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Constructs, measurements and models of acculturation and acculturative stress

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ABSTRACT

This critique of acculturation research is anchored on an historical examination of the development of acculturation constructs and their operationalizations as psychometric scales. An historical search finds the origins of acculturation in derogatory beliefs about aboriginal and immigrant minorities, finds the old and continuing paradox that acculturation is presumed to improve mental health and to damage mental health, finds the near universal inter-twining of acculturation with mental health issues, and finds that nearly one century of such research has had little utility. Measurements of acculturation by bipolar scales since the 1940s and by unconstrained ipsative scales since the 1970s have confounded the research record. Measurements of acculturative stress by scales designed for mental health screening have confounded dependent and independent variables. More recent measures based on factor analytic sub-scales have confounded acculturative stress with acculturation and with other constructs. This review recommends (a) that acculturation be defined as second-culture acquisition, (b) that acculturative motivations, learning, and changes be conceived, measured, and sometimes studied independently of health issues, (c) that bilineal measures be used, (d) that acculturative stress be discontinued as an intervening variable, and (e) that SES and discrimination always be controlled by covariate methods.

The purpose of this review is to anchor a critique of acculturation research on an historical examination of the development of acculturation constructs and their operationalization as psychometric scales. First, a brief history will note the origins of acculturation in derogatory beliefs about aboriginal and immigrant minorities, will note the old and continuing paradox that acculturation is presumed to improve mental health and to damage mental health, will note the near universal inter-twining of acculturation with mental health issues, and will note that this approach has had little utility. Second, disentangling the confusions will require considerations of enculturation as first-culture acquisition in order to understand acculturation to be second-culture acquisition, not to be confused with cultural change at the collective level. Third, the measurement of acculturation by bipolar scales since the 1940s and by fourfold scales since the 1970s will be shown to entail complications that have confounded the research record. Contemporary reviews recommend bilineal scales. Fourth, the measurement of acculturative stress by scales designed for mental health screening will be shown to have confounded dependent and independent variables. More recent measures based on factor analytic sub-scales confound acculturative stress with acculturation, with discrimination, and with SES. This review will recommend (a) that acculturation be defined as second-culture acquisition, (b) that acculturative motivations, learning, and changes be conceived, measured and sometimes

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studied independently of health issues, (c) that bilineal measures be used, (d) that acculturative stress be discontinued as an intervening variable, and (e) that SES and discrimination always be controlled by covariate methods.

1. Historical review

Although acculturation phenomena are ancient, for example, discussed by Plato, the word "acculturation" was coined only in 1880 (Rudmin, 2003a,b,c). Historically, immigrants and aboriginal peoples were stereotyped as ignorant, unhygienic, and prone to disease, insanity, and criminality, such that the assimilation of these peoples to Anglo-Saxon ways was thought to relieve these problems through modernization and mental evolution (Escobar, Nervi, & Gara, 2000; Escobar & Vega, 2000; Hunt, Schneider, & Comer, 2004; Jastrow, 1886; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Rudmin, 2003c; Thielman, 1985). In other words, acculturation was thought to improve health and well-being.

However, one of the earliest empirical studies of immigrants, using diaries and letters, found that assimilation to urban, industrial modernity could cause personality disintegration if traditional mental schemas (habits of perception, cognition and emotion) were not maintained (Thomas & Znaniecki, 1918). The idea that acculturation caused mental disorders and marginality was further developed in the 1920s by Bartlett (1923/1970), Miller (1924), Park (1928) and others. For example, Redfield, Linton, and Herskovits (1936, p. 152) argued that "psychic conflict" can arise from incompatible cultural norms. Early psychiatric studies (e.g., Ødegaard, 1932, 1936) confirmed the high prevalence of schizophrenia and depression among immigrants.

The paradox that acculturation is thought to decrease mental problems and to increase mental problems is well illustrated by a 1942 study that found the most assimilated American Indians to have "*much higher percentages of both best adjusted and most maladjusted individuals*" (Hallowell, 1942, p. 42). This paradox is also well illustrated in the opening presumptions of a 1948 review of "Acculturation and Illness":

> Crime, suicide, and mental disease are examples of abnormal behavior which commonly are correlated with foreign nativity and ethnic background. Recent neurotic behavior and psychosomatic conditions have been found to be in part expressions of maladjustment due to culture change (Ruesch, Jacobsen, & Loeb, 1948, p. 1).

The presumption persists to the present day that ethnic minorities should have impaired health either due to the inferiority of their cultures, or to the distress of intercultural contact, or to the distress of acculturative change. Most research seeks to find modes of acculturation that improve minority mental health under the presumption that it needs improving. Thus, it is called a "paradox" and "counter-intuitive" when data show minorities to have superior mental health (e.g., Franzini, Ribble, & Keddie, 2001; Markides & Coreil, 1986; Palloni & Arias, 2004; Sam, 2006; Sam, Vedder, Ward, & Horenczyk, 2006; Stimpson & Urrutia-Rojas, 2007).

Such presumptions about minority mental health have come to dominate acculturation research. For example, from the 1940s, 1950s, and 1960s, there were studies about "conflicts in the process of acculturation" (Long, 1944, p. 64), about "emotional stress accompanying the acculturation process" (Kuhlen, 1945, p. 121), about the "psychosocioeconomic problems" of acculturation (Wolman, 1949, p. 601), about "frustrations of acculturation" (Hallowell, 1950, p. 732), about the "cultural stresses" of acculturation (Eggan, 1952, p. 469), about the "stress reactions" of acculturation (Caudill, 1958, p. 34), about "increasing intrapsychic tensions" during acculturation (DeVos & Miner, 1958, p. 255) and about ["the influence of acculturation on mental equilibrium"] (Merten de Wilmars, & Niveau, 1960, p. 385). These conceptualizations coalesced into the concept of "acculturative stress", which may have been coined by Barnett, Broom, Siegel, Vogt, and Watson (1954, p. 994) and which was first used in a title by Ausubel (1960).

The idea that acculturative stress and ill health are the central features of acculturation is well illustrated by Hong and Holmes (1973, p. 683) in the abstract to their report of a case study:

> "Presents a case study of transient diabetes mellitus occurring in migration from a foreign country (Korea) to the US. The patient described a dream-like, semishock state in which he experienced overwhelming frustrations, a sense of insecurity, feelings of helplessness, and inability to reason clearly and think logically when he faced sudden cultural changes induced by the migration. The diabetic symptoms and signs disappeared within 3 years after onset when the patient regained a sense of security and competence, and when he had become adapted to the new culture."

With this strong historical focus on the problems posed by minority peoples, and with the salience of such clinical cases, acculturation theory has become totally intertwined with stress. A simplified model of acculturation theory is illustrated in Fig. 1, drawn from historical surveys of 20th century acculturation literature (Rudmin, 2003a,b), most recently articulated by Born (1970), Berry (1970, 1980, 2006), Tadmor and Tetlock (2006) and others. The presumption is that the strangeness of a new culture causes stress at time of contact (T1), which motivates the minority to have an orientation to be assimilated by the new culture, or to be separated from it, or to become biculturally integrated, or to just endure the stress of marginalization (Berry, 1970, 1980; Born, 1970; Lewin, 1948). These orientations are presumed to determine how much the minority culture changes. Such cultural changes result in changes in stress, which will have health consequences.

This kind of conceptualization of acculturation has come to dominate acculturation research, such that it is not commonly studied independently of stress and health issues. For example, a full-text search of PsycARTICLES (comprised of 63 psychology journals from 1894 to the present) found 1532 articles mentioning "acculturation", and of these, 1328 (87%) also mention "stress" or "health".