposed to being perceived as a process affecting both the culture of origin and the host culture. It seems to be reasonable to believe that changes that take place among immigrants will also result in the need for adaptation by the culture of majority. Schwartz and Zamboanga (2008) believe that the attention to acculturation was initiated following the large wave of immigration in the late 60s, which was mostly from collectivistic cultures. The United States has also been experiencing additional waves of immigration in the last two decades resulting in a certain mixture of the various ethnic minority cultures and the American culture (Schwartz & Zamboanga, 2008).

In a research study by Borrayo and Jenkins (2003), the process of acculturation was conceived from the learning perspective. It was stated that acculturation involves the adaptation of what was learned in one’s culture of origin into the new culture. It is also important to note that, during the 80s, researchers were acknowledging confounding
variables within their descriptions of acculturation. For example, Griffith and Villavicencio (1985) addressed the importance of socioeconomic factors that might influence the relationship between acculturation and immigrants’ beliefs and behaviors upon arrival to the United States. In addition to the socioeconomic status, Schwartz et al. (2010) addressed multiple other aspects of acculturation that cannot be overlooked. He focused on the influential and interactive nature of the process of immigration between the individual immigrant and the host culture. Schwartz et al., (2010) stated that

The context includes the characteristics of the migrants themselves, the groups or countries from which they originate their socioeconomic status and resources, the country and local community in which they settle, and their fluency in the language of the country of settlement (p. 240).

In their 2003 study, Chun, Organista, and Marin described “culture change” as the abandonment of one’s “indigenous” culture in order to adapt to another culture, which is usually of a White majority. They asserted that when acculturating, immigrants choose between retaining their culture of origin and adopting the host culture (Chun, Organista, & Marin, 2003). More specifically, Miller (2007) addressed acculturation as a change from one’s culture of origin to a host culture. However, he also specified that the adaptation process manifests itself in various fields such as “language, ethnic identification, cognition, affective expression, and affiliation preferences” (Miller, Kim, & Bennet-Martinez, 2011, p. 300). It is evident that acculturation has been defined similarly by multiple researchers along the years, yet minor differences apply within those definitions. Upon choosing to adopt a definition, one ought to take into account the uniqueness of each definition and the details it accounts for. Also, one should take into consideration the manner in which the definition applies to his or her specific sample of an ethnic
minority group. Relevant to the current research, when addressing Arab Americans, there are multiple challenges and within-group differences that will be discussed later on.

Further, Berry (2006) has also accounted for possible reasons for immigration and the types of people who immigrate. He differentiated between four types of immigrants: Voluntary immigrants, refugees, asylum seekers, and sojourners. The voluntary immigrants are, just as the name implies, those who leave their countries of origin out of their own free choice for purposes of employment, marriage, or other reasons. The refugees are those individuals who were forced out of their countries for reasons of wars, natural disasters, and other similar dramatic and life threatening events. As for asylum seekers, those are the ones who choose to seek stability and safety in another country out of fear for their lives. The sojourners are those who relocate to a different country to accomplish a specific goal during a certain period of time with the intention of returning to their home country when the goal has been attained (Schwartz et al., 2010).

Regardless of the reasons for immigration and whether it was voluntary or forced, acculturation occurs differently among immigrant. Its characteristics can progress at different rates taking into account the individual and the family experiences. Also, it is important to take into account the impact acculturation has on immigrants’ lives including their economic, social, and educational status (Birman & Trickett, 2001).

Mental health professionals have been interested in the process of acculturation since the 1930s (Cheung, Chudek, & Heine, 2010). The impact that acculturation has on the mental and physical well-being of individuals and families has always been of interest to psychologists. It has been clear that the process of acculturation is stressful and entails multiple challenges and difficulties. Nonetheless, it required decades of research to delve into the various possible challenges and survival techniques. Therefore, to better understand acculturation, various models
were created. Berry, Trimble, and Olmedo (1986) suggested four different possible categories for acculturation. They chose to expand the bidimensionality and independence of both constructs; the receiving culture and the heritage culture. The four suggested categories allowed for certain fluidity among them, which in turn accounted for individual differences as well. The first category of acculturation suggested was integration, which refers to the strong identification with both the culture of origin as well as the host culture. Thus, the individual or the family is able to become a part of value system and tradition of the hosting culture. Nonetheless, integration assumes that the immigrant individual or family will not ignore, neglect, or marginalize their heritage, and will continue to celebrate it. The second category was referred to as assimilation, indicating a strong identification with the culture of majority or the host culture. Upon assimilating to the host culture, an individual or a family will cease to practice and attend to the values of their heritage culture. They will adopt the values, tradition, and beliefs or the host culture and attempt to gain a complete sense of belongingness to it. The third category was referred to as separation. It refers to those who strongly identify with their culture of origin and neglect the hosting culture. Thus, the individual or family would practice the traditions, rituals, language, food, and fashion of their heritage culture and fail to adopt those of the host culture. The last acculturation category was referred to as marginalization, which refers to the lack of identification with either the culture of origin or the host culture. In such a situation, the individual or family will presumably fail to belong to either the host or the heritage culture. As a result, there will be a lack of belongingness to any culture, and an ambiguous sense of identity.

The bidimensional acculturation model refers to the two orthogonal dimensions along which the immigrant’s acculturation status exists. According to the bidimensionality model, acculturation lies on two dimensions: the first is the acculturation dimension and the second is
the enculturation scale. One can be high or low on these dimensions. This model supported Berry’s (1986) model of acculturation. Chun, Organista, and Marin (2003) supported the bidimensional model and identified four possibilities resulting from it. Those possible outcomes, although supportive of Berry’s (1986) acculturation model, were labeled differently. Chun et al. (2003) labeled the process of maintaining the culture of origin as Traditional, the process of complete adaptation to the culture of majority was labeled Acculturated, avoiding both cultures was labeled Marginalized, and being immersed in both cultures was labeled Bicultural (Chun et al.; Corral & Land, 2008). Certain researchers refer to the retention of the culture of origin as an “in-group orientation.” The term refers to the extent to which immigrants are oriented toward their own culture’s value and belief system. In contrast, those who choose to adapt to the American culture are referred to as having an “out-group orientation” (Schwartz et al., 2011).

Among the critics, Rudmin (2003) suggests that it is quite impossible to locate a clear and specific mid-point on either dimension, which makes it even harder to generalize results to other ethnic minorities. In addition, Schwartz et al. (2010) referred to Del Pilar and Udasco (2004) who argue that it is extremely difficult to assume that an individual can marginalize both the host culture and culture of origin, and remain without a cultural identity. This argument is supported by the fact that measures of marginalization have extremely poor psychometrics and thus ought to be addressed and utilized with caution (Unger, Gallagher, Shakib, Ritt-Olson, Palmer, & Johnson, 2002).

It has recently been suggested that the process of acculturation should be examined from a multidimensional perspective (Rudmin, 2009; Schwartz et al., 2010). It is argued that acculturation includes multiple levels related to the behavioral, cognitive, and affective aspects of an individual’s functioning (Kim & Abreu, 2001). Multiple
authors have offered their own interpretation of the three main domains of acculturation previously discussed. For example, Chirkov (2009), Rudmin (2009), and Schwartz et al. (2010) (2010) have all suggested that the behavioral domain of acculturation includes language, media, and food among other things; the cognitive domain refers to the individualistic versus the collectivistic approach to life; and the affective domain refers to the attachment and sense of belongingness to the host country or the country of origin. It is interesting to note that the concepts of individualism and collectivism were defined in the early 70s. According to Triandis (1972), individualism is described as putting one’s needs before the group he or she belongs to, such as his family and community. He also referred to collectivism as putting others’ needs over the individual ones.

Individualism and collectivism are related in many ways to the concept of independence and interdependence. According to Schwartz et al. (2011), one can address those two concepts as essential parts of the process of cognitive acculturation. Consequently, it is argued that the American culture in the United States has been consistently characterized as individualistic and supportive of the individual’s independence. Thus, it could be proposed that immigrants who adapt to the U.S. culture become increasingly independent and individualistic. However, those who choose to retain their culture of origin maintain their sense of interdependence and collectivism (Schwartz et al., 2011).

The multidimensional model of acculturation has been recently perceived as inclusive and reliable. Borrayo and Jenkins (2003) considered the multidimensionality of acculturation as accounting for the fact that people acculturate differently and at different rates. They mentioned, as an example, immigrants of Mexican descent who tend to acculturate differently than other groups of Latino immigrants (Borrayo & Jenkins). Birman and Trickett (2001) conducted a study
that combined both the orthogonal as well as the multidimensional models of acculturation. They were interested in the “Cultural Transitions in First-Generation Immigrants: Acculturation of Soviet Jewish Refugee Adolescents and Parents” (Birman & Trickett, 2001). They examined acculturation independently among both cultures (i.e., the host culture and the culture of origin) alongside the three aforementioned multidimensional domains of acculturation (i.e., behavioral, cognitive, and affective).

Nonetheless, I opted to label the three domains as the behavioral domain, the language competence domain, and the cultural identity domain. Interestingly enough, Birman and Trickett (2001) also accounted for the arrival age to the United States, which was believed to influence the level of acculturation. Results indicated that the more acculturated immigrants were to the U.S. culture, the less enculturated they were to their culture of origin. As a result, the aforementioned results were supportive of the orthogonal model of acculturation. The authors also argued that first generation immigrants are the ones that go through the most impactful and influential acculturation process (Birman & Trickett, 2001). Consequently, despite the suggested multidimensionality of the acculturation process, there is supportive evidence for the applicability of the bidimensional model among immigrants. Therefore, one can conclude that further research is required in order to better determine the similarities, differences, and overlap between both the bidimensional and the multidimensional models of acculturation.

**Acculturative Stress: Challenges, Resiliency, and Coping**

In addition to examining the impact of acculturation on immigrants, it is important to be able to discuss the challenges presented by the hosting culture (Schwartz
et al., 2010). In an attempt to understand the multiple facets of acculturation, there is a need to address the challenges it poses for immigrants. Acculturative stress was defined as “a physiological and psychological state brought about by culture-specific stressors rooted in the process of acculturation (Berry et al., 1987 as cited in Miller et al., 2011, p. 300). In support of Berry et al.’s (1987) definition, Miller, Kim, and Bennet-Martinez (2011) suggested that the acculturative stress has a strong influence on the immigrant’s physical, psychological, and social functioning. Socially, it is presumed to be quite stressful to get accustomed to new social norms and values in the host culture (Miller et al., 2011). An additional source of acculturative stress is related to the distance and differences between the immigrant’s country of origin and the American culture (Miller et al., 2011). It is suggested that acculturative stress increases as the gap between one’s culture of origin and the U.S. culture widens (Berry, Poortinga, Segal, & Dasen, 2002; Miller et al., 2011; Suanet & Van de Vijver, 2009). To follow, one can assume that acculturative stress would be increasingly present among first generation Christian Arab Americans. This is due to the fact that the Arabic culture is known to be a collectivistic culture compared to the individualistic western culture represented in the United States as well as several European countries. One can also predict the presence of generational gaps, especially if the age of arrival to the US is accounted for. A study conducted in 1964 by Gordon attested to the fact that first generation immigrants will only partially acculturate to the host culture, whereas second generation immigrants will most likely be fully acculturated to the American culture (Gordon, 1964). Moving in time from the 60s to the 90s, Puerto Rican adults were found to be increasingly acculturated to the American culture the longer they resided in the US. They are also decreasingly enculturated to their culture of origin (Cortes, Rogler, & Malgady 1994). As for Christian Arab Americans, those of a Middle Eastern descent, acculturation among them has not
been addressed. The field of mental health has failed to examine the impact of the acculturation process on Christian Arab Americans, and this is where the importance of the current study lies.

Discrimination against immigrants in the United States challenges posed by the process of acculturation. According to Schwartz et al. (2010), discrimination against minority groups by the culture of majority has been common for decades, if not centuries. It has been proven that experiences of discrimination strongly impact the physical and mental health status of minority groups (Galliher, Jones, & Dahl, 2011). Multiple studies have confirmed the positive correlation that exists between acts of discrimination and mental distress, depression, and anxiety (Whitbeck, Hoyt, McMorris, Chen, & Stubben, 2001; Williams, Neighbors, & Jackson, 2003).

Germine Awad (2010) investigated the impact of acculturation and religious identification on perceived discrimination among Arab and Middle Eastern individuals. Awad (2010) investigated acculturation as it manifested itself in immersion in the dominant society or the culture of origin. The sample consisted of 177 participants of an Arab/Middle Eastern descent, with 114 females, 61 males, and 2 who did not specify; participants had a mean age of 29 (range 14-65). In terms of education, 53% of participants stated that they were not students. As for religion, 45% were Christian, and 42% were Muslim. Participants whose country of origin was Egypt consisted of the largest group, 36% of all participants. As for Palestinians, they consisted of 17% and 7% from Iraq. Further, 52% indicated that they were first generation immigrants (born outside of the US) and 33% were second generation immigrants (born in the US to immigrant parents). As for the length of stay in the United States, it ranged from 1 to 44
years. In terms of socioeconomic status, 42% reported being middle class and 34% reported belonging to the upper-middle class. The survey was distributed in person, via mail, and email, as well as through professional listservs that are interested in Arab Americans issues (Awad, 2010).

The author utilized multiple measures in order to account for the impact of acculturation, religious affiliation, and ethnic identity on the perception of discrimination among Arab/Middle Eastern participants (Awad, 2010). The first measure was the Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000). It measures two dimensions of acculturation on a 4-point Likert scale: ethnic society immersion and dominant society immersion. The Perceived Ethnic Discrimination Questionnaire (PEDQ; Contrada et al., 2001) consists of 22 items that measure perceived discrimination on a 7-point Likert scale. The Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) consists of 12 items that measure ethnic identity search as well as affirmation. Also, participants had to complete a demographic questionnaire. Study findings indicated that acts of discrimination remain prevalent against Arab Americans. A large number of participants (77%) indicated that they were subjected at some point to an act of discrimination related to their ethnicity, and 52% shared that they were perceived as dangerous or violent due to their ethnicity. Interestingly enough, religion was a stronger predictor of perceived discrimination among participants. Results showed that Muslim participants perceived more incidents of discrimination than Christians, whether they were immersed in the dominant culture or not. As for Christians, the more acculturated they were to the U.S. culture the less likely they were to perceive acts of discrimination. This might be due to the fact that Christianity is the religion of majority in the United States. Therefore, Christian Arabs are less likely to feel marginalized. As for ethnic identity, participants with a high sense of ethnic identity were more
likely to report acts of perceived discrimination than those with a low sense of ethnic identity (Awad, 2010). This research study sheds light on some major concerns related to the Arab American community in general. Nonetheless, it also reveals the importance of further investigating the commonalities and differences between and within Muslim and Christian Arab Americans.

Moradi and Hasan (2004) were also interested in the Arab American experience with prejudice and discrimination following the 9/11 attacks. They investigated prejudice as a stressor that negatively impacts mental health. The research hypotheses were:

Perceived discrimination is related to the level of self-esteem among Arab Americans through perceived self-control, and that one’s self-control mediates the relationship between perceived discrimination and psychological distress. In addition, self-esteem was examined as a moderator between perceived discrimination and psychological distress.

Research participants were 108 Arab Americans with a mean age of 26.48 (range 18-60), and 53% women and 47% men. It was reported that 68% of participants were students, and 58% of them were single. In terms of religion, 61% were Muslim and 34% were Christian. In terms of socioeconomic status, 46% reported being middle class and 39% upper-middle class. As for their ethnic identities, participants reported being Egyptian, Iraqi, Jordanian, Lebanese, Palestinian, Omani, Saudi, Syrian, and others reported having a multi-ethnic background. It is important to note that the largest group was the Palestinian Arab Americans that consisted of 38% of the sample (Moradi & Hasan, 2004).

The instruments utilized in the Moradi and Hasan’s (2004) study were not meant for Arab Americans. Nonetheless, after consulting with professionals and students who
are Arab Americans, the authors agreed on certain modifications to the instruments. Those measures were as follows: The Brief Symptoms inventory (BSI; Derogattis, 1993) which is a self-report consisting of 53 items that measure psychological distress and symptomology; The Schedule of Racist Events (SRE; Landrine & Klonoff, 1996) that is a self-report and consists of 18 items that measure the frequency of experiences of reported racist events for African Americans; the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965) which consists of 10 items that assess for self-esteem; and Environmental Mastery (EM; Ryff, 1989) which consists of 20 items and assesses for well-being and one’s perceived control over one’s life and environment.

The results of Moradi and Hasan’s (2004) study indicated that there is a link between exposure to acts of discrimination and mental distress among Arab Americans. This link is similar to the discrimination-distress link found across other groups, such as White women and African Americans (Moradi & Hasan, 2004). As for self-control, results revealed that it partially mediated the link between perceived discrimination and self-esteem. Perceived discrimination was directly related to greater mental distress, lower self-esteem, and self-control (Moradi & Hasan, 2004). In conclusion, there is greater support for the need to further investigate the uniqueness of the Arab American experience with discrimination and acculturation, in addition to the Christian Arab American experience as well.

Immigrants’ countries of origin seem to be strong determinants in the probability of confronting acts of discrimination. Overall, people who were born in the United Stated perceive immigrants from Latino countries in a less favorable light than those who migrated from European countries (Cornelius, 2002). It is unfortunate that, according to research, immigrants who are not White or are not perceived as White will experience increased acts of discrimination
and prejudice in the United States as well as other western countries (Portes, 2001). Rumbaut (2008) offers the concept of reactive ethnicity as a reaction of ethnic minority immigrants against acts of discrimination. He defines reactive ethnicity as the strong attachment to one’s culture of origin, alongside an increased resistance to the host culture (Rumbaut, 2008). Rumbaut’s (2008) conclusion is supportive of Berry’s (1980) theory around the fact that acts of discrimination against minority groups increase their enculturation and attachment to their heritage culture.

People who immigrate to the US as adults are believed to have the most difficult experience with acculturation. This is due to the fact that adults, and especially older adults, are those with more memories of their heritage culture. Therefore, they are presumed to have certain difficulties adopting the values, traditions, and habits of the host culture. Those first generation adults maintain and increase their attachment to their country of origin. Consequently, they are recognized as immigrants by their physical appearance or heavy accent and are subjected to discrimination by the larger American White community (Schwartz et al., 2010).

**Arab Americans: Discrimination and Coping**

Considering American history, it is somewhat surprising that discrimination against minority and underrepresented groups in the United States persists. Nonetheless, it is not a surprise to learn that acts of discrimination mostly take place with those who visibly belong to one group or another. Discrimination can be religious, ethnic, racial, sexual, and even academic among other various types. According to Naber (2000), acts of discrimination against Arab Americans or those from the Middle East existed as early as the 1900s. However, there is no denying that the 9/11/2001 events have resulted in a
tremendous increase in acts of discrimination against Arabs in the United States (Awad, 2010; Ibish, 2003; Moradi & Hasan, 2004). According to the American-Arab Anti-Discrimination Committee (ADC), there were more than 700 acts of violence and discrimination aimed at Arab American a few weeks following after the 9/11 attacks (Ibish, 2003).

The ADC received four times its typical reports of airline discrimination; denial of services; police, FBI, and INS misconduct; and physical and psychological attacks against Arab Americans (Ibish, 2003 as cited in Moradi & Hasan, 2004). In their research, Abu-Raiya, Pargament and Mahoney (2011) discuss acts of discrimination against Arab Americans, which included “hate crimes, defamatory speech, harassment, job discrimination, and Islamophobia” (p. 1). They support their argument with a Human Rights watch report that was released in November 2002 and stated that since 2001 there has been a great increase in anti-Muslim crimes across the United States (Human Rights Watch, 2002).

A study conducted by Abu-Ras and Abu-Bader (2008), was one of the very few that addressed the impact of the September 11 attacks on the well-being of Arab Americans. After interviewing 83 Arab Americans, they have come to the conclusion that they were mostly afraid of being marginalized, isolated, or attacked. The study also revealed that Muslim as well as Christian Arab Americans mostly turned to their religious beliefs for support and coping (Abu-Raiya et al., 2011). Arab Americans might also experience an increase in their fear from acts of discrimination as a result of the very well-known American policy which has always been supportive of Israel. The American alliance with Israel has always caused Arab Americans to be doubtful and cautious when expressing their political opinions about U.S. foreign policies (Abudabbbeh, 1996; Erickson & Al-Timimi, 2001). Historically, Europe had occupied many of the Arab countries in the Middle East which resulted in a European sense of superiority over
Arabs. These feelings of superiority have been adopted by the American culture as well (Nasir, 1979; Said, 1997). It is widely assumed that the United States benefits from the widely spread bias against Arabs and Arab Americans. For political and financial reasons, America is assumed to aim at maintaining its control over the situation in the Middle East. This Arab American dissatisfaction with the U.S. foreign policy that surfaced as early as 1967 during the Arab-Israeli war was followed by both Gulf wars and also all throughout the years with the continuous Israeli-Palestinian conflict (Abraham, 1995; Erickson & Al-Timimi, 2001). Consequently, political stress and anxiety, among other acculturative challenges, can be directly related to mental distress among Arab Americans.

Resiliency and coping mechanisms for confronting acculturative challenges might vary among immigrant groups and individuals. To confront those challenges, some choose to retain their goals, modify them, or change them as a whole (Pargament, Trevino, Mahoney, & Silberman, 2007). According to the General Coping Theory (Pargament, 1997), humans interact with their environment and the various events that take place over time. We are thus considered to be proactive and continuously setting goals for ourselves and seeking to attain them (Pargament, 1997). Choosing to retain, modify, or change our goals might have negative implications for our mental and physical status. Stress, fear of the unknown, anxiety, and depression might result from the aforementioned challenges. In addition, acculturation in and of itself is a stressful process whereby individuals and families are confronted with a new reality and are directly and indirectly required to either adapt or become isolated.
The Religious Coping Theory (Pargament, 1997) encompasses the belief in a higher power as a source of motivation. Coping with life stressors and challenges might be facilitated through one’s belief in a higher power and the need to comply with it in order to achieve inner peace. Religious coping is defined as a way of dealing with stressful life events in a spiritual or sacred manner (Abu-Rayia & Pargament 2010). Religious coping, nonetheless, can be experienced negatively and positively (Abu-Rayia, Pargament, & Mahoney, 2011). Certain individuals, families, or communities might refer to religion in an extreme and, at times, pathological way. The positive religious coping methods reflect the perception of a secure relationship with God, a belief that there is a greater meaning to be found, and a sense of spiritual connectedness with others. In contrast, the negative religious coping pattern involves expressions of a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle to find and conserve significance in life (Abu-Rayia et al., 2011).

Coping is viewed as assisting people with decreasing the negative feelings associated with stressful life events. Research suggests that active coping is when people take action to address the problems and challenges at hand, and avoidant coping is when people tend to ignore, avoid, or repress those problems. As a result, it is most effective to cope with stress actively and cognitively (Crockett et al., 2007). Multiple studies with college students of ethnic minority groups have shown that active coping is considered a protector against the stress related to acculturation and adjustment. Whereas, avoidant coping can increase the negative impact of acculturative stress (Crean, 2004; Crockett et al., 2007; Gloria, Castellanos, & Orozco, 2005; Zea, Jarama, & Bianchi, 1995).

A study conducted by Aby-Raiya et al. (2011) aimed at investigating the manner in which Muslims who resided in the United States coped with stressful events after the 9/11
attacks. The religious coping theory (Pargament, 1997) was utilized in order to examine how 138 individuals coped with stressful events. Participants were Muslims who lived in the United States, 62% were female and 38% were male, with a mean age of 27.95 and a range of 18-60. Participants were mostly highly educated, with 43.1% having had more than 18 years of education. Also, 62.7% were never married, and 31.4% were married. Participants completed multiple questionnaires online, including: The Negative Events and their Stressfulness, an 11-item scale developed for this study; the Religious Practices scale that was adapted from the Psychological Measure of Islamic Religiousness (PMIR; Abu-Raiya, Pargament, Mahoney, & Stein, 2008) consisting of four items; the Sacred Loss and Desecration scale (Pargament, Magyar, Benore, & Mahoney, 2005) consisting of 23 items; and the religious Coping with Events scale that consisted of 16 items from the three religious coping subscales of the PMIR (Aby-Raiya et al., 2008).

In general, results revealed that certain coping methods with stressful life events are related to people’s health and well-being (Abu-Raiya et al., 2011). The majority of participants admitted being subjected to discrimination or anti-Muslim comments following the 9/11 attacks. These findings, according to the authors, support the fact that the 9/11 attacks have caused a “collective trauma” to Muslims residing in the United States (Abu-Rayia et al., 2011, p. 10). Results also indicated that participants were mostly inclined to turn to religion and spirituality in order to cope with the aftermath of the 9/11 attacks. Religion is thus perceived as a support system that offers a higher purpose for life. Abu-Rayia et al. (2011) also shared the fact that Muslims living in the US might have felt the need to protect their religion following the constant and apparent portrayal of it as a religion of violence and terrorism. In addition to religious coping, participants
endorsed unreligious coping that was divided into two camps: those who became involved in outreach in order to spread the true meaning of Islam, and those who chose to isolate themselves from the larger community. However, positive religious coping, in this study, was practiced more widely among participants, and was positively correlated to good health and well-being (Abu-Rayia et al., 2011).

There has been no research in the field of mental health that addresses the coping skills utilized among Christian Arab Americans. As previously noted, the Arabic culture is a collectivistic one, and therefore, families and communities usually opt to solve their problems and confront their challenges within themselves as well as with their religious leaders. Due to the lack of research on Arab Americans in general and Christian Arab Americans in particular, there is a great need to examine the uniqueness of this group and their coping strategies. Confronting discrimination and harassment has a negative impact on people’s acculturation processes. It can also result in mental distress and depression if not handled constructively and with culturally appropriate methods.

**Depression and Culture**

Mental illness is defined and perceived differently across various cultures. According to Fields (2010), mood disorders, as defined in certain cultures, might be normalized in other cultures. Understanding the cross-cultural variations requires the development of cross-culturally valid and reliable measures of mental illnesses. Fields (2010) continues to display the relationship between culture and depression as explained by two theoretical views, the universal view and the social constructionist view. The universal view is that depression is experienced equivalently across cultures and can, therefore, be measured by utilizing a one unified measure. The social constructionist view holds that depression is experienced differently and uniquely
across cultures and ought to be measured accordingly. It is important to account for possible variations among cultures, communities, and individuals as far as mental illness definitions, diagnoses, and treatment are concerned. It was asserted in the past that depressive feelings can develop as a result of a personality trait (Beck, 1983). Blatt’s Theory of Depressogenic Personality (Blatt, 1974; Shahar, Joiner, Zuroff, & Blatt, 2004) is that personality develops along two dimensions, interpersonal relatedness and self-definition. Blatt suggested that when an individual places more attention on one dimension of his or her personality development, he or she can experience psychopathology. When a greater focus is placed on interpersonal relationships, a sense of dependency on others is developed. Consequently, if the person experiences a lack of attention and care from others, he or she might experience depressive symptoms. On the other hand, if an extreme emphasis is placed on self-definition, one might be overly independent and critical of him or herself and set unattainable goals for his or her life. When those goals are not attained, the person might experience frustration and depression (Ahmad & Soenens, 2010). In order to maintain stability, it is theorized that self-criticism and dependency ought to develop alongside environmental and life events (Zuroff, Mongrain, & Santor, 2004).

Fields (2010) contended that the World Health Organization (WHO) address and investigates the phenomenon of depression as part of an overall emphasis and research on illness. It was suggested back in 1996 in The World Health Report that depression is not only a mental illness but a social one as well. Its social precedents can be related to socioeconomic status, violence, and more. The authors also suggested that depression, just as any other mental illness, is directly related to cultural characteristics and environmental influences (Fields, 2010).
Multiple studies have attempted to measure mental illnesses across cultures. One study was conducted in the United States and The United Kingdom and was labeled United States-United Kingdom (US-UK) Diagnostic Project (Cooper et al., 1972, as cited in Fields, 2010). The study results indicated that people were more likely to be diagnosed with depression in London and schizophrenia in New York. However, even though standardized diagnostic criteria were used, one cannot generalize those results. The reason being that the American and the British cultures have multiple commonalities, among which is the fact that they are both individualistic and westernized cultures (Fields, 2010). In addition to cultural differences and similarities, there is a problem finding a terminology for psychopathologies that is equivalent across cultures. For example, in certain cultures one cannot find a word to describe depression, and in others the same term might have various interpretations (Fields, 2010). A study that was meant to examine the *Diagnostic and Statistical Manual (DSM)* criteria for depression among Korean participants found that the *DSM* depression criteria accounted for one fourth of the rate of Korean depression as it did in the United States. These results suggest that the presence, consistency, and intensity of symptoms might differ across cultures (Chang et al., 2008).

The universal measures of depression are utilized across cultures, yet not without cautioning researchers from unique cross-cultural and within-group differences. In order to measure psychopathologies across cultures, researchers ought to initiate the process with the development of appropriate instruments. It has been evident that the milder the psychopathology the greater the cultural variability and the more pronounced the psychopathology the more blurred cultural differences became. It is also important to account for the culture of the examiner, the researcher, or the person collecting the data. This shows the importance of attempting to minimize researcher bias. It is almost impossible to eliminate bias related to
examiners, yet being aware of its possible existence might increase the validity of the instrument (Draguns & Tamaka-Matsumi, 2003).

A study conducted by Aprahamian, Kaplan, Windham, Sutter, and Visser (2011) examined the relationship between acculturation and mental health among Arab Americans. The authors discussed previous studies that proposed that the acculturation process and adaptation to the American culture is difficult for Arab Americans. Thus, they preferred to remain in their own community and away from the American culture (Aprahamian, et al., 2011; Faragallah et al. 1997; Ghanem-Ybarra, 2003; Naff, 1983). It is suggested that among the various reasons for acculturation difficulty is religion. Muslim Arabs are more likely to confront challenges related to acculturation than Christian Arabs. Also, the traditional values and customs practiced in the Arabic culture are perceived as more conservative than the ones experienced in the American culture (Faragallah et al. 1997; Ghanem-Ybarra, 2003). Upon adding discriminatory acts against Arab Americans to the aforementioned challenges, there is a noticeable increase in mental distress among them (Faragallah et al. 1997; Ghanem-Ybarra, 2003).

The study consisted of 1016 participants (466 males and 538 females), Arabs and Chaldeans, ages 18 and older from the Detroit metropolitan area. Chaldeans are Christians whose roots go back to Iraq, Iran, Turkey, and Syria (Faragallah et al. 1997; Ghanem-Ybarra, 2003). As far as religion and marital status, 579 participants were Christian and 422 were Muslim; 724 participants were married. The authors utilized multiple measures; The Kessler Psychological Distress Scale (K10; Kessler & Mroczek, 1992) which consists of 10 items that measure mental distress; and for acculturation and discrimination, the Detroit Arab American Study (DAAS; Baker et al., 2003) which consisted of items from multiple instruments that were validated to measure acculturation as well as discrimination. Despite the fact that it was hypothesized that
increased acculturation is related to better mental health, results indicated that multiple other variables impacted that relationship. Those variables were gender, age, income, education, age at immigration, length of stay in the United States, and exposure to acts of discrimination (Faragallah et al. 1997; Ghanem-Ybarra, 2003). Those factors should be accounted for separately in order to better understand the variance they account for in the level of mental distress. As evidenced in the Aprahamian et al. (2001) study, there have been very few measures, if any, that have been validated to assess mental health among Arab Americans. It is thus very important for researchers in the mental health field to become increasingly aware of the psychometric properties of the instruments, their generalizability, and their utility across ethnic minorities. To examine mental illness and psychopathologies within the Arabic culture, multiple issues ought to be taken into account. It is crucial to note that within-group differences may be more evident than between-group differences. As far as terminology is concerned, the Arabic language consists of multiple dialects that might account for various psychopathologies in various ways and with the use of different words. These dialects may influence their respective meanings and diagnoses. Further, despite the fact that the Arabic culture is considered to be a collectivistic one, it is important to note that collectivism varies across the Arab countries, communities, and families. Therefore, it is advisable to caution mental health professionals and researchers not to generalize across all Arab communities.

**Religion**

Erikson (1968) stated that religion and spirituality are among the influential factors in an individual’s life and decision making process (Erikson, 1968, as cited in Duffy & Blustein, 2004). Religiousness is defined as a social phenomenon: People attend services and display commitment to a certain frame of worship (Duffy & Blustein, 2004). Multiple studies have revealed that being
religious or spiritual can provide the individual with a sense of purpose and assist worshipers or believers during times of stress (Baumeister, 1991; McIntosh, 1995; Pargament, 1997, as cited in Duffy & Blustein, 2004).

Christianity, according to Lynch (2001), is not considered a monolithic religion and it constitutes various denominations. It is important to learn the influence that Christianity has both culturally and psychologically. When discussing the type of culture that is associated with Christianity, one can find both collectivistic and individualistic cultures that are known to be Christian. Historically, states Lynch (2001), Christianity was dominated by “Catholicism in the West and by Orthodoxy in the East” (p. 1174). Both Catholicism and Orthodoxy place extreme importance on the collectivistic nature of the church and the “mutual responsibility of the members of the Christian church for one another” (Lynch, 2001, p. 1174). It is this aforementioned collectivism that is believed to have a psychological influence on Christian individuals.

Upon investigating the lives of Arab Americans, both Christians and Muslims, one would come to notice the similarities and commonalities among them. Erickson and Al-Timimi (2001) argued that Islam is not that different from Christianity and Judaism. They argued that Muslims believe in the same God as Christians and Jews, except they simply call it Allah instead of God. The authors proceeded to discuss all existing similarities between the three religions. Those include fasting and dietary restrictions, praying, and worship services (Erickson & Al-Timimi, 2001). Also, as previously mentioned, both Christian and Muslim Arab Americans resort to their religion for support and coping.

Despite existing and presumed similarities among Christian Arabs, there remains within-group variability that ought to be accounted for. Christian Arabs who live in the
Middle East differ from those who chose to migrate to the United States. It is widely assumed that Christian Arabs, who leave their countries, do so in search of a better life. In addition, Christian Arabs are considered a minority in the mostly Islamic Arab world. Therefore, migrating to the United States, for example, presumably offers them a sense of safety and belongingness, as well as free religious practice. Additional differences are witnessed among Christian Arabs in the Middle East, depending on their geographical location, socioeconomic status, and level of education. Nonetheless, they mostly share a desire for a better quality of life, smaller family size than Muslims, and an emphasis on higher education. It is unfortunate that there has been very little research in the field of mental health that addresses the Christian Arab American experience with acculturation and psychological functioning. Therefore, the variability as well as commonalities among this group is worthy of increased attention, examination, and investigation.
CHAPTER III

METHODS

Power Analysis

The current study aims at investigating the relationship between acculturation, the predictor variable, with its two factors (ethnic-society immersion and dominant-society immersion) and depression, the criterion variable, with its two factors (cognitive-affective and vegetative-somatic). The number of participants was determined based on a G*Power analysis from Erdfelder, Faul, and Buchner (1996). The analysis was based on two multiple regressions; the first, measures the relationship between acculturation with its two factors and depression in its cognitive-affective factor, and the second, measures the relationship between acculturation with its two factors and depression in its somatic-affective factor. The analysis was also based on the following assumptions; power of 0.80, effect size $f^2 = 0.15$, $\alpha$ err prob 0.05. Through this analysis, it was determined that 68 participants are required to detect a moderate effect in the current study, and 100 participants would be required to detect a small effect (effect size $f^2 = 0.10$).

Participants

The current study was designed to assess the relationship between the levels of acculturation and depression among first generation Christian Arab American adults. Thus, the study is limited to those who are 18 years of age and older and who self-identify as first generation Christian Arab Americans (i.e., who were not born in the United States). Non-Christians are also excluded from participation. Further, participants were required to be fluent in English. Semi-fluent and non-fluent participants were excluded from participation.
Measures

The Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000). The SMAS is the first scale that was developed to study acculturation across ethnic minorities. This scale was developed to assess two factors: ethnic society immersion (ESI) and dominant society immersion (DSI). It includes 32 items rated on a 4-point Likert scale ranging from 1 (false) and 4 (true), where the participant responds in the manner that fits best how he or she usually feels.

The SMAS was standardized on a sample of 436 participants from five ethnic groups. Reliability was reported as $\alpha = 0.86$ for the whole scale ($\alpha = 0.97$ for the first factor, and $\alpha = 0.90$ for the second factor). The item correlations on factor one ranged from .51 and .87 and ranged from .57 and .83 on factor two. Validity estimates were strong, too, especially in predicting the relationship between generational status and the subscales on the SMAS. After conducting a two one-way between-groups analysis of variance, there appeared to be significance for generational status, for both factor one, $F(3, 432) = 31.48, p < .001$, and factor two, $F(3, 432) = 73.644, p < .001$. Also, according to the Tukey post hoc test results, most of the variance took place among first and second generation immigrants at a significance level at $p < .05$. Despite the fact that the SMAS does not examine all aspects of acculturation, such as values and traditions, it is still perceived as an influential tool to assess for acculturation. Its results are to be accounted for in clinical presentations and research to facilitate understanding of the degree of immersion in the host culture or lack thereof (Stephenson, 2000).

After conducting an exploratory factor analysis, the research (Stephenson, 2000) resulted in a 2 factor solution. The two factors were ethnic society immersion and dominant society immersion. The second study proved to be consistent with the theoretical background underlying the concept of acculturation. The 32-items that were retained accounted for 50.6% of the
variance; factor one that included 17 items accounted for 27.4% and factor two that included 15 items accounted for 23.2% of the variance. Interestingly enough, the results also indicated that participants who were less acculturated to the host culture required increased cultural sensitivity and awareness throughout clinical assessment. Despite the fact that the SMAS appears promising in evaluating acculturation and enculturation, there remains to be a need to use the SMAS across cultures and translate it into languages other than English (Stephenson, 2000).

The Beck Depression Inventory-II (BDI-II; Beck, Rush, Shaw, & Emery, 1979). The Beck Depression Inventory-II was first created in 1961 by Beck, Ward, Mendelson, Mock, and Erbaugh and was considered one of the best measures of depression. The BDI-II is a self-report scale that measures the existence and severity of depression among both adolescents and adults. It is not constrained to normal functioning individuals, but can also be utilized with psychiatric patients (Dozois, Dobson, & Ahnberg, 1998). Beck, Steer, and Garbin (1988) have reported the BDI reliability to be $\alpha = .86$ for psychiatric patients and $\alpha = .81$ for psychologically healthy individuals. Despite the fact that factor analysis accounted for one to seven factors, the three factor solution for the DBI was the most widely used (Dozois, Dobson, & Ahnberg, 1998). The three factors are negative attitudes toward self, performance impairment, and somatic disturbance. The BDI has proven to have adequate test-retest reliability, and construct and factorial validity. However, it only accounted for six of the nine Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV) criteria for depression. Furthermore, the two-factor solution has been validated among a population of psychiatric outpatients and college
students. The two factors are cognitive-affective and somatic-vegetative symptoms among the aforementioned sample of participants (Dozois, Dobson, & Ahnberg, 1998).

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) was a revision of the original BDI to address the problematic areas that were not dealt with in the initial edition. The scale is appropriate for use with ages 13 to 80 and includes 21 items answered on a 4-point scale (0 to 3), and the sum of scores ranges between 0 and 63. A few responses were re-worded in the BDI-II, some items were rewritten, and four items (Body Image Change, Work Difficulty, Weight Loss, and Somatic Preoccupation) were replaced. The BDI-II has an internal consistency of $\alpha = .93$ among college students and $\alpha = .92$ among psychiatric outpatients. Also, content and factorial validity have proven to be adequate (Dozois, Dobson, & Ahnberg, 1998). The BDI-II has been translated into multiple languages among which is Arabic, Chinese, Japanese, and other European languages; however, it will be administered in English in the current study.

**Design**

The purpose of this study is to measure levels of specific constructs (acculturation with its two factors; ethnic society immersion and dominant society immersion, and depression with its two factor structure; cognitive-affective and somatic-vegetative) and examine the relationships between them. The research questions were (a) What is the overall relationship between acculturation and depression among first generation Christian Arab Americans? (b) What is the relationship between the cognitive-affective symptoms and ethnic society immersion? (c) What is the relationship between cognitive-affective symptoms and dominant society immersion? (d) What is the relationship between somatic-vegetative symptoms and ethnic society immersion? (e) What is the relationship between somatic-vegetative symptoms and dominant society immersion?
Since there is no manipulation of variables, the design is non-experimental. The best fitting statistical methodology based on the research questions is to conduct two linear multiple regressions to measure the relationship between acculturation, the predictor variable with its two factors, and depression, the criterion variable with its two factors. The first linear multiple regression measured the strength of the relationship between two acculturation factors; ethnic society immersion and dominant society immersion, and one depression factor; cognitive-affective. The second linear multiple regression measures the strength of the relationship between the two acculturation factors; ethnic society immersion and dominant society immersion, and the other depression factor; somatic-vegetative. The relationship between both variables (i.e., acculturation and depression) is measured by the SMAS and the BDI-II.

**Procedure**

Upon obtaining the IRB approval for the current research, I approached prospective participants through personal contacts. Due to the difficulty of locating first generation Arab Americans who are fluent in English, they were contacted via phone or in person and presented them with the letter of solicitation (see Appendix A). I asked each participant to review the letter of solicitation (see Appendix A) and I was available to answer any inquiries. I also explained the confidential and voluntary nature of the research. If participants agreed to complete the survey, I asked them to review the informed consent form (see Appendix B). Each participant was asked to sign two copies of the informed consent form; one for the participant’s records and one for myself. Prior to completing the survey, each participant received a number to represent his or her name. The names with their equivalent numbers were stored on a USB flash drive and kept in a locked drawer in my office. The survey consisting of the three aforementioned questionnaires
was distributed to each participant. Each participant was instructed to complete the survey on their own and hand them back to me when done. Participants needed about 30 minutes to complete all questionnaires.

Upon completion of the survey, I offered each participant two methods by which they could assist me in finding additional participants that fit the inclusion criteria for this study, if they agreed to do so. The first method was for current participants to ask potential participants for permission to share their names, phone numbers, and/or email addresses with me, so that I might contact them with further information. The second method was for participants to provide my contact information to potential participants so they could contact me directly. Potential participants, who agreed to be contacted by me, or who contact me themselves, received, upon their agreement to participate, the research packet in the mail with a self-addressed envelope in order to mail back the completed survey. The packet included the solicitation letter (see Appendix A), two copies of the informed consent form (see Appendix B), the demographic questionnaire (see Appendix C), the SMAS (see Appendix D), and the BDI-II. In order to maintain confidentiality, potential participants were instructed to mail back the self-addressed envelope without identifying information. I recorded their names and equivalent numbers prior to mailing their individual packets. Because there is no deception component in this study, a debriefing process following the administration of the study was not necessary.
CHAPTER IV

RESULTS

Overview

The purpose of the current study was to investigate the relationship between acculturation and the level of depression among first generation Christian Arab American adults. In addition to the overall relationship between acculturation and depression, the study aimed to examine the relationship between the cognitive-affective and somatic-vegetative components of depression and both ethnic society and dominant society immersion. The current chapter provides an analysis and an explanation of the data collected as well as answers to each of the study questions.

Data Screening

The statistical analysis was conducted using SPSS Statistics 21 (SPSS Inc., 2013). Prior to screening the data, I removed 16 participants who did not respond to the last four items on the SMAS scale (items 29 to 32). The initial total number of participants was N = 117 but the data analysis was conducted using N = 101 participants. As suggested by Graham (2009), it is plausible to substitute for certain missing data to maintain the general characteristics of the data set. After screening for missing data in this study, the mean value within the present sample was substituted for missing items from 18 participants: There was one missing item under “age of arrival,” nine missing items in the SMAS scale, and 14 missing items in the BDI-II scale.

Four out of the five study variables (Depression Total, Cognitive-Affective Depression, Somatic-Vegetative Depression, Dominant Society Immersion, and Ethnic Society Immersion) were positively skewed. However, as examination of residual plots indicated that this did not significantly affect the linear relationships among the study variables, these skewed variables were not transformed. The data were screened for outliers, and three outliers were found in the
cognitive-affective symptoms of depression variable. The three cases were not eliminated due to the fact that they constituted a small percent of the total number of cases. Collinearity diagnostics did not indicate a multicollinearity problem. I also conducted a dependent-samples t-test to evaluate whether research participants were more acculturated to the dominant society or the ethnic society. Results indicated that the mean for ethnic society immersion ($M = 58.55$, $SD = 5.89$) was higher than the mean for dominant society immersion ($M = 48.14$, $SD = 6.69$), $t(100) = 9.85$, $p < .01$). The 95% confidence interval for the mean difference between the two ratings was 8.32 to 12.51.

**Descriptive Statistics**

Upon visually screening the data, I was able to determine that there were no severe levels of depression among study participants. Table 1 provides descriptive statistics for the demographic information provided by participants ($N=101$; Age: $M = 48.3$, $SD = 13.6$). The mean age of arrival in the US was 22 ($SD = 9.4$); 17% of participants arrived during the second largest wave of immigration to the United States, the wave that occurred after the war between the Arab countries and Israel in 1967 (Erickson & Al-Timimi, 2001); and 30% migrated to the US during the second significant wave of immigration that took place during the last decade of the 20th century (U.S. Department of Homeland Security, 2010). Further discussion of these results are presented in Chapter V. Additional descriptive statistics for the study variables are provided in Table 2. Also, Table 3 presents the correlation matrix for the study variables.
Table 1

*Descriptive Statistics and Frequency for Participants Demographics*

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female = 48</td>
<td>48</td>
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</tr>
<tr>
<td>Male = 53</td>
<td>53</td>
<td>52.5</td>
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<tr>
<td><strong>Country of Origin</strong></td>
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<tr>
<td>Palestine = 27</td>
<td>27</td>
<td>26.7</td>
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<tr>
<td>Israel = 23</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Lebanon = 17</td>
<td>17</td>
<td>16.8</td>
</tr>
<tr>
<td>Jordan = 14</td>
<td>14</td>
<td>13.9</td>
</tr>
<tr>
<td>Egypt =10</td>
<td>10</td>
<td>9.9</td>
</tr>
<tr>
<td>Syria = 9</td>
<td>9</td>
<td>8.9</td>
</tr>
<tr>
<td>Iraq = 1</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Country of Birth</strong></td>
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<td></td>
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<td>20</td>
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<td>Israel = 25</td>
<td>25</td>
<td>24.8</td>
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<tr>
<td>Jordan = 18</td>
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<tr>
<td>Egypt =10</td>
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<td>9.9</td>
</tr>
<tr>
<td>Syria = 9</td>
<td>9</td>
<td>8.9</td>
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<tr>
<td>Iraq = 1</td>
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</table>
Table 2

Descriptive Statistics for Study Variables

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Skewness</th>
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<tbody>
<tr>
<td>EthAcc</td>
<td>58.55</td>
<td>5.89</td>
<td>40.00</td>
<td>67.00</td>
<td>-5.26</td>
</tr>
<tr>
<td>DomAcc</td>
<td>48.14</td>
<td>6.69</td>
<td>32.00</td>
<td>60.00</td>
<td>2.08</td>
</tr>
<tr>
<td>SomDep</td>
<td>2.75</td>
<td>2.56</td>
<td>0.00</td>
<td>13.00</td>
<td>5.20</td>
</tr>
<tr>
<td>CogDep</td>
<td>2.13</td>
<td>1.62</td>
<td>1.00</td>
<td>9.00</td>
<td>8.13</td>
</tr>
<tr>
<td>DepTot</td>
<td>4.88</td>
<td>3.72</td>
<td>1.00</td>
<td>18.00</td>
<td>5.97</td>
</tr>
</tbody>
</table>

Note. EthAcc = Ethnic Society Immersion, a subscale of the SMAS scale; DomAcc = Dominant Society Immersion, a subscale of the SMAS scale; SomDep = Somatic-Vegetative Depression, a subscale of the BDI-II scale; CogDep= Cognitive-Affective Depression, a subscale of the BDI-III scale; DepTot = Depression Total Score of the BDI-II scale.

Table 3

Correlations (N = 101)

<table>
<thead>
<tr>
<th></th>
<th>EthAcc</th>
<th>DomAcc</th>
<th>SomDep</th>
<th>CogDep</th>
<th>DepTot</th>
</tr>
</thead>
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<tr>
<td>EthAcc</td>
<td>1</td>
<td>-.424**</td>
<td>.097</td>
<td>.157</td>
<td>.135</td>
</tr>
<tr>
<td>DomAcc</td>
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<td>1</td>
<td>-.153</td>
<td>-.259**</td>
<td>-.218*</td>
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<tr>
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<td>.561***</td>
<td>.933***</td>
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<tr>
<td>CogDep</td>
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<td></td>
<td></td>
<td>1</td>
<td>.822***</td>
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<tr>
<td>DepTot</td>
<td></td>
<td></td>
<td></td>
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<td>1</td>
</tr>
</tbody>
</table>

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

Note. EthAcc = Ethnic Society Immersion, a subscale of the SMAS scale; DomAcc = Dominant Society Immersion, a subscale of the SMAS scale; SomDep = Somatic-Vegetative Depression, a subscale of the BDI-II scale; CogDep= Cognitive-Affective Depression, a subscale of the BDI-III scale; DepTot = Depression Total Score of the BDI-II scale.
Tests of Questions

Question 1. The first study question asked about the relationship between acculturation and depression among first generation Christian Arab American adults. In order to account for both acculturation subscales (i.e. ethnic society immersion and dominant society immersion), a multiple regression was conducted to evaluate the relationship between dominant and ethnic society immersion as the independent variables and the total depression score, as the dependent variable. Results indicated that there is not a significant relationship between the acculturation subscales and the total depression scale; $F(2, 98) = 2.572, p = .082$ (see Tables 4 - 6).

Table 4

<table>
<thead>
<tr>
<th>$R$</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>Std. Error</th>
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<tr>
<td>.223</td>
<td>.050</td>
<td>.030</td>
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Table 5

ANOVA

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<tr>
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<th>Mean Square</th>
<th>$F$</th>
<th>Sig.</th>
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<tr>
<td>Regression</td>
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<td>2.572</td>
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<tr>
<td>Residual</td>
<td>1317.420</td>
<td>98</td>
<td>13.443</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1386.574</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dependent Variable: DepTot
Independent Variable: (Constant), DomAcc, EthAcc
Table 6

*Question 1: Model Summary of Coefficients*

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
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<tbody>
<tr>
<td></td>
<td>( B )</td>
<td>Std. Error</td>
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<tr>
<td>(Constant)</td>
<td>8.239</td>
<td>5.894</td>
</tr>
<tr>
<td>EthAcc</td>
<td>.033</td>
<td>.069</td>
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<tr>
<td>DomAcc</td>
<td>-.109</td>
<td>.060</td>
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</tbody>
</table>

*Questions 2 and 3.* The second study inquired about the relationship between cognitive-affective symptoms of depression and ethnic society immersion among first generation Christian Arab American adults. The third study question inquired about the relationship between cognitive-affective symptoms of depression and dominant society immersion among first generation Christian Arab American adults. A multiple regression was conducted to evaluate the relationship between the independent variables, ethnic and dominant society immersion and the dependent variable, cognitive-affective symptoms of depression. Results indicated that there is a significant relationship between the acculturation subscales and cognitive-affective symptoms of depression, \( F(2, 98) = 3.687, p = .029 \). Approximately 7% of the variance of the cognitive-affective symptoms of depression index is accounted for by its relationship with the ethnic and dominant society immersion indices (see Tables 7 & 8). The beta coefficient of the relationship between the ethnic society immersion and the cognitive-affective symptoms of depression indices is .057, \( t (2, 98) = .53 \), and the beta coefficient of the relationship between the dominant society immersion and the cognitive-affective symptoms of depression indices is -.235 \( t (2, 98) = -2.19 \). The negative sign associated with the beta coefficient (\( \beta = -.235 \)) indicates that there is
a tendency for cognitive-affective symptoms of depression to increase when the dominant society immersion decreases and vice versa (see Table 9). Thus, higher levels of dominant society immersion are associated with lower levels of cognitive-affective symptoms of depression.

Table 7

*Questions 2 & 3: Model Summary for Linear Regression for Study Variables*

<table>
<thead>
<tr>
<th></th>
<th>R</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.265</td>
<td>.070</td>
<td>.051</td>
<td>1.58</td>
</tr>
</tbody>
</table>

Table 8

*ANOVA*

<table>
<thead>
<tr>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>$F$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>18.428</td>
<td>1</td>
<td>9.214</td>
<td>3.687</td>
</tr>
<tr>
<td>Residual</td>
<td>244.899</td>
<td>98</td>
<td>2.499</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>263.327</td>
<td>100</td>
<td>2.499</td>
<td></td>
</tr>
</tbody>
</table>

Dependent Variable: CogDep
Independent Variable: (Constant), DomAcc, EthAcc
Table 9

Questions 2 and 3: Model Summary of Coefficients

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>Std. Error</td>
</tr>
<tr>
<td>(Constant)</td>
<td>3.95</td>
<td>2.54</td>
</tr>
<tr>
<td>EthAcc</td>
<td>.016</td>
<td>.030</td>
</tr>
<tr>
<td>DomAcc</td>
<td>-.057</td>
<td>.026</td>
</tr>
</tbody>
</table>

Questions 4 and 5. The fourth study question inquired about the relationship between ethnic society immersion and somatic-vegetative symptoms of depression among first generation Christian Arab American adults. The fifth study inquired about the relationship between dominant society immersion and somatic-vegetative symptoms of depression. A multiple regression was conducted to evaluate the relationship between the independent variables, ethnic and dominant society immersion, and the dependent variable, somatic-vegetative symptoms of depression $F(2, 98) = 1.239, p = .294$. There was no significant relationship between both independent variables and the dependent variable (see Tables 10 - 12).

Table 10

Questions 4 & 5: Model Summary for Linear Regression for Study Variables

<table>
<thead>
<tr>
<th>$R$</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>.157</td>
<td>.025</td>
<td>.005</td>
<td>2.56</td>
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</table>
### Table 11

**ANOVA**

<table>
<thead>
<tr>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>16.193</td>
<td>8.096</td>
<td>1.239</td>
<td>.294</td>
</tr>
<tr>
<td>Residual</td>
<td>640.619</td>
<td>6.537</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>656.812</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dependent Variable: SomDep  
Independent Variable: (Constant), DomAcc, EthAcc

### Table 12

**Questions 4 and 5: Model Summary of Coefficients**

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>(Constant)</td>
<td>.428</td>
<td>4.11</td>
</tr>
<tr>
<td>EthAcc</td>
<td>.017</td>
<td>.048</td>
</tr>
<tr>
<td>DomAcc</td>
<td>-.052</td>
<td>.042</td>
</tr>
</tbody>
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CHAPTER V
DISCUSSION

This chapter presents a discussion of the results of the research questions as well as implications for the field of mental health. Additionally, this chapter addresses the limitations of the current study and directions for future research regarding both acculturation and depression among ethnic minorities in the United States, and particularly among Christian Arab Americans.

As noted in the first and second chapters, the Christian Arab American community has been largely ignored in the field of mental health. As stated by Awad (2010), most of the research conducted around Arab American issues investigated acts of discrimination and bias against them, disregarding significant matters such as mental health and acculturation. Consequently, the relationship between acculturation and depression is addressed through the research hypotheses in the present study.

Significant results were evident in the relationship between dominant-society immersion and cognitive-affective symptoms of depression. The finding that a higher integration into the American society is associated with lower levels of cognitive-affective symptoms of depression may be partly due to religion. Awad (2010) concluded that Muslims perceived more incidents of discrimination than Christians, especially post 9/11. Because Christianity is the religion of majority in the US, this may facilitate the integration of Christian Arab Americans into the larger American culture; they are then less likely to experience elevated levels of depression. Christianity, then, may mediate the relationship of Christian Arab Americans with the culture of majority and result in decreased cultural dissonance and increased resilience. The effect sizes of the relationship between ethnic and dominant-society immersion and total depression, as well as between dominant society immersion and cognitive-affective symptoms of depression, are strong enough to support the need for further research to clarify this relationship.
As indicated in Chapter II, in addition to acculturation, multiple factors may impact the level of depression and both its somatic-vegetative and cognitive-affective symptoms. Factors such as gender, age, income, education, age at immigration, length of stay in the United States, and exposure to acts of discrimination can play a significant role in the presence or existence of mental distress for immigrant populations (Faragallah et al. 1997; Ghanem-Ybarra, 2003). Overall, the participants in this study did not report high levels of depression or its somatic-vegetative symptoms. It is possible that this is related to self-report bias, as individuals and families in collectivistic cultures tend to resolve their problems on their own and avoid seeking external support. Therefore, they may under-report any type of distress. Nonetheless, participants of the current study were drawn from a community rather than a clinical population, which would not be expected to produce a high proportion of depressed individuals.

**Clinical Implications**

The current study proposed that the level of acculturation may impact the level of depression experienced by Christian Arab American adults. Results revealed that, in congruence with their experience, Christian Arab American adults are highly immersed in their ethnic culture, yet feel at home and well-acculturated to the American culture of majority. Clinicians working with Arab Americans are initially advised to clarify their religious affiliation, rather than assuming all Arab American clients are Muslim. If relevant, addressing the role of religion in each client or family’s life may shed some light over certain coping skills. Christianity, being the religion of majority, may facilitate the adjustment of Christian Arab immigrants to a new culture and, as a result, they may feel more at home. In addition to religion, the integration of Christian Arab Americans within the larger American society can also be due to their physical appearance; Christian Arab Americans may not be distinguished by their clothing for example,
as may be the case for religious Muslim Arab Americans. Additionally, it may be a common stereotype among Americans that all Arabs have a dark skin, which is a false assumption. In reality, Arabs’ skin colors vary from white to black.

Upon planning, organizing, and implementing outreach programs and workshops around mental health awareness, professionals may benefit from consultation with important religious figures and church leaders. There is no research available that has investigated the relationship between mental health professionals and church clergy among Christian Arab Americans. That being said, Moreno and Cardemil (2013) investigated the relationship between religiosity and mental health among Latinos. They argued that religiosity and mental health may be perceived by Latinos as opposed entities for various reasons, including: (a) their belief that mental health problems occur for a spiritual reason or by a higher power and (b) their conviction that mental health treatment and the values associated with it may negate their religious beliefs. They may opt to engage in religious counseling as opposed to mental health counseling. They discussed additional hindrances among Latinos and other ethnic minority groups in seeking mental health treatment. Those barriers included the lack of access to these services, financial difficulties, the lack of trust in the effectiveness of mental health, the shame and guilt associated with it, and the fear of being misdiagnosed and/or misunderstood. Similar barriers have been found among the African American community (Allen, Davey, & Davey, 2010; Moreno & Cardemil, 2013).

The Arab American community may very likely experience similar hindrances to seeking mental health treatment. Based upon my personal experience with the Christian Arab American community for the past decade, I have come to realize that its members do not necessarily appreciate mental health services. This seems to stem from various reasons: (a) they do not trust that a mental health professional will abide by the confidentiality agreement, (b) they trust
their priest will protect them and their well-being more than any other professional, (c) they may not invest in a therapeutic relationship with a mental health professional due to its assumed high expense, (d) they resort to their elders and other family members for support, and (e) they believe that a stranger would not fully understand their unique experience. Additionally, members of the Christian Arab American community may avoid seeking mental health treatment even with an Arab counselor for lack of trust in his or her expertise or ethical and moral obligation. They are highly likely to presume that an Arab counselor will disclose their private stories to others in the community, especially if the counselor belongs to the same community or lives amongst them. I have occasionally found myself having to explain significant elements in the therapeutic relationship, including confidentiality, to my Arab American friends in order to challenge their stereotypical misconceptions.

Allen, Davey, and Davey (2010) argued that ethnic minorities, and especially African Americans, tend to require mental health services similarly to the American culture of majority. Nonetheless, there are presumably multiple factors that hinder them from seeking or accepting mental health services. Taking into consideration the previously discussed difficulties, Allen et al. suggested that clergy be identified to form a link between their congregations and mental health professionals. They believe that minority individuals tend to turn to their clergy for assistance and guidance in times of distress. The existing rapport and trust between church figures and members of their congregation may pave the way to ameliorating mental health awareness and integration in the community at large. It is mostly true that, among African Americans for example, the church is an integral part of the community and Black clergy are considered to be the gatekeepers of that community (Aten, Topping, Denney, & Hosey, 2011). Thus, it seems to be of benefit for mental health professionals to provide Black clergy, among
others, with training opportunities, and present them with outreach programming. These findings encourage further investigation as per the relationship between religion and mental health.

On the individual level, mental health professionals are advised to recognize that regardless of religion, each client has a story that is unique. An intriguing story that I heard from one of the participants in the current study highlights the experience of those who immigrated either following the establishment of the State of Israel in 1948 or in the period following the 1967 war. The participant is a man who indicated that following the war in 1967, he had nothing left to stay in his country for. The Arab world was then defeated by Israel, and the Arabs who remained within Israel were treated poorly and discriminated against by the Israeli government as well as individual citizens. Arabs who remained in Israel were also perceived as traitors by the Arab world. The participant continued to reveal that the fear of discrimination and bullying by Israeli Jews was elevated among Christian Arab Israelis. That was due to the fact that Muslim Arab Israelis were, and still are, considered a majority within the Arab population in Israel; Christians were the minority within a minority and an easy target for injustice and inequality. This participant reported that he was not accepted into a university due to the fact that he was an Arab, he was unable to find a job due to the same reason, and he felt as though there was no future for him there. Consequently, he and a group of his Christian Arab friends left the country and migrated to the United States, where he was able to finally find freedom and dignity. He completed his higher education and was able to establish a decent life with his American wife. He also shared with me that he continues to be in touch with most of his friends who emigrated; they are all reportedly successful, accomplished, and lead happy lives. He expressed his gratitude to the United States, yet admitted to missing his home country, or the way it was in 1967.
There are various facets to the Christian Arab American life that remain challenging and frustrating. Those challenges may stem from linguistic, vocational, financial, educational, familial, and political hindrances. Members of the Arab American community may continue to have difficulties voicing their opinions, needs, and concerns due to potential linguistic hardship. As with many immigrants, they may have a thought in their mother-tongue language (i.e. Arabic) and attempt to translate it simultaneously into English. Consequently, the translation may be perceived by the majority group as awkward, weird, or ignorant. Moreover, educational difficulties may arise from the inability to transfer academic credits, transcripts, or earned degrees from one’s country of origin into the American system. They may also confront difficulties earning an equivalent license enabling them to practice their respective professions. I have personally met various Arab Americans who have failed to pursue their original profession for failing to pass an equivalency test or even account for their academic achievement from their country of origin. These aforementioned obstacles are assumed to alter the quality of life of an immigrant Arab American. Thus, even though results shown in the current study indicate significant levels of acculturation among the sample participants, there remain innumerable concerns surrounding the accumulative quality of life, both for individuals and communities at large.

Limitations of the Present Study

The current study has a number of limitations to be taken into consideration. Most significant are the limitations related to variations in religious practices among Arab Christians, country of origin, age, age of arrival to the United States, and immigration status. This study included Christian Arab Americans from various congregations and denominations, but the sample size does not allow analysis by denomination. Christian Arab Americans share multiple
commonalities in their religious beliefs. However, the current study does not take into consideration potential religious differences within the Christian Arab community. It does not address the variations among congregations, communities, families, or individuals with respect to their religious beliefs, rituals, and practices. For example, Coptic Egyptians are known to be a close-knit congregation that pays increased attention to maintaining and strengthening their community ties through church. More than other congregations, such as Catholics, Maronite, and Orthodox, the Coptic Church has longer masses that may last up to 4 hours, to be followed by community bonding activities, fundraising, and other services. In the current study, participants were not asked about their level of religiosity, the time and resources they may dedicate to their church, whether their faith is an integral part of their life, or whether it has eased their acculturation process. It is possible that those differences, however minor, may impact the manner in which an individual Christian Arab American acculturates to the American society as well as his or her level of depression, if existent.

Another limitation concerns participants’ countries of origin, which is significant given the current political atmosphere in the Middle East. Christians have been migrating from the Middle East in large waves mostly due to the political and religious atmosphere. The number of Christians in the Middle East has decreased tremendously in the last two decades. The World Council of Churches reports that there are now fewer than two million Christians in the Middle East, whereas the number was close to 12 million towards the end of the 20th century (Nordland, Peraino, Mehdi, Nadeau, & Fahmy, 2007). Countries where Christians have been suffering politically and religiously include Lebanon, Palestine, and, most recently, Syria. Participants in the current study are mostly from Palestine (26.7%), Israel (23%), and Lebanon (16.8%). Lebanon, which was considered the only country in the Middle East with a Christian majority, is
currently two-thirds Muslim. In Jerusalem, Palestine, there are 12,000 Christians left. In Bethlehem, Christians are now only 20% of the total population, and there are only 3000 Christians left in Gaza. As for Egypt, the Coptic Christians are now only 6% of the total population (Nordland et al., 2007). As a result, it seems to be reasonable to understand the desire, conscious or not, for an increased acculturation to the American culture by Christian Arab Americans, which allows for a political and religious sense of security and belongingness.

An additional limitation to consider in addition to politics and religion is the time of arrival to the United States. Certain participants migrated to the United States following significant political events in the Middle East that left them hopeless, in need of asylum, or in search for a better future. For example, as mentioned in Chapter IV, 30% of participants had arrived to the United States before and during the third and largest immigration wave in 1967. It is likely that, prior to the 1967 war between the Arab world and Israel, the political and financial reality for Christian Arabs was already becoming harsh. The severely agonizing reality, which was evidenced by the killings and displacement of Arab families and villages, had been predominant since the State of Israel was declared in 1948. The second immigration wave occurred during that time to be followed by increased frustration among Arabs leading to the third wave in 1967. Additionally, the largest group of participants in the current study arrived in the 1990s (n = 30). This number is congruent with The Department of Homeland Security report (2010), stating that 245,000 individuals from Arab countries had immigrated to the United States between the years 1990 and 2000. Further, those who arrived after or shortly before 9/11/2001 would have faced an intense anti-Arab climate, which would have complicated their adjustment to a new country. Nonetheless, all participants in the current study who arrived around the 9/11 attacks scored within the minimal range of depression on the BDI-II, which refutes the
assumption that 9/11 had negatively impacted their mental health or caused their depression. This emphasizes the importance of taking into consideration all aspects related to religion, physical appearance, and resiliency that may facilitate the Christian Arab American experience with acculturation in the midst of political hardship.

The current study did not control for age group or age of arrival to the United States. The age range (22 to 80-years old, $M = 48.32, SD = 13.65$) was large and included young adults, adults, and older adults. Thus, it is reasonable to assume that variations might be present as a result of a participants’ age, age of arrival, and the number of years spent in the United States. It is likely that there are developmentally based differences among participants who had arrived to the United States during their childhood, adolescence, early adulthood, or later adulthood years. Those who arrived at a younger age may have had an easier path through the journey of acculturation versus those who arrived at a later stage in their lives. A group of participants in the current study, who are currently in their sixties and seventies, disclosed migrating to the United States during their young adulthood and admitted being very happy and fully acculturated.

Results of previous research pertaining to the age of arrival to the United States among ethnic minority groups have not been consistent. Lam, Yip, and Gee (2012) stated that an immigrant’s age of arrival, among other variables such as socioeconomic status, education, and more, can be related to his or her physical health and mental health status. Their research concluded that age of arrival impacts immigrants’ physical health, yet has an insignificant relationship with their mental health status. Nonetheless, other research findings suggest that the mere process of immigrating to another country can pose challenges to one’s mental health. Angel, Buckley, and Sakamoto (2001) found that ethnic minority groups, and specifically Latinos looking to retire in the United States and who immigrate at a later stage in life, are likely
to experience depression more than those who immigrate during their childhood years (Angel et al., 2001). Other research suggests that Chinese Americans were more likely to experience depression when they immigrated to the United States during their childhood years, and that those who arrived at a later stage in their lives were more likely to experience depression following their immigration (Hwang, Chun, Takeuchi, Myers, & Siddarth, 2005). Furthermore, higher levels of intergenerational stress between immigrant adolescents and their parents may result from a discrepancy in the level, rate, and speed of acculturation, with the younger generation typically adapting more easily (Farver, Narang, & Bhadha, 2002; Hwang, Wood & Fujimoto, 2010).

Consequently, it may be unrealistic to draw conclusions about the relationship between age of arrival and level of depression among Christian Arab Americans; further research is needed in this area.

Another significant limitation to the present study is immigration status. Despite the fact that participants in the current study identified themselves as Arab Americans, they were not asked whether they are legal residents of the United States or are American citizens. Several potential participants expressed their concern around the fact that the questionnaires they were completing (Demographics, SMAS, BDI-II) were in some way related to the government. Despite the detailed description of the study proceedings, a handful of potential participants refused to complete the questionnaires due to the fear of being questioned at a later time by governmental agencies. One cannot help but wonder whether those who were legal residents, and not yet citizens, or those who were undocumented but failed to disclose that, suffered from an increased or decreased level of acculturation or depression. It is safe to assume that it is increasingly difficult for undocumented immigrants to acculturate to the dominant American
society; thus possibly inflating their levels of depression. There is a dearth of research addressing the relationship between mental health and immigration status. In one of the few theoretical articles on the topic, Ryan-Ibarra, Epstein, Induni, and Wright (2012) suggested that immigrants may not suffer from depression as American-born individuals do. Nonetheless, they continue to argue that this may be due to cultural differences as per the manner in which depression manifests itself. No research exists that addresses symptoms of depression among Arab American immigrants. It is, thus, difficult to assume whether Arab immigrants suffer from depression as a result of their immigration status, or not.

Lastly, the results of the current study are unique to the ethnic society in question, Christian Arab Americans. It is not expected that these findings will necessarily generalize to other Arab American communities, let alone other ethnic minority groups.

**Future Directions for Research**

As mentioned above, the goal of the current study was to gain a better understanding of the unique experience of Christian Arab American adults as it relates to acculturation and depression. Results of the present study indicate that the more acculturated Christian Arab Americans are, the less likely they are to be depressed. The current study is the first that investigates the unique experience of Christian Arab Americans from a mental health perspective. An investigation of other factors that may influence depression, among other psychological constructs, is encouraged, especially among the ethnic minority of Christian Arab Americans.

Moreover, there is a need for research that aims at developing cross-culturally valid and reliable measures. This entails agreeing on a terminology for depression, or other constructs of interest, that would be harmonious and in synchrony with each perspective culture. According to
Fields (2010), there are cultures where certain constructs, such as depression, do not have a terminology that describes them. In other cultures, depression may manifest itself differently; Chang et al. (2007) suggested that symptoms of depression in Korea were somewhat different than those accounted for by the *DSM*. Since the *DSM* diagnostic criteria was used to detect symptoms of depression in their study, Chang et al. (2007) concluded that certain symptoms that are not included in the *DSM* might have not been neglected or went unnoticed. In addition, it is also important to caution test administrators against possible cross-cultural biases and stereotyping.

Additionally, the therapeutic relationship is also a source of unique cultural experience among individuals, families, and communities of an ethnic minority population. Thus, researching therapists’ attitudes and cultural competencies requires further attention in the field of mental health. Lastly, attempting to understand the unique experience of Christian Arab Americans might require outreach planning and increasing awareness, not only among Americans, but also among Arab Americans at large.

**Conclusion**

The current study provides evidence supporting the relationship between acculturation and depression. Results deserve further investigation, especially since the variance in the total depression and the cognitive-affective symptoms of depression accounted for by dominant society immersion was small. Other factors may impact the presence and intensity of acculturation and depression. Also, this study did not provide sufficient support for the possibility that higher levels of dominant society immersion are associated with lower levels of ethnic society immersion, and vice versa. This offers support to Berry’s acculturation model (1986) which proposes that individuals can be acculturated to both ethnic and dominant societies.
in a process labeled “integration” (Berry, Trimble, & Olmedo, 1986). Participants in the current study tended to be highly associated with the majority American culture; however, they maintain a strong bond with their ethnic society (i.e. language, food, social events, music, and prayer).

The literature review in this study included several studies that addressed the unique experiences of Arab/Middle Eastern Americans in the past decade. After 9/11, Arabs, and specifically Muslims, were increasingly targeted and discriminated against. The research that developed as a result focused on discrimination and bias against Muslim Arabs, barely acknowledging the existence of Christian Arabs. Multiculturalism has been a center of focus within the field of mental health. I am hopeful that current findings alongside growing appreciation for multiculturalism will encourage mental health professionals and researchers to delve deeper into psychological constructs within ethnic minorities. Moreover, I strongly believe in the ethical and moral obligation that mental health professionals, whether in the fields of academia, research, or clinical practice, hold towards an increasingly diverse world.
APPENDIX A

SOLICITATION LETTER
Dear Potential Participant,

My name is Salma Khshaiboon and I am a doctoral student at Seton Hall University’s Counseling Psychology Ph.D. program.

As a Christian Arab American, I am interested in learning more about how Christian Arab Americans, who were not born in the US, get used to living between both the U.S. and the Arabic culture. If you are an Arab American who were not born in the United States (i.e. first generation), fluent in English, and are at least 18 years old, you can participate in this study. I would also appreciate it if you could help me reach out to more Christian Arab Americans that were not born in the U.S. and are fluent in English. If you choose to, you can give them my information (listed below) so that they are able to contact me directly. If you have any questions or concerns about the study please feel free to contact me or my advisor using the contact information provided below.

The study consists of three surveys. You can complete them at your convenience, and it should take about 30 minutes to complete.

Participation in this study is voluntary and confidential and you are free to withdraw at any time by not completing the surveys, not mailing them back, or throwing them away.

If you choose to participate, I will give you a code that corresponds with your name. With the exception of your code, there will be no additional identifying information on the questionnaires or forms attached.

All data will be kept on a USB memory key in a locked filing cabinet, which can only be accessed by myself and my academic advisor, Dr. Pamela Foley.

Sincerely,

Salma Khshaiboon, M.A.
Doctoral Student
Counseling Psychology PhD Program
Department of Professional Psychology and Family Therapy
Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079
Tel: (201) 658-3430
Email: salmahabibusa@gmail.com
APPENDIX B

INFORMED CONSENT
Informed Consent

Researchers’ Affiliation
Salma Khshaiboon is a student in the Counseling Psychology program at Seton Hall University. Pamela Foley, Ph.D., ABPP is a faculty member in the Counseling Psychology Program at Seton Hall University.

Purpose and Duration of Research
This study explores the relationship between living in the United States, in the American culture, and the level of depression among first generation Christian Arab Americans ages 18 to 80. First generation means those who were not born in the United States.

Procedures
Participants will complete three questionnaires.

Instruments
The participant will fill out three questionnaires: The Stephenson Multigroup Acculturation Scale (SMAS), The Beck Depression Inventory-II (BDI-II), and a demographic questionnaire. A sample question from the SMAS is “I feel totally comfortable with (Anglo) American people” (Participant marks “false”, “partly false”, “partly true”, or “true”). A sample question from the BDI-II is “Sadness” (Participant marks 0- I do not feel sad, 1- I feel sad much of the time, 2- I am sad all the time, 3- I am so sad or unhappy that I can’t stand it).

Voluntary Participation
Participation in this study is completely voluntary. The participant may drop out of the study at any time by not completing the surveys, not mailing them back, or throwing them away.

Anonymity
There is no anonymity in this study. However, the researcher and her supervisor will be the only ones to have access to names and other identifying information of participants. The coding system is important to keep identifying information confidential and be able to follow up with participants if certain issues come up.

Confidentiality
Confidentiality is the fact that when data from this study is used, participants’ identifying information will not be used with it.

Record Retention
The researcher and her supervisor will be the only ones who can see results. All results will be stored for at least three years, as required by Seton Hall University.

Anticipated Risks or Discomfort
There is no real expected risk in this study. However, if a participant feels the need to talk to a professional person, they are advised to go to their primary care physician, local emergency room or visit the national referral link from the APA website, locator.apa.org. This is true whether the participant chooses to mail the survey back or not.

If information comes up in the questionnaires about a participant thinking about hurting him or herself, the researcher will contact him or her and remind them of the three options listed above where they can get professional assistance in their area.

Benefits to Research
There are no direct benefits from this research. The indirect benefits of this study include that the information resulting from it may inform other researchers. The results can also be used to help those who have experienced difficulties in acculturating to the United States majority culture or maintaining their culture of origin.

Contact Information
If you have any questions about this study feel free to contact the researcher at (201) 658-3430 or the co-investigator, Dr. Pamela Foley at (973) 275-2742. Questions about your rights as research participants should be directed to the Director of the Institutional Review Board at Seton Hall University, Dr. Mary F. Ruzicka, Ph.D. at (973) 313-6314 and irb@shu.edu.

Salma Khshaiboon, M.A.  Pamela Foley, Ph.D., ABPP
Tel: (201) 658-3430  Tel: (973) 275-2742
Email: salmahabibusa@gmail.com  Email: Pamela.foley@shu.edu

Participants should sign the enclosed two copies of this consent form, keep one and send the other copy back with the survey to the researcher.

_________________________________  _______________________
Participant Signature  Date
APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
DEMOGRAPHIC QUESTIONNAIRE

Please read each statement/question carefully. From the available choices, please fill in the blank or circle the one that provides the best answer.

Thank you for your participation in this study.

1. Age: ______________

2. Sex: Male Female

3. I am a Christian Arab American (please circle one): Yes / No

4. I am originally from: ________________________ (list name of country of origin)

5. I was born in the United States (please circle one): Yes / No
   If NOT:
   a) What is the country in which you were born? ________________________
   b) How old were you when you migrated to the United States? ________

6. I am fluent / semi-fluent / not fluent in reading English (please circle one)
APPENDIX D

STEPHENSON MULTIGROUP ACCULTURATION SCALE (SMAS)
Stephenson Multigroup Acculturation Scale (SMAS)

Below are a number of statements that evaluate changes that occur when people interact with others of different cultures or ethnic groups.

For questions that refer to "COUNTRY OF ORIGIN" or "NATIVE COUNTRY," please refer to the country from which your family originally came. For questions referring to "NATIVE LANGUAGE," please refer to the language spoken where your family originally came.

Circle the answer that best matches your response to each statement

_False, Partly false, Partly true, True_

1. I understand English, but I'm not fluent in English.
2. I am informed about current affairs in the United States.
3. I speak my native language with my friends and acquaintances from my country of origin.
4. I have never learned to speak the language of my native country.
5. I feel totally comfortable with (Anglo) American people.
6. I eat traditional foods from my native culture.
7. I have many (Anglo) American acquaintances.
8. I feel comfortable speaking my native language.
9. I am informed about current affairs in my native country.
10. I know how to read and write in my native language.
11. I feel at home in the United States.
12. I attend social functions with people from my native country.
13. I feel accepted by (Anglo) Americans.
15. I regularly read magazines of my ethnic group.
16. I know how to speak my native language.
17. I know how to prepare (Anglo) American foods.
18. I am familiar with the history of my native country.
19. I regularly read an American newspaper.
20. I like to listen to music of my ethnic group.
21. I like to speak my native language.
22. I feel comfortable speaking English.
23. I speak English at home.
24. I speak my native language with my spouse or partner.
25. When I pray, I use my native language.
27. I think in my native language.
28. I stay in close contact with family members and relatives in my native country.
29. I am familiar with important people in American history.
30. I think in English.
31. I speak English with my spouse or partner.
32. I like to eat American foods.


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