Acculturative Family Distancing, Religious Support, and Psychological Well-Being Among Young Adult Eastern European Immigrants in Western Washington

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ABSTRACT. Researchers have begun to explore how factors such as religious support and discrepancy in parents' and children's acculturation to their host country (acculturation gap or acculturative family distancing) affect various immigrant groups and generations. However, the body of research on these topics remains underdeveloped. This cross-sectional study investigated the relations between perceived acculturative family distancing, religious support, and well-being in a sample (N = 200) of Eastern European immigrant young adults. We predicted that lower levels of acculturative family distancing and higher levels of religious support would both be positively related to well-being. We also predicted that religious support would moderate the relation between acculturative family distancing and well-being, such that religious support would protect against the detrimental influence of acculturative family distancing on well-being. Participants completed an online survey containing demographic questions and measures assessing the 3 study variables. Both acculturative family distancing (B = .25, t = 3.50, p = .001) and religious support (B = .26, t = 2.81, p = .005) significantly predicted well-being. Additionally, religious support protected against the detrimental association of acculturative family distancing with well-being (B of Acculturative Family Distancing x Religious Support = .12, t = 2.18, p = .030), but only when the acculturation gap was small. Future research should focus on developing acculturation gap distress prevention and intervention methods.

The United States is a nation of immigrants. It is estimated that more than 40 million immigrants reside in the United States today, with 1.1 million more entering legally every year and almost as many entering illegally (Camarota, 2007). The immigration process is stressful in and of itself, but it is only the beginning of the difficult journey of learning to live in a new country and culture. The long-term stressors immigrants experience while adapting to their new lives can leave them with significant adverse psychological outcomes such as anxiety and depression (Pumariega & Rothe, 2010). These negative effects may be particularly salient in the lives of individuals who immigrated as children (one-and-a-half generation) and individuals who were born to immigrant parents in the host country (second generation immigrants). An increasing acculturation gap between them and their parent(s) can leave such individuals at an elevated risk for mental and behavioral health problems, as compared to their parents' generation (Hwang & Wood, 2009; Pumariega & Rothe, 2010). Familial acculturation gaps generally occur when children adopt host-country languages, values, and practices more quickly than their parents. The present study examined this *acculturation gap*, or "the discrepancy in acculturative status between parents and youth" (Hwang, 2006a, p. 397), and how it predicts psychological well-being in a sample

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of immigrants.

In addition to risk factors, research has suggested that there are also protective factors associated with the well-being of immigrants. The present study examined *religious support*, defined as support derived from God, religious leaders, and/or a religious congregation (Fiala, Bjorck, & Gorsuch, 2002), as a protective factor of psychological well-being. To date, studies examining these risk and protective factors among immigrants including acculturation gap and religious support have primarily considered Asian American and Latino/a experiences and may, therefore, not be generalizable to other immigrant groups. Thus, the focus of the present study was to examine how the association between acculturation gap and psychological distress is influenced by religious support in an Eastern European immigrant community in Western Washington.

Eastern European Immigrants From the Former Soviet Union (FSU)

Eastern European immigrants, refugees, and asylum seekers number more than 2.2 million individuals and constitute about 5% of the United States' total foreign-born population (Migration Policy Institute, 2012). In King County of Washington State, Eastern European immigrants and refugees number more than 33,000 individuals and account for roughly 9% of the county's foreign-born population (Felt, 2013). Most of these individuals speak Russian and/or Ukrainian and identify as Protestant Christians. Many fled to the United States in hopes of escaping religious persecution and repression in the former FSU and finding better economic opportunities in the United States.

Given their background of persecution, immigrants and refugees from the FSU are at a heightened risk for psychological distress. Even before immigration is taken into account, Eastern Europeans tend to score lower on life satisfaction surveys than people of other nationalities (Jurcik, Chentsova-Dutton, Solopieieva-Jurcikova, & Ryder, 2013). The stress of immigration and acculturation can exacerbate this vulnerability. Ginsburg (as cited in Hundley & Lambie, 2007) found that Russian speaking immigrants had higher levels of depression and demoralization than the general U.S. population. Furthermore, Chow, Jaffee, and Choi (2002) found that Russian refugees seeking mental health services were twice as likely (62.4%) to be diagnosed with an affective disorder as non-Russian refugees (31.3%). Men from the FSU are also at a high risk for alcoholism and women are four to five times more likely to experience domestic violence than women of Western countries (Jurcik et al., 2013). Given these risks, there is a great need for careful research and intervention with Eastern European immigrants from the FSU.

This immigrant group, however, poses a unique challenge to mental health service providers. For various cultural and historical reasons, many immigrants from this background are reluctant to seek professional mental health services, even if they are aware of their existence (Chow et al., 2002; Hundley & Lambie, 2007). Instead, most prefer to rely on family, friends, and religious institutions for emotional support (Hundley & Lambie, 2007; Leipzig, 2006). If these support systems remain intact, they can play an important protective role in the lives of new immigrants and refugees.

After immigration, however, these traditional support systems are vulnerable and can break down. Adjusting to a new culture and society can involve family and gender role restructuring as well as acculturation gaps and other stressors that strain family relationships and can lead to family dysfunction (Hundley & Lambie, 2007). Immigrants may grieve the loss of their old friends and have a hard time making new ones in an unfamiliar place. Support traditionally derived from religious leaders may also be strained as churches attempt to reorient to a new culture and social structure. Many leaders may be inadequately equipped to properly understand and handle the many challenges facing new immigrants and refugees, especially those confronting the one-and-a-half and second generations.

Acculturation Gap and Mental Health

One-and-a-half and second generation immigrants are at particular risk for experiencing the unfavorable mental health outcomes associated with the challenges of acculturation. Their parents and ethnic communities may expect them to retain their traditional culture while their host culture expects them to assimilate. A preference for immigrant assimilation remains a strong sentiment among the U.S. public. A Gallup poll conducted in 2007 found that 37% of U.S. respondents thought that immigrants were changing social and moral values in the United States for the worse. Additionally, 77% of respondents thought that immigrants should be required to become proficient in English in order to remain in the United States. A more recent poll

conducted by the Pew Research Center (2014) likewise found that 35% of U.S. respondents considered immigrants to be a threat to traditional U.S. customs and values. These attitudes are likely to create assimilation pressure and increase acculturative stress given that perceptions of prejudice and discrimination have been found to be related both to increased levels of acculturative stress and psychological distress among Latinos and South Asians (Alamilla, Kim, & Lam, 2010; Torres, Driscoll, & Voell, 2012; Tummala-Narra, Alegria, & Chen, 2012). In areas dominated by political conservatives, this pressure is especially strong because 81% of those who identify as Republican Steadfast Conservatives consider immigrants to be a threat to their customs and values (Pew Research Center, 2014).

According to the acculturation gap distress theory, dissonant acculturation strategies and rates within immigrant families can increase intergenerational conflict and lead to heightened distress for parents and children alike (Hwang 2006a; Lee, Choe, Kim, & Ngo, 2000; Lui, 2015). However, this conflict is often particularly detrimental to the mental health of one-and-a-half and second generation immigrants (Pumariega & Rothe, 2010; Zhou, 1997). Studies of different immigrant generations have found that one-and-half and second generation immigrants have higher levels of psychopathology including anxiety, mood, impulse control, and substance use disorders than first generation immigrants (Breslau & Chang, 2006; Breslau et al., 2007; Harker, 2001; Oquendo et al., 2001; Peña et al., 2008).

In families with large acculturation gaps, children may prefer the host country language (e.g., English), values (e.g., independence, egalitarianism), and practices (e.g., styles of dress, celebrations) while parents prefer their traditional ways and beliefs. Additionally, children may have life experiences very different from those of their parents as they more fully integrate into mainstream society. In such families, children are subject to added stress and decreased social support (Pumariega & Rothe, 2010). If they find it difficult to navigate acculturation pressures and other struggles outside the home, they may not readily go to their parents for help, believing that their parents do not understand their world and experiences well enough to properly assist them or that they are too overwhelmed with their own resettlement struggles to attend to their children's needs (Birman & Taylor-Ritzler, 2007). Furthermore, in households with significant acculturation gaps, parents often rely on their children to help them with financial and legal documents as well as doctors' appointments, parent-teacher conferences, and other situations that require host culture language and cultural skills (Portes & Rumbaut as cited in Birman & Taylor-Ritzler, 2007; Jones & Trickett, 2005). These realities not only add additional stressor to immigrant children's lives, but also disrupt typical family hierarchies and roles, and may lead to intergenerational conflict and family dysfunction.

Recognizing the importance of these issues, Hwang (2006a) developed a theory and construct termed *acculturative family distancing* to more carefully pinpoint the aspects of acculturation gaps that can become problematic. Hwang (2006a, p. 398) defined acculturative family distancing as

> the problematic distancing that occurs between immigrant parents and children that is a consequence of differences in acculturative processes and cultural changes that become more salient over time. Acculturative family distancing consists of two dimensions, a breakdown in communication and incongruent cultural values that develop as a consequence of different rates of acculturation and the formation of an acculturation gap.

Hwang and Wood (2009) have demonstrated that greater acculturative family distancing is strongly correlated with familial conflict which, in turn, is strongly correlated with depression and other symptoms of distress in Asian American and Latino/a college students. Acculturative family distancing seems to be linked to an increased risk for many behavioral and emotional problems in immigrant adolescents and young adults including anxiety, depression, problematic substance use, and various conduct problems (Carrera & Wei, 2014; Hwang & Wood, 2009; Pumariega & Rothe, 2010; Rasmi, Chuang, & Hennig, 2014; Ying & Han, 2007). The acculturative family distancing framework may reflect the experiences of Eastern European immigrants as well, but to date there is no research examining this. Based on the conceptual, theoretical, and empirical evidence, we hypothesized that acculturative family distancing would inversely predict psychological well-being in a group of Eastern European immigrant young adults.

Religious Support as a Protective Factor

Although immigrants certainly experience many challenges that put them at an increased risk for mental health issues, there are also protective factors that can lessen the detrimental impact of various stressors. Religious support is one such factor (Ai, Huang, Bjorck, & Appel, 2013; Hovey & Magana, 2000; Yi & Bjorck, 2014). There is strong evidence that religiosity is positively correlated with mental health in the general population. In a review of 100 studies, 80% "found religious beliefs and practices [to be] consistently related to greater life satisfaction, happiness, positive affect, and higher morale" (Koenig & Larson, 2001, p. 71). There is also some evidence that religious support is positively correlated with good mental health outcomes in immigrant populations. For example, Hovey and Magana (2000) found religiosity to be negatively correlated with anxiety in a population of migrant Mexican farm workers. They also found that church attendance was negatively correlated with depression. Similarly, in a study conducted with Korean Americans, Yi and Bjorck (2014) found that religious attendance, God support, and religious community support were all positively correlated with life satisfaction and negatively correlated with depression. Kim, Kendall, and Webb (2015) likewise found that positive religious coping was positively correlated with psychological well-being in Asian American college students of Christian backgrounds.

Despite these findings, the literature regarding this topic remains inconsistent because other studies have drawn contrary conclusions. For example, Dunn and O'Brien (2009) did not find religious coping to be related to mental health in Latino immigrants. Similarly, Ai et al. (2013) found no relationship between religious coping and depression. Additionally, they found that religious attendance significantly predicted reduced likelihood of depression in both Christian and non-Christian Asian Americans, but that this relationship was mediated by social support in the Christian sample (and not the non-Christian sample) and hence could not be attributed to religious coping directly. Given the discrepancy in these findings, more research needs to be conducted in this area before firm conclusions can be drawn. Based on the lack of empirical findings on the role of religiosity in the context of acculturating groups and their mental health, we decided to examine religious support as a predictor of well-being, as well as a moderator between acculturative family distancing and well-being.

Study Hypotheses

In the present study, we hypothesized that (a) acculturative family distancing would be inversely associated with well-being, (b) religious support would be positively associated with well-being, and (c) religious support would moderate the relation between acculturative family distancing and well-being by buffering the detrimental association between acculturative family distancing and well-being. More specifically, higher religious support would mean that the inverse relation between acculturative family distancing and well-being would be weaker; lower religious support would mean that the inverse relation between acculturative family distancing and well-being would be stronger.

Method

Participants

Using convenience sampling, we recruited participants from local Eastern European immigrant churches located in the Pacific Northwest via Facebook and through community leaders. Participants were asked to complete an online survey. Two hundred of the 261 individuals who started the survey completed it. One hundred eleven identified as women and 87 as men; their ages ranged from 18 to 32, with a mean of 22.36 (SD = 3.40). One hundred seventy-six participants selected Ukrainian as their ethnicity, 34 selected Russian, 17 selected Belarusian, Moldovan, or Romanian, and 3 selected other. Participants were able to select multiple ethnicities. One hundred sixty-four participants (82%) were one-and-a-half generation immigrants born overseas. The remainder were second generation immigrants born to immigrant parents in the United States. The mean number of years lived in the United States was 16.82 (SD = 4.36). One hundred sixteen participants (58%) identified as Christian Pentecostal; 71 (35.5%) as Christian Baptist, Charismatic, Nondenominational, or other; 11 (5.5%) claimed no religion; and 2 (1%) said they were unsure. Sixteen percent of participants had a high school education or below, 31.5 percent held an associate degree, and 18.5 percent held a bachelor's degree. Most (70%) were living with their parents at the time of participation.

Procedure

After Seattle Pacific University's institutional review board granted approval (IRB#: 141502007), the survey was administered online using Qualtrics® software. Participants received the link either

by e-mail or on social media. Participants were also offered the option to complete the survey in hard copy format, but none preferred this option. All participants were asked to sign an informed consent form before being directed to the demographic questions and then the three measures. The survey took 10 to 20 min to complete. Individuals were offered no incentive to participate.

Materials

In addition to a set of demographic questions regarding immigration background, religiosity, and level of education, we used three measurement instruments in this study.

Acculturation gap. The first was the Acculturative Family Distancing Measure (AFDM; Hwang, 2006a, 2006b; Hwang, Wood, & Fujimoto, 2010), a measure used to assess the size of the problematic acculturation gap between immigrant children (young adults) and their parents. This instrument consists of two scales: Communication Difficulties (CD) and Incongruent Cultural Values (ICV). We used only the English, Youth Report version, so all insight was from the young adult perspective. Participants were asked to indicate the degree to which they agree or disagree with a series of statements on a Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) for both scales. There are 24 items on the CD, 12 of which are reverse coded. A sample reverse coded item is, "I feel like there is a communication barrier between me and my parent(s)" (Hwang, 2006a, 2006b; Hwang et al., 2010). The ICV consists of 22 items; seven items are reverse coded. A sample regularly coded item is, "My parent(s) and I share the same values," (Hwang, 2006a, 2006b; Hwang et al., 2010). The CD and ICV in this study had excellent internal reliability, $\alpha = .95$ and $\alpha = .95$, respectively. The AFDM as a whole had excellent internal reliability, $\alpha = .97$. The mean score on the CD was 5.03 (SD = 1.26, range = 4.92). The mean score on the ICV was 5.42 (SD = 1.14, range = 5.77. With the CD and ICV scores combined, the mean score on the AFDM was 5.22 (SD = 1.10, range = 5.22; Higher AFDM scores indicated a smaller familial acculturation gap or less acculturative family distancing.

Religious support. The second measure we used was the Religious Support Scale (RSS; Fiala et al., 2002). This instrument consists of 21 items and measures the degree to which participants feel supported by God, their church leaders, and other members of their congregation on a Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). A sample item is, "My church leaders care about my life and situation" (Fiala et al., 2002). Three of the items are reverse coded. The mean scores for perceived support from God, church leaders, and others in the congregation were 4.35 (SD = 0.92, range = 4.00), 3.55 (SD = 1.07, range = 4.00), and 3.62 (SD = 1.00, range = 4.00), respectively. The overall perceived religious support score was 3.84 (SD = 0.87, range = 4.00). Higher scores indicate a perception of greater religious support. The RSS had excellent internal reliability, $\alpha = .96$.

Well-being. The third measure we used consisted of the psychological well-being items from the Mental Health Inventory (MHI; Veit & Ware, 1983). This measure assessed participants' general psychological well-being over the past month. Participants were asked to respond to 11 of the 14 items on a 6-point Likert-type scale ranging from 1 (*none of the time*) to 6 (*all of the time*). Each of the remaining three items has six similar, but more specific, answer choices. A sample item from this instrument is, "During the past month, how much of the time have you felt that the future looks hopeful and promising" (Veit & Ware, 1983)? The mean score for well-being was 4.11 (SD = 0.99, range = 4.79). Higher scores indicated greater well-being. The MHI also had excellent internal reliability, $\alpha = .95$.

Results

Preliminary Analyses

We first examined the bivariate Pearson correlations between acculturative family distancing, religious support, and well-being. The two AFDM scales, CD and ICV, were highly correlated, $r = .69$, $p < .001$, and results were very similar when each scale was analyzed separately. Hence, we decided to include the overall AFDM scores (i.e., CD and ICV scores combined) in all of our analyses. Consistent with the first two hypotheses, lower levels of acculturative family distancing (higher AFDM scores) and higher levels of religious support were significantly correlated with well-being, $r = .35$, $p < .001$ and $r = .32$, $p < .001$, respectively. Lower levels of acculturative family distancing (higher AFDM scores) were also positively correlated with church attendance ($r = .35$, $p < .001$) and religious support ($r = .54$, $p < .001$). Fifty-seven percent of individuals who scored over one standard deviation below the mean on the AFDM (high acculturative distancing) also scored over one standard deviation below the mean on the RSS. See Table 1 for additional correlation results.

Main Analyses

To test the study hypotheses, we used hierarchical multiple regression (results displayed in Table 2). We entered AFDM and religious support scores as predictors of well-being in the first step and the interaction term (AFDM x religious support) in the second step. All predictors were mean centered. Step 1 accounted for 14.8% of variance in well-being, $R^2 = .15$, which was statistically significant, $F(2, 196) = 16.98$, $p < .001$. Step 2, with the interaction term added, accounted for 16.8% of variance in well-being, $R^2 = .168$, and was also statistically significant $F(3, 195) = 13.12$, $p < .001$. Both AFDM ($B = .25$, $t = 3.50$, $p = .001$) and religious support ($B = .26$, $t = 2.81$, $p = .005$) were significant predictors of well-being in the second step. The regression coefficient associated with the interaction term (AFDM x religious support) was also statistically significant, $B = .12$, $t = 2.18$, $p = .030$.

To probe the nature of the interaction, we examined the relation between AFDM and well-being at various levels (+1 *SD*, M, and -1 *SD*) of religious support. We found that, at greater levels of religious support (+1 *SD*), the positive association between AFDM and well-being (i.e., lower acculturative gap predicting higher well-being) was statistically significant ($B = .35$, $t = 3.92$, $p < .001$), and the same significant trend was observed at the mean of religious support ($B = .25$, $t = 3.50$, $p < .001$). At a lower level of religious support (-1 *SD*), however, the relation between AFDM and well-being was rendered nonsignificant ($B = .14$, $t = 1.77$, $p = .078$; see Table 2). Taken together, these results indicated that higher levels of religious support (at +1 *SD* and *M*) were associated with better well-being, compared to a lower level (at - 1 *SD*) of religious support.

Moreover, examining the plot of the three levels (see Figure 1) suggested that the discrepancy between the levels of religious support was more pronounced at higher levels of AFDM scores (i.e., smaller acculturation gap). In other words, the benefit of religious support seems to be present only when there was small acculturation gap. When initially graphed (see Figure 1), the three lines representing the above findings intercepted so that, at low levels of AFDM (large acculturation gap), participants with lower religious support scores were more likely to have a higher level of well-being compared to participants with higher level of religious support. This trend was eliminated when the responses of participants who indicated that they were not religious ($n = 11$) or were "figuring it out" ($n = 2$) were taken out of the analysis. Once we excluded nonreligious responses, the lines representing the +1 *SD*, - 1 *SD*, and *M* levels of religious support converged near the origin of the graph (see Figure 2), indicating that religious support had little impact on the relation between AFDM and well-being when the acculturation gap was larger. However, the regression coefficient associated with the interaction term in this model was nonsignificant, $B = .13$, $t = 1.94$, $p = .054$. Thus, the third hypothesis was only partially supported. Religious support buffered the detrimental association between acculturative family distancing and well-being, but its protective role got weaker as acculturation gap size increased.

TABLE 1

Means, Standard Deviations, Alphas, and Intercorrelations Among Key Study Variables

	M	*SD*	*Range*	*a*	1	2	3	4	5	6	7	8	9
1. Gender [a]					-								
2. Age	22.36	3.40	14		-.09	-							
3. Place of birth [b]					-.05	.23**	-						
4. Years lived in the United States	16.82	4.36	24		.08	.17*	-.44***	-					
5. Education [c]					-.02	.20**	.03	.15*	-				
6. Church attendance [d]					.00	-.21**	-.06	-.13	-.04	-			
7. Acculturative family distancing [e]	5.22	1.10	5.22	.97	.11	-.11	-.09	-.03	-.08	.35***	-		
8. Religious support	3.84	0.87	4.00	.96	.06	-.13	-.03	-.10	-.04	.56***	.54***	-	
9. Psychological well-being	4.11	0.99	4.79	.95	-.06	-.03	.09	.07	-.06	.03	.35***	.32***	-

Note. [a] 1 = men, 2 = women; [b] 1 = United States, 2 = overseas; [c] 1 = some high school, 10 = PhD; [d] 1 = never, 2 = three of more times a week; [e] Acculturative Family Distancing Measure scores. *$p < .05$; **$p < .01$; ***$p < .001$.

TABLE 2

Results of the Moderating Effects of Religious Support on the Relation Between Acculturative Family Distancing and Psychological Well-Being

Predictor	B	β	SE	*p*
Step 1				
Constant	4.11	–	–	–
Acculturative family distancing [a]	0.23	0.26	0.07	.001
Religious support	0.21	0.18	0.09	.022
$R^2 = .148$				.000
Step 2				
Constant	4.05	–	–	–
Acculturative family distancing [a]	0.25	0.27	0.07	.001
Religious support	0.26	0.23	0.09	.005
Acculturative family distancing [a] × Religious support	0.12	0.15	0.06	.030
$\Delta R^2 = .020$				.031
Conditional Effects		B	SE	*p*
- 1 *SD*		0.142	0.080	.078
M		0.246	0.070	.001
+1 *SD*		0.349	0.089	.000

Note. [a] = Acculturative Family Distancing Measure scores

Discussion

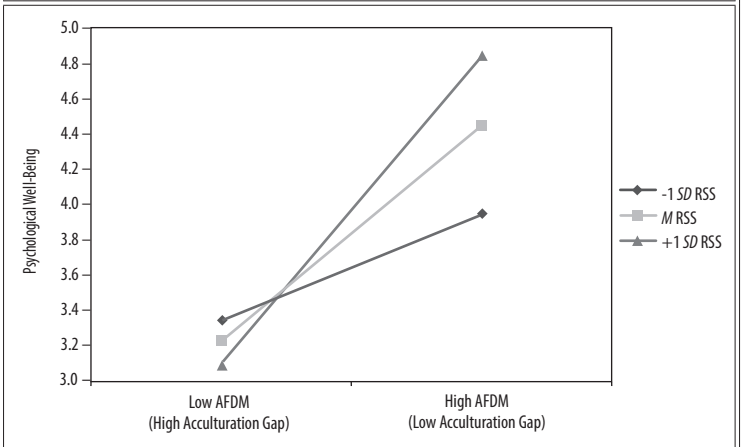
We found that lower acculturative family distancing and religious support were significant positive predictors of well-being, supporting the first two hypotheses, respectively. We also found that the third hypothesis, regarding the moderating role of religious support on the relation between acculturative family distancing and well-being, was partially supported: Well-being was greatest when acculturative family distancing (actual acculturation gap) was small and religious support was strong. Our findings were consistent with extant acculturation gap and acculturative family distancing research, providing further evidence to suggest that one-and-a-half and second generation immigrants are more likely to have greater psychological well-being if they have smaller acculturation gaps within their families (Hwang & Wood, 2009; Pumariega & Rothe, 2010). Acculturation gaps may heighten the number of stressors that immigrant children experience, decrease the amount of social support available to them, and otherwise increase family conflict, thus resulting in negative psychological outcomes for the one-and-a-half or second generation immigrant children (Hwang & Wood, 2009; Jones & Trickett, 2005; Pumariega & Rothe, 2010; Taylor-Ritzler, 2007).

In addition to supporting the acculturation gap distress hypothesis, this study added to the literature on religious support as a protective factor for immigrants. We found that well-being was positively associated with religious support including perceived support from God. In contrast to the findings of Ai et al. (2013), our findings suggested that religious support may be important to the well-being of immigrants independent of potentially related or confounding factors such as social support. In other words, religious support may be a unique protective factor, separate from other factors that positively impact immigrant well-being. However, we present this statement cautiously because we did not assess social support.

Our findings also suggested that religious support may buffer against the adverse influence of familial acculturation gaps on immigrant children or young adults, but only when the gaps are not too big. One clue that might help explain why the protective role of religious support weakened as acculturation gap size increased may be the significant correlation we found between acculturative family distancing and religious support. One-and-a-half and second generation immigrants who have retained their traditional culture along with their parents may feel supported by their traditional churches. Conversely, immigrant children and young adults who have been largely assimilated along with their parents may feel supported by U.S. churches. This leaves one-and-a-half and second generation immigrants who are too assimilated to feel supported by traditional churches but whose parents are not assimilated enough to approve of them attending U.S. churches (families with

FIGURE 1

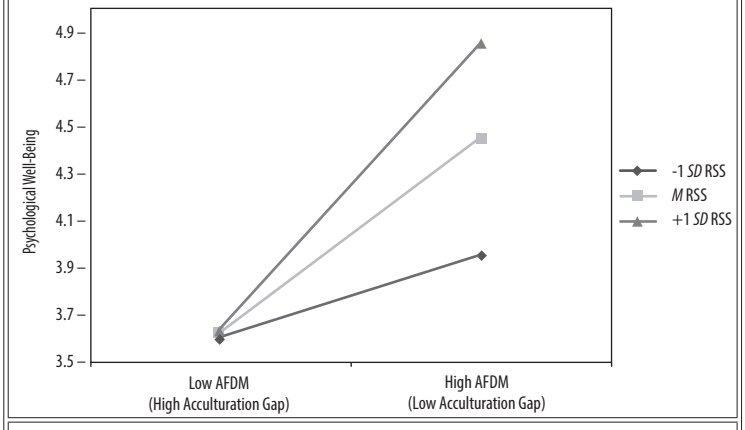
Relation Between Acculturative Family Distancing and Psychological Well-Being at Varying Levels of Religious Support



Note. The relation between Acculturative Family Distancing Measure (AFDM) and psychological well-being at +1 *SD*, *M*, and -1 *SD* levels of religious support (RSS). Note that higher AFDM scores indicate smaller acculturation gaps.

FIGURE 2

Relation Between Acculturative Family Distancing and Psychological Well-Being at Varying Levels of Religious Support Excluding Nonreligious Responses



Note. The relation between Acculturative Family Distancing Measure (AFDM) and psychological well-being at +1 *SD*, *M*, and -1 *SD* levels of religious support (RSS) after excluding nonreligious responses. Note that higher AFDM scores indicate smaller acculturation gaps.

large acculturation gaps) with little religious support. Thus, the individuals in greatest need for support may be the ones falling through the cracks. Religious communities concerned with the well-being of immigrant individuals may find this an important point to explore.

Another implication of our study may be a call for a culturally sensitive, community-based approach to working with this particular population group. Because this culture has a stigma against professional psychology and appears to benefit from close, intergenerational family relationships and religious support, mental health needs may be best addressed indirectly, through these avenues. In other words, it may be best to focus on strengthening and supporting families and religious organizations within this community instead of only relying on the method of encouraging individuals to utilize professional counseling.

Limitations and Directions for Future Research

Our study had several limitations. First, there was likely a self-report bias because the study was based on participants' own perception of the acculturative family distancing in their families, the religious support they were experiencing, and the state of their well-being. Self-report bias may be especially salient with this population because this culture places high value on respect for older adults and church leaders, and also has a stigma against mental health issues and discussing problems with outsiders. For these reasons, participants might not have been honest about their experiences, despite the confidential nature of our study. Alternatively, immigrants experiencing high familial acculturation gap might have inadequately judged the amount and/or quality of religious support they were experiencing. Second, a self-selection bias might have occurred because we used convenience rather than random sampling. Individuals with higher educational attainment and those better versed in English were probably more likely to take the survey and therefore be overrepresented in the sample. The survey might also have been too difficult for some individuals with less educational attainment or English proficiency to complete successfully. Third, individuals who were more religious might also have been overrepresented in the study because we recruited primarily from churches and through church leaders. The median amount of church attendance for this participant group was twice a week.

Given these limitations, the findings of the present study should not be generalized to FSU immigrants residing outside of Western Washington, those who are less religious, or those who differ from the present participant group in any other systemic way. This study should also be repeated with a random sample if possible before any strong conclusions about FSU immigrants within Western Washington are drawn.

There is still much room for research within this immigrant population. In addition to a repetition of the present study, a study exploring the experiences of a younger participant group may be of particular value. Adolescents might be uniquely sensitive to acculturative stress, intergenerational conflict, and religious support. Therefore, understanding how they are impacted by these factors can be crucial to their current and future success and well-being. It may also be interesting to explore the direct impact that different family and community acculturation strategies have on one-and-a-half and second generation immigrants as well as the strategies these adolescents and young adults employ to cope with acculturation gaps within their families. Finally, research focused on acculturation gap distress prevention and intervention methods could be especially beneficial to immigrant individuals, families, and communities.

Conclusion

The present study highlighted the moderating role of religious support in the association between acculturation gap and well-being in a sample of Eastern European participants. We are optimistic that our findings will contribute to the larger body of empirical work focused on bettering the lives of acculturating immigrants in the United States.

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