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PSYCHOLOGICAL DISTRESS AMONG CUBAN AND COLOMBIAN  
IMMIGRANTS IN MIAMI: CONSIDERING THE ROLES OF  
ACCULTURATION AND ETHNIC DISCRIMINATION

By

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## ABSTRACT

Although researchers concerned with Hispanic American mental health have long recognized the roles of acculturation and ethnic discrimination in shaping health, many questions remain about the conditions under which these factors have their influence. To what extent do acculturation and discrimination matter for Hispanic American health in US contexts with strong Latin cultures? Can acculturation and ethnic discrimination explain Hispanic subgroup variation in distress? Using data from the Physical Challenge and Health study, the current investigation examines the roles of five dimensions of acculturation as well as perceived ethnic discrimination in predicting depressive symptoms among Colombian and Cuban adult immigrants in Miami (N=451). Cuban and Colombian immigrants represent an interesting comparison in this context because of similar reasons for migration and because both groups are relatively high in SES in comparison with other Hispanic immigrant groups. Results indicate that Colombian immigrants report higher mean levels of psychological distress than Cuban immigrants. While the indicators of acculturation together attenuate the observed elevation in Colombian distress relative to Cubans to some extent, there is a differential influence of level of American orientation across groups on distress. Specifically, stronger American orientation is beneficial for Cuban immigrant health but detrimental for Colombian immigrant health. Also, stronger ethnic identity is associated with less distress across immigrant groups. However, preference for socializing with others from within one's ethnic group is associated with more distress. Finally, perceived ethnic discrimination is associated with higher levels of distress net of all dimensions of acculturation, social status considerations, and difficulties with the performance of functional activities. These findings support the conclusion that acculturation and discrimination are universal factors in Hispanic American mental health and reinforce the importance of assessing the independent contributions of multiple dimensions of acculturation in the study of Hispanic American mental health.

## CHAPTER ONE

### INTRODUCTION

Recent epidemiological studies reveal variation in rates of psychiatric disorders (Kessler et al 2003; Alegría et al 2007) and levels of psychological distress (Bratter and Eschbach 2005) across Hispanic American groups. A related and growing body of literature provides evidence of the role of social factors, such as acculturation and ethnic discrimination in Hispanic American mental health (Narrow et al 1990; Williams, Neighbors, and Jackson. 2003; Finch et al 2004; Thoman and Surís 2004; Bratter and Eschbach 2005; Ramos 2005; Borrell et al 2006; Paradies 2006; Alegría et al 2007). However, most information gathered across these literatures concerns the largest ethnic groups: Mexican Americans and Puerto Ricans, and to a lesser extent, Cuban Americans. Far less is known about smaller groups, such as Colombian Americans. Moreover, experiences of acculturation and ethnic discrimination can be expected to differ across national origin groups in the same community given relative location in the social structure. However, few studies of the acculturation-health and discrimination-health relationships include more than one Hispanic group in the same community for purposes of comparison. Thus, while there have been recent advances in estimating Hispanic American mental health and establishing the role of social factors in health, opportunities remain to broaden knowledge by studying two or more lesser-studied Hispanic groups who co-exist within the same community context.

Hispanic American groups differ in their circumstances of migration and choice of US destination (Zhou 2001). These factors have been found to be associated with exposure to social stress and psychological distress (Berry et al 1987). While many Cubans and Colombians migrated to Miami or New York as political refugees/asylum-seekers (Portes and Stepick 1993; Collier 2004), Mexicans and Puerto Ricans<sup>1</sup> largely migrated to seek employment in these and other US locations (Zhou 2001). Reasons for

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<sup>1</sup> I here refer to Puerto Ricans who migrated to the mainland US as Puerto Ricans born on the island are native US citizens.

migration likely affect attitudes of the receiving populations. In addition to Federal residency policies that hinder or facilitate migration, communities differ in the provision of accommodations to Hispanic immigrants through local policy, which likely mirror local attitudes<sup>2</sup>. It is thus reasonable to suspect that immigrant mental health may be affected by the character of the local environment through experiences of ethnic discrimination and the process of acculturation. However, the Hispanic mental health literature rarely takes into account a historical reading of migration and social factors in the receiving community that may influence the acculturation process. For these reasons, scholars on the cutting edge of Hispanic mental health research have begun to stress the importance of contextualizing health at the community level (e.g. Alegría et al 2006).

Miami represents a unique social environment in which to study Hispanic immigrant mental health and associated psychosocial factors. Miami contains the largest proportion of immigrants of any US city (Zhou 2001). The majority (57.3 percent) of the population is of Hispanic origin, with Cuban Americans being the largest ethnic group (US Bureau of the Census 2000). However, there are also sizable numbers of other Hispanic ethnic groups, notably Colombian Americans, who might be meaningfully compared with the Cuban majority given similarities in their SES and reasons for migration.

The comparison of these groups is of further interest because Cuban and Colombian Americans are similar and dissimilar in several respects associated with Hispanic mental health. These groups share similar patterns of migration to Miami, with earlier waves generally consisting of wealthier individuals and subsequent waves being more socioeconomically heterogeneous (Portes and Stepick 1993; Collier 2004). Many Cuban and Colombian immigrants are also Spanish-English bilingual (Zsembik 2000). In terms of differences, Cubans represent a numerical and, some have argued, a cultural majority in Miami (Portes and Stepick 1993; US Bureau of the Census 2000). In

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<sup>2</sup> Consider the cases of New Haven, Connecticut, where the local Aldermen approved a municipal identification card system for undocumented, mostly Hispanic, immigrants in order for them to open bank accounts, etc. (New York Times Section B, p.1 column 1 June 8, 2007) and successful “English-only” initiatives in the towns of Oak Point, Texas (Dallas Morning News June 18, 2007) and Carpentersville, Illinois (Northwest Herald June 20, 2007).

contrast, Colombians have less cultural influence and have not yet achieved the sociopolitical gains that their Cuban counterparts enjoy (Collier 2004). At the surface, group cohesion and the feelings of being welcomed to the new environment also appear to differentiate these groups. Cubans have strong group solidarity that is largely grounded in their opposition to Cuban leader Fidel Castro<sup>3</sup> and access to a thriving social and economic ethnic enclave (Portes 1984; Portes and Stepick 1993). In comparison, Colombians in Miami are a relatively fragmented group and lack their own ethnic enclave (Guarnizo and Díaz 1999; Collier 2004). Finally, whereas Cubans received substantial government assistance in their resettlement (Portes and Stepick 1993), many Colombians experienced most “unwelcoming environments” upon arrival due to prohibitive US immigration policies and difficulties gaining entry into the existing Latin economy of Miami (Guarnizo and Díaz 1999). These differences suggest that, in Miami, Colombians may be disadvantaged in terms of risk for psychological distress relative to their Cuban neighbors. However, given the strong Latin influence in the community and protective benefits of high SES, it is not yet known whether the Cuban majority will be meaningfully differentiated from Colombians by social factors such as acculturation and ethnic discrimination: factors that are generally implicated in the mental health of Hispanic Americans. The context of Miami thus represents a natural laboratory in which to study the role and significance of acculturation and discrimination in accounting for Cuban and Colombian immigrant psychological distress. Such a study may advance understanding of Hispanic American mental health by assessing and comparing the levels of psychological distress among understudied groups and examining the extent to which ethnic discrimination and acculturation matter for Hispanic immigrants’ health among groups with relatively high SES residing in a Latin-dominated community.

Attending to these considerations, I present results from two sets of exploratory analyses. In the first set, I investigate mean levels of psychological distress as well as the proportions of respondents who meet criteria for clinically significant depressive symptomatology across and within Cuban and Colombian immigrant groups. These analyses also compare these groups in levels of five separate dimensions of acculturation

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<sup>3</sup> This opposition continues in relation to Fidel Castro’s First Vice President and brother Raúl Castro, who is currently leading the country.

as well as the perception of ethnic discrimination. In the second set of analysis, I assess the extent to which acculturation and ethnic discrimination are associated with distress net of social status factors and examine whether acculturation and ethnic discrimination either independently or together account for group differences in depressive symptoms observed. I also assess whether these social factors have differential effects on the relationship between group membership and level of distress. I thus employ a competing hypothesis framework to discover whether acculturation and discrimination work through mediating or moderating effects to account for any ethnic group differences observed in psychological distress.

To do so, I employ Wave One of the Physical Challenge and Health study (Turner, Lloyd, and Taylor 2006). The central focus of this parent study is to assess the associations between physical disability and DSM-IV psychiatric and substance use disorders. However, this data set is also well-suited to meet my objectives. Roughly 50 percent of respondents are Hispanic adults residing in Miami-Dade County, Florida. Among these respondents, there are adequate numbers of both Cuban (N=373) and Colombian (N=78) immigrants with data on sociodemographic, acculturation, and discrimination variables to permit multivariate analyses. Also, multiple dimension of acculturation will be investigated for their independent and combined roles in distress. While the central intention of study which produced this data set was to provide information on how physical disability is associated with mental health, roughly half (46 percent) of the relevant sample is without any physical disability<sup>4</sup>, indicated by functional activity limitations. However, as a consequence of employing these data, difficulties experienced in the performance of functional activities will need to be controlled in descriptive group comparisons and OLS multivariate models.

I first review existing research on Hispanic American psychological distress and disorder, with particular attention to the available literature considering Colombians and Cubans. I then review factors considered to be important indicators of acculturation. Following this, I review the empirical literature on the acculturation-mental health

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<sup>4</sup> In the full sample, which includes non-Hispanic whites, African Americans, and Hispanic groups other than Cuban and Colombian Americans, roughly 28 percent (559/1986) confirmed the presence of a physical disability (Turner, Lloyd, and Taylor 2006:217).

relationship, with particular attention given to research concerning Hispanic Americans. I then review the empirical literature on the racial/ethnic discrimination-mental health relationship, again with particular attention to Hispanic Americans. Subsequent to this, I review the migration patterns of Cuban and Colombian Americans in Miami and compare these groups in terms of social location in this community. I then describe the sample and measures and discuss statistical methods used to address my concerns prior to presenting empirical findings and discussing their implications. I now turn to the empirical literature assessing Hispanic American mental health, with particular consideration given to race/ethnic group differences in depressive disorders and psychological distress.

## CHAPTER TWO

### REVIEW OF THE LITERATURE: DISTRESS AND DISORDER AMONG RACE/ETHNIC GROUPS

#### Introduction

This review of empirical literature will focus on the social distribution of two depressive disorders: Major Depressive Disorder (MDD<sup>5</sup>) and Dysthymia, as well as psychological distress among Hispanic Americans. My general goal is to document how Hispanic Americans in general and Cuban Americans and Colombian Americans in particular compare in terms of their relative levels of depression. I also review the literature concerning Hispanics as a pan-ethnic group as well as the literature on Mexican Americans and Puerto Ricans, as the majority of literature available concerns these social categories. Much of the literature involving Hispanic Americans as a pan-ethnic category compares levels of distress and rates of disorder with non-Hispanic whites. I will thus provide some information about how Hispanic Americans suffer from depression relative to non-Hispanic whites to demonstrate how disaggregation of the pan-ethnic Hispanic category results in a very different picture of the social distribution of depression.

I have organized this chapter from the most general to the most specific literature pertaining to Cuban and Colombian immigrants in Miami. I consider the social distribution of depression among Hispanics by first reviewing key studies that group Hispanic Americans into a pan-ethnic category. I then review the research pertaining to the largest national-origin groups (i.e., Mexican Americans and Puerto Ricans). Following this, I consider the available information on Cuban and Colombian Americans and finally focus on those studies concerning these groups conducted in Miami. I now turn to review the empirical literature on Hispanic American psychological distress and depressive disorder.

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<sup>5</sup> I will refer to Major Depressive Episodes as MDD as well.

## Findings from National Studies Aggregating Hispanics

Major depression and depressive symptoms are among the most widely observable mental health problems experienced in the U.S. (Kessler et al 1994; Bratter and Eschbach 2005; Hasin et al 2005). Depression is defined as an unpleasant mood that negatively affects individuals through factors such as disability, economic productivity, suicidality (World Health Organization 2004), and comorbid conditions including other psychiatric disorders (Kessler et al 2003) and alcohol/substance abuse (Zayas, Rojas and Malgady 1998; Hasin et al 2005). At severe levels, depression can be incapacitating. As such, depression represents a major public health concern that may greatly diminish the quality of life of individuals suffering its effects. In recognition of this concern, several major studies have been conducted to assess the prevalence and social distribution of depression.

The National Comorbidity Survey (NCS) was the first national epidemiological study to assess a range (14 in total) of DSM psychiatric diagnoses among the general US population (Kessler et al 1994) using the Composite International Diagnostic Interview (CIDI; World Health Organization 1990). This study sampled non-institutionalized English-speaking individuals aged 15-54 years. Hispanic Americans were not found to differ from non-Hispanic whites in lifetime prevalence of any affective disorder, though Hispanics had 38 percent higher odds of having any past year affective disorder than non-Hispanic whites.

However, another study (Breslau et al 2005) using the NCS data provided prevalence estimates of any lifetime, past-year, and past-year among lifetime mood disorders (MDD, dysthymia, and mania) by race/ethnicity. Lifetime prevalence rates for Hispanic Americans and non-Hispanic whites were 17.9 percent and 19.8 percent, respectively. While Hispanic Americans appear to be slightly advantaged in risk for lifetime mood disorder over non-Hispanic whites, this difference did not reach statistical significance. In terms of past year mood disorders, 13.4 percent of Hispanics and 10.7 percent of non-Hispanic whites met diagnostic criteria for caseness. While Hispanic Americans appear to be slightly disadvantaged in risk for past-year mood disorder over non-Hispanic whites, this difference again did not reach statistical significance.

Hispanics were found to be at significantly higher risk for mood disorders than non-Hispanic whites in the 12 month prevalence among lifetime cases category, with 29.1 percent of Hispanics and 20.6 percent of non-Hispanic whites reporting ever suffering from at least one of the three specific disorders. Thus, according to the NCS data, a higher proportion of Hispanic Americans have suffered from a mood disorder in their lifetime compared to the general population (Kessler et al 1994), though Hispanic Americans may be slightly advantaged, if anything, over non-Hispanic whites in lifetime mood disorder (Breslau et al 2005). However, Hispanic Americans appear to be slightly disadvantaged compared to non-Hispanic whites, if anything, in more recent recurrent mood disorders (Breslau et al 2005).

Using data from the replication of the NCS (NCS-R), Kessler and colleagues (2003) examined lifetime and past year MDD among adults 18 years or older in the general US population. In this study, an aggregated Hispanic group was no more likely than non-Hispanic whites to have experienced MDD in their lifetime without adjustments. Nor were differences found across these groups among those who have experienced past year MDD within those reporting lifetime MDD, or among severe past year cases. However, Breslau et al (2005b), also using NCS-R data, though adjusting for age and gender, found that Hispanics had lower lifetime prevalence of both MDD (13.5 percent vs. 17.9 percent) and dysthymia (2.2 percent vs. 4.3 percent) compared to non-Hispanic whites. Hispanics were found to have a 30 percent lower lifetime risk of MDD and a 50 percent lower risk of lifetime dysthymia than non-Hispanic whites. In contrast to the original NCS, the NCS-R findings support the conclusion that Hispanics are relatively advantaged in lifetime depression compared to non-Hispanic whites, if any group difference exists.

In another national study, Hasin and colleagues (2005) employed data from the National Epidemiological Survey of Alcoholism and Related Conditions (NESARC) to estimate race/ethnic rates of MDD among US adults ages 18 years and older. This study employed the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version (Grant, Dawson, and Hasin 2005) to assess the presence of lifetime and past year MDD, among other disorders. Lifetime MDD for an aggregated Hispanic group was estimated to be 9.6 percent compared to 14.6 percent among non-Hispanic

whites. Hispanics were at significantly lower risk of lifetime MDD than Non-Hispanic whites (OR=0.6). Hispanics were also found to have a lower prevalence of past year MDD (4.3 percent) than non-Hispanic whites (5.5 percent), though no test of statistical significance was provided with this comparison. Thus, prevalence estimates of Hispanic American depression are lower in the NESARC data than in the NCS-R data. However, these studies both support the conclusion that Hispanic Americans are relatively advantaged over non-Hispanic whites in depression, where differences exist.

However, not all national studies agree. For example, Dunlop and colleagues (2003) employed data from the Health and Retirement Survey (HRS) to compare Hispanics with non-Hispanic whites in rates of past-year MDD. This study sampled adults aged 54-65 years and employed the short form of the CIDI to estimate the prevalence of disorder. Hispanics were found to have 44.0 percent greater odds of having MDD than non-Hispanic whites, with 10.8 percent of Hispanics and 7.8 percent of non-Hispanic whites reporting past-year disorder. Of course, this finding that is contrary to both the NCS-R and the NESARC and may be due to differences in the age range of the samples considered or use of different diagnostic instruments.

Taking these studies together, little can be confidently stated about the occurrence of MDD or dysthymia in the US Hispanic population. Estimated prevalence rates of lifetime MDD range from 9.6 percent (Hasin et al 2005) to 13.5 percent (Breslau et al 2005). Moreover, it is not clear whether Hispanic Americans significantly differ from non-Hispanic whites in terms of depression. However, it appears that Hispanic Americans may be slightly advantaged in depression, if any differences exist. Inconsistencies across studies may be due to differences in sampling and assessment or the inclusion of adjustments. Perhaps more importantly, it is not clear how the Hispanic group rates are affected by the heterogeneity present in the category due to a variety of national origins being subsumed under the same heading. Nor is it clear if Hispanic subgroup differences in depression exist and if this may partially explain different findings due to unequal representation of various groups across studies. As a consequence, even if agreement were reached across studies in estimated prevalence of depression among Hispanic Americans and relative odds were agreed upon across race/ethnic groups, this would do little to inform programs and policies.

Scholars are increasingly recognizing this limitation and some have re-analyzed data with the Hispanic group disaggregated into national origin groups while others have collected new data capable of making comparisons across Hispanic national origin groups and other race/ethnic groups. This disaggregation generally includes only the three largest US Hispanic groups: Mexican Americans, Puerto Ricans and Cuban Americans, as well as an aggregation of “other” Hispanic origin groups. While we may directly learn about Cuban American mental health from these studies, we may also be able to find clues to inform expectations about the health of more under-studied groups such as Colombian Americans. For example, if Cuban Americans are found to be advantaged in depression relative to Mexican Americans and Puerto Ricans after adjustments for SES<sup>6</sup>, it may be reasoned that Cuban Americans may also be advantaged relative to Colombian Americans. I reason that, in a possible world where Hispanic American ethnic groups do not differ in SES, and Cubans are advantaged over the two largest Hispanic ethnic groups in distress, that Cuban Americans may also be advantaged in distress over another Hispanic group equal in SES in an environment where Cuban Americans dominate.

### **Findings from National Studies Investigating Hispanics of Various National Origins**

The national studies that have disaggregated the “Hispanic” group into national origin groups and compared these groups with other race/ethnic groups also present inconsistent findings. Ortega and colleagues (2000) investigated Mexican Americans, Puerto Ricans, and other Hispanics using the NCS data and compared lifetime prevalence of affective disorders, consisting of both MDD and dysthymia, with rates for non-Hispanic whites. No group differences in affective disorders were found with adjustments for age, income, and education. However, these finding may differ from Kessler and colleagues’ findings (1994) reported above due to disaggregation or

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<sup>6</sup> This adjustment would be appropriate because Hispanic subgroups differ in average SES and because SES is associated with mental health.

adjustments for age, income, and education. No group-specific prevalence estimates were reported.

Bratter and Eschbach (2005) employed the National Health Interview Survey data (NHIS) to compare levels of past-month non-specific psychological distress across Mexican Americans, Cuban Americans, Puerto Ricans, other Hispanics, Native Americans, African Americans, Asian Americans and non-Hispanic whites. Analyses included males and females eighteen years of age and older. Distress was assessed through the K6 scale<sup>7</sup> (Kessler et al 2002). Mexican Americans and Puerto Ricans were found to have significantly higher mean levels of distress than non-Hispanic whites, though no differences were found between Cubans or other Hispanics compared with whites.

The National Latino and Asian American Study (NLAAS; Alegría et al 2006) is the first national study specifically designed to assess psychiatric disorders across Hispanic national origin groups as well as race groups. The Hispanic subsample is nationally representative of both Spanish and English speaking individuals ages 18 years and older. Alegría and colleagues (2007) investigate the prevalence of past year and lifetime DSM-IV psychiatric disorders assessed via the CIDI. While prevalence rates of *any* of eleven specific lifetime and past-year disorders were reported by ethnic group, only comparisons of group risk were offered specifically for depressive disorders. Dysthymia and MDD were included in the composite category “depressive disorders.” Group comparisons were made across Mexican Americans, Cuban Americans, other Hispanics, and Puerto Ricans, with the latter-most serving as the reference group. Cuban Americans were not significantly different from Puerto Ricans in either past year or lifetime MDD. Mexican Americans were found to be significantly advantaged over Puerto Ricans for both males (OR=.57) and females (OR=.69) in terms of lifetime depressive disorders. No significant group differences were found for past year depressive disorders.

These few national studies that are capable of disaggregating Hispanic national origin groups together (i.e., Ortega et al 2000; Bratter and Eschbach 2005; Alegría et al

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<sup>7</sup> This is a six item short form scale based on a larger ten item scale, both developed by Kessler and colleagues (2002)

2006, 2007) suggest that Puerto Ricans and Mexican Americans may be disadvantaged in terms of depression compared to non-Hispanic whites and Puerto Ricans appear to be disadvantaged compared to Mexican Americans. Cuban Americans do not appear to be significantly different from either non-Hispanic whites or Puerto Ricans in terms of depression. While national studies of depression that permit analyses of Hispanic national origin groups represent a clear advancement over studies that permit only an aggregated Hispanic group, the uneven regional distribution of Hispanics (Zhou 2001) may require community-based studies to better understand Hispanic American mental health, especially among Cuban Americans and Colombian Americans who are located in just a few communities, including South Florida. This is because social factors that influence Hispanic mental health may differ across communities.

### **Findings from Community Studies**

Oquendo and colleagues (2001) investigate past-year prevalence rates of MDD for Mexican Americans, Puerto Ricans, Cuban Americans, non-Hispanic whites, and African Americans using pooled data from the Epidemiological Catchment Area Survey (ECA) and the Hispanic Health and Nutrition Epidemiologic Survey (HHANES). Both surveys sampled Cuban Americans from the Miami area and both employed the National Institute of Mental Health Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, and Ratcliff 1981) to assess MDD. Respondents between the ages of 20-74 were included in Oquendo and colleagues' (2001) analyses. Mexican Americans were found to be advantaged (2.8 percent) and Puerto Ricans were found to be disadvantaged (6.9 percent) in the prevalence of past-year MDD relative to non-Hispanic whites (3.6 percent). No difference was found between Cuban Americans and non-Hispanic whites, though it may be noted that 2.5 percent of Cuban Americans reported past year MDD (lifetime, six month, and one month prevalence rates are presented below), which is a lower proportion than among any other group.

Lifetime MDD was later assessed by Oquendo and colleagues (2004) using the same pooled data. Mexican Americans interviewed in the HHANES served as the reference group in statistical analyses. Non-Hispanic whites and Puerto Ricans had

significantly higher proportions of lifetime MDD (6.3 percent and 9.3 percent, respectively) than the Mexican American reference group (4.2 percent). Cuban Americans, African Americans, and other Hispanics in the ECA study (primarily Mexican Americans in the Los Angeles Area) were not significantly different than the reference group in lifetime MDD. It may also be noted that 3.2 percent of Cuban Americans (all sampled in Miami) reported lifetime MDD, a proportion that is lower than that of any other group. Thus, among the three largest Hispanic groups, Cuban Americans report the lowest prevalence of both past year and lifetime MDD.

I reason that, since Cuban Americans in Miami appear to be at a relative advantage over other Hispanic groups and non-Hispanic whites sampled in the ECA, Cubans in Miami may also be advantaged relative to their Colombian neighbors. Later, I will argue that, beyond this evidence based on empirical findings, that a reading of social history of immigration to and incorporation in Miami may also be seen as evidence to support the hypothesis of a relative Cuban mental health advantage over Colombians.

This review of empirical literature thus far suggests that there is some heterogeneity inhering within the classification “Hispanic American” in terms of depression. Hispanic groups of various national origins appear to be at differential risk for depression. Specifically, it appears that Puerto Ricans are disadvantaged relative to other Hispanic groups and that Cuban Americans appear to be advantaged relative to other Hispanic groups. In an attempt to refine this understanding of Cuban American mental health, I will now turn to studies that specifically address this issue as it applies to the context of Miami.

### **Depression among Cubans in Miami**

Given that the majority of Cuban Americans reside in the greater Miami area (Zhou 2001), several studies assessing the mental health of Cuban Americans have been conducted in South Florida. As mentioned above, the Cuban American subsample of the HHANES was drawn from South Florida (Narrow et al 1990). In addition to the assessment of MDD (past-year and lifetime reviewed above; Oquendo et al 2001, 2004), significant depressive symptomatology was assessed using the standard cut-off point of

16 on the 20-item CES-D scale using the HHANES data (Radloff 1977; Narrow et al 1990). This threshold has been found to be correlated with clinician assessments of depression (Radloff 1977)<sup>8</sup>. The mean CES-D score for Cuban American adults ages 20-74 years was 5.5 on the scale ranging from zero to 60, with 10 percent of the sample reaching the threshold for significant depressive symptomatology. The DIS prevalence rates by time period were as follows: lifetime=3.2 percent, six-month=2.1 percent, and one-month=1.5 percent. The authors report that “the results of this survey show relatively low rates of depressive symptoms and depressive disorders in Cuban Americans compared to other Hispanic groups and the United States population as a whole” (Narrow et al 1990:267).

In a study of psychiatric disorders among young adults (ages 19-21 years) in Miami-Dade County, Turner and Gil (2002) estimated the prevalence of MDD and dysthymia using the CIDI diagnostic instrument within nativity status. Nineteen percent of US-born and 17.8 percent of foreign-born Cuban Americans met criteria for lifetime MDD. Rates were similar for other Hispanics, with 18.3 percent of US-born and 18.0 percent of the foreign-born experiencing lifetime MDD. Also similar to Cuban Americans, 20.0 percent of non-Hispanic whites experienced lifetime MDD. It appears that there were no significant group differences within nativity status in past year MDD, with group prevalence as follows: US-born Cuban = 12.4 percent, foreign-born Cuban = 7.4 percent, US-born other Hispanic = 13.6 percent, foreign-born other Hispanic = 11.6 percent, non-Hispanic white = 13.1 percent. These groups also appear to be similar in terms of dysthymia, with 1.7 percent of US-born Cubans Americans, 0.5 percent of US-born other Hispanics, and 0.2 percent of non-Hispanic whites experiencing dysthymia in their lifetime. Thus, among young adults, Cubans do not appear to be at any greater or lesser risk for depressive disorders than other Hispanics or non-Hispanic whites.

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<sup>8</sup> CES-D scores of 16 and higher have been described in the literature as “minor depression” and have been found to be associated with increased risk for cardiac mortality (Penninx et al 2001). There is also some evidence that this traditional cut-off point has “satisfactory criterion validity for major depression” (Beekman et al 1997:234). However, some researchers caution that significant CES-D scores are not equivalent to clinician-assessed diagnoses (Weissman et al 1977).

Another investigation (Turner, Taylor, and Van Gundy 2004), employing the same data, found that mean scores of depressive symptoms on a modified version of the CES-D scale<sup>9</sup> (Radloff 1977) were significantly lower for Cuban Americans (Mean = 1.7) than other Hispanics (Mean = 2.4; Nicaraguan Americans represent the largest proportion of national origin groups in this category), and distress was higher among other Hispanics than non-Hispanic whites (Mean = 1.6). Still another unpublished study based on these data suggests a Cuban advantage over other Hispanics in psychological distress. Turner, Taylor, and Russell (2004) found Cuban Americans to report substantially lower psychological distress in the second wave of data collection (two years after the initial collection) than other Hispanics.

No group differences were found between Cuban Americans and non-Hispanic whites in a sample of female college students in Miami (Rodriguez-Hanely 2004). In this study, depression was assessed with the Beck Depression Inventory (Beck et al 1961). Non-Hispanic white women reported a mean depression score of 10.2, while Cuban American women reported a mean score of 9.5<sup>10</sup>, though this difference was not statistically significant. As in the Turner and Gil (2002) study, Cuban Americans in Miami do not appear to differ in depression from non-Hispanic white neighbors to any meaningful degree.

In the study from which I draw data for the current analyses (Turner, Lloyd, and Taylor 2006), major depression and dysthymia (among other disorders) were assessed by the CIDI among Cuban Americans and other race/ethnic groups in Miami-Dade County, Florida. Among respondents without physical disability, Cuban Americans were found to have a higher prevalence of lifetime MDD (6.8 percent) than an aggregated group of other Hispanics (4.4 percent; Colombians being the largest group in this composite category). In contrast, among respondents with a physical limitation, Cuban Americans had a lower prevalence of MDD (18.5 percent) than other Hispanics (21.5 percent). Cuban Americans fared better in MDD (6.8 percent) than non-Hispanic whites (9.1 percent). This pattern was reversed among the disabled, with 18.5 percent of Cuban

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<sup>9</sup> The instrument was shortened and set in the past month, as opposed to the past week.

<sup>10</sup> These mean scores bridge Beck's categorization of minimum and moderate depression.

Americans and 12.8 percent of non-Hispanic whites suffering from lifetime MDD. It thus appears that Cuban Americans' relative risk of lifetime MDD compared to other Hispanics and non-Hispanic whites is conditioned by the presence or absence of physical limitations. There does not appear to be meaningful group differences in dysthymia. Among the non-disabled, 1.5 percent of Cuban Americans, 1.1 percent of other Hispanics, and 1.4 percent of non-Hispanic whites suffered this disorder in their lifetime (Turner, Lloyd, and Taylor 2006). Among the disabled, other Hispanics appear to be the most likely to experience dysthymia with 11.3 percent meeting criteria, though only 4.1 percent of Cuban Americans and 3.0 percent of non-Hispanic whites do so. However, group differences were not statistically significant.

Table 1 presents a summary of the studies reviewed assessing depressive disorders and/or psychological distress among Cuban Americans. The studies support the conclusion that Cuban Americans in Miami are either advantaged over other race/ethnic groups (Narrow et al 1999; Turner, Taylor, and Van Gundy 2004; Turner, Taylor, and Russell 2004) or that no group differences exist (Oquendo et al 2001, 2004; Turner and Gil 2002; Rodriguez-Hanely 2004; Bratter and Eschbach 2005; Turner, Lloyd, and Taylor 2006; Alegría et al 2007;) in terms of distress or depression.

### **Depression among Colombians and Colombian Americans**

There are few estimates of depression among Colombians or Colombian Americans in the literature. Because Colombians are, as I will later detail, a relatively recently arriving group in the US, and because of the sparseness of information available on the mental health of Colombians, I provide estimates from both Colombia and the US. I begin by reviewing studies that occurred in Colombia.

Table 1. Summary of Studies Assessing Miami Cuban Depressive Disorders or Psychological Distress Noting Comparisons with any other Race/Ethnic Group.

| Study                         | Author(s)                          | Ages Considered (In Years) | Gender(s) Considered | Outcome                   | Cuban Advantage | Cuban Disadvantage | No Sig. Group Difference | Notes   |
|-------------------------------|------------------------------------|----------------------------|----------------------|---------------------------|-----------------|--------------------|--------------------------|---|
| HHANES                        | Narrow et al 1990                  | 20-74                      | M/F                  | CES-D & DIS MDD           | X               |                    |                          | No direct tests of group differences reported though Cuban advantage based on group scores in same data |
| Transitions W1                | Turner and Gil 2002                | 19-21                      | M/F                  | CIDI MDD                  |                 |                    | X                        |   |
| Transitions W1                | Turner, Taylor, and Van Gundy 2004 | 19-21                      | M/F                  | Modified CES-D            | X               |                    |                          |   |
| Transitions W1 & W2           | Turner, Taylor, and Russell 2004   | 19-21                      | M/F                  | W2 CES-D                  | X               |                    |                          |   |
| Unpublished Dissertation Data | Rodriguez-Hanely 2004              | 18-22                      | F                    | Beck Depression Inventory |                 |                    | X                        |   |
| Physical Challenge and Health | Turner, Lloyd, and Taylor 2006     | 18-94                      | M/F                  | CIDI MDD & Dysthymia      |                 |                    | X                        | Oversampling of physically-challenged respondents   |

Table 1. - Continued

| Study        | Author(s)                 | Ages Considered (In Years) | Gender(s) Considered | Outcome | Cuban Advantage | Cuban Disadvantage | No Sig. Group Difference | Notes |
|--------------|---------------------------|----------------------------|----------------------|---------|-----------------|--------------------|--------------------------|-------|
| NHIS         | Bratter and Eschbach 2005 | Adults 18+                 | M/F                  | K6      |                 |                    | X                        |       |
| NLAAS        | Alegría et al 2007        | Adults 18+                 | M/F                  | CIDI    |                 |                    | X                        |       |
| HHANES & ECA | Oquendo et al 2001        | 18-74                      | M/F                  | DIS     |                 |                    | X                        |       |
| HHANES & ECA | Oquendo et al 2004        | 18-74                      | M/F                  | DIS     |                 |                    | X                        |       |

The World Health Organization (WHO) surveyed a representative sample of residents aged 18-65 years in urban settings in Colombia to estimate the prevalence of several classes of DSM-IV psychiatric disorders (WHO World Mental Health Survey Consortium 2004). Past-year prevalence of mood disorders (composite of depressive, dysthymia, and bipolar disorders) was estimated to be 6.8 percent via the CIDI<sup>11</sup>. Other studies that focus specifically on depression have reported higher prevalence estimates than this composite mood disorder estimate.

In particular, two studies estimated the prevalence of current depression in Colombia. One of these estimated that 15.8 percent of Colombian citizens, ages 12-60 years, suffered some level of current depression measure with Zung's Depression Scale (Gómez and Rodriguez 1997; Zung 1965). Of these, 11.8 percent were estimated to have mild depression, 3.4 percent to have moderate levels, and 0.6 percent to have severe depression via Zung's Depression Scale (Gómez and Rodriguez 1997). Another study employed both Zung's Depression Scale and clinical interviews among a random general population sample in Bucaramanga, Colombia (Campo-Arias et al 2006). Clinically meaningful symptoms were found to be present in 35.7 percent of the sample via Zung's Self-Administered Depression Scale, which is intended for the screening for those at risk of major depression. Clinical interviews estimated that 16.5 percent of subjects met criteria for MDD. It thus appears that somewhere between 7.0 percent and 17.0 percent of Colombians have experienced some mood disorder, including MDD, in the recent past, though roughly 36 percent have experienced a significant level of psychological distress.

Within the US, Portes and Zady (2002) sampled second generation Colombian American 8<sup>th</sup> and 9<sup>th</sup> grade students in both South Florida and San Diego. Data were drawn from Youth Adaptation and Growth Questionnaire collected for the Second Generation Project in Miami and San Diego (Portes and McLeod 1996). The sample included both males and females and a sufficient number of students of both Colombian and Cuban descents for analyses by national heritage. While the focus of analysis was Hispanic group differences in self-esteem, a four-item subscale of the CES-D (Radloff

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<sup>11</sup> These results are from a larger, international study of mental health involving fourteen countries. Of the countries investigated, Colombia and the US had the highest prevalence estimates of psychiatric disorders.

1977) was used to assess depressive symptoms. Analyses combined students from South Florida and San Diego and separated students of Cuban heritage into those enrolled in private and public schools. Portes and Zady (2002) found that Colombian students reported a marginally higher mean level of distress (6.6) compared to Cuban students in both private (6.0) and public (6.5) institutions, though no tests of statistically significant group differences were provided, nor were estimates provided for the occurrence of significant depressive symptoms.

A study of young adult (18-32 years) Hispanic American men in New York City included CES-D (Radloff 1977) depression as a predictor of alcohol use (Kail, Zayas, and Malgady 2000). These researchers found that Colombian men reported a mean distress score (4.5) higher than that of Dominican men (2.8), though lower than that of Puerto Rican men (4.7). While these three groups significantly differed in CES-D distress, no particular group comparisons were provided across any two groups. Nonetheless, this is some additional evidence of Hispanic national origin group differences in depression.

Because what is known of Colombian and Colombian American distress and depression has been derived through a variety of instruments (i.e., DIS, Zung, CES-D), and inferred from samples that varied in age ranges and community circumstances (i.e., Bucaramanga, San Diego, Florida, New York), conclusive statements about Colombian depression remain elusive. This is especially so among Colombian Americans for whom only one community estimate is available and this is limited to young men in New York. It should be noted that estimations from New York likely offer little insight into Colombians residing in Miami because Colombians in Miami lack the ethnic enclave that they enjoy in New York.

Further research is needed to estimate the level of distress among Colombian Americans and how this level compares with other Hispanic American groups. We may speculate that Colombian Americans in Miami are more distressed on average than are Cuban Americans given clues from this review of empirical literature. First, Cuban Americans, predominately sampled in Miami, appear to be advantaged where differences exist, over other US race/ethnic groups in terms of depression. Second, Colombians in their homeland have among the highest occurrence of mood disorder among fourteen countries assessed (WHO World Mental Health Survey Consortium 2004). This

propensity for mood disorder may carry over or even increase with migration to the US<sup>12</sup>. Third, as I later argue in detail, Cubans in Miami are in a position of significant social, economic, and political advantage over all other race/ethnic groups in this community. These considerations suggest that Cuban Americans in Miami are likely advantaged relative to other race/ethnic groups, including Colombian Americans. I will argue that immigrant acculturation and experiences of ethnic discrimination likely contributes to levels of distress and group differences in distress observed in the analyses that I present below. A review of literature on the acculturation-distress and discrimination-distress literatures (below) will make this point clear. Before reviewing these literatures, I will briefly discuss the concept of “acculturation.”

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<sup>12</sup> I will later review the literature that links greater exposure to the US to higher levels of psychological distress and rates of disorder among Hispanic immigrant groups.

## CHAPTER THREE

### CONCEPTUALIZING “ACCULTURATION”

As Marín, Organista, and Chun (2003) have noted, acculturation is “arguably the most important moderating variable or construct considered when conducting [mental health] research...that involve[s] ethnic minority individuals” (p. 208). In the case of the currently study, we may expect acculturation to moderate the relationship between ethnic group and psychological distress. Marín, Organista, and Chun (2003) identify nativity; time in the US; cultural pride; cultural practices, beliefs and values; language preference, and preference for in-group social affiliation as dimensions of acculturation.

The term “acculturation” has been used for decades with some variety of intended meanings. However, until recently, most understood the concept in terms of its classical definition: “...those phenomena which result when groups of individuals having different cultures come into continuous first hand contact with subsequent changes in the original cultural patterns of either or both groups” (Redfield, Linton, and Herskovits 1936:149). Theorists and researchers have taken this broad definition and emphasized various components of “change” and how this might affect individuals and groups. Despite Redfield and colleagues’ recognition that change can happen to either or both groups, research has suggested that most of the change happens in the newly arriving culture (Ruiz 1994). Furthermore, most research has focused on changes in the immigrant culture as they adapt to the host, or receiving culture<sup>13</sup> and has taken a snapshot in one point of time as opposed to assessing change in adaptation over time.

“Adaptation” is usually understood to mean beneficial changes in the immigrant culture in terms of attitudes, behaviors, and/or values that enable the individual and, by extension, the group to more successfully navigate the receiving culture and the stressors associated with getting on in a new social environment. Successful navigation may entail learning a new language, changing the makeup of one’s social network, and changing

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<sup>13</sup> I will describe in detail below how this may not have been the case for later Cuban immigrants to Miami.

social identity, as examples. Stressors involved may include difficulties experienced in these changes or experiences of ethnic discrimination. The acculturation literature documents a historical struggle to best conceptualize and measure acculturation.

Early conceptualizations of acculturation (e.g., Stonequist 1935; Redfield et al 1936) largely held an “assimilation” perspective. These “assimilation” models presume that the foreign culture will be lost over time and that arriving populations will become less distinguishable from the receiving culture in most respects<sup>14</sup>. In this model, a zero-sum characterization of cultural orientation is implied wherein the more an individual or group takes on the social patterns, preferences, and behaviors of the receiving culture, the less will they maintain their culture of origin. Stonequist (1935) held that when an individual maintained a bicultural orientation, one that is placed midway between native and host orientation, she or he would experience a marginalized identity with no strong ties to either culture, and thus become more susceptible to the insults that are potentially avoidable through cultural ties. While this zero-sum conceptualization has largely fallen out of favor, examples of its use persist in recent literature (Arcia et al 2001; Zayas, Rojas, and Malgady 1998).

There remain some situations where the assimilation model is useful. One example is when an investigator is interested in the frequency of Spanish or English language use. It is conceptually necessary in such a case that the more often one speaks English, the less often one speaks Spanish, or vice versa. This is necessarily a zero-sum sort of scenario for which the assimilation model is well-suited.

It is important to note that in the assimilation model, there is no allowance for individuals to simultaneously be strongly or weakly oriented toward *both* the ethnic and receiving cultures in terms of identification. Recognizing this conceptual limitation, scholars began to measure acculturation with what Ward (2001) refers to as the “acculturation model.” Here, native and receiving cultures are seen as counteracting forces and an individual may have equal balance of orientation toward both though is not necessarily presumed to be marginalized or at risk. However, a limitation remains. Being

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<sup>14</sup> These early works were largely anthropological, concerned groups over individuals, and paid little attention to the influence of personal agency (Berry 1999; Salant and Lauderdale 2003).

bicultural is understood to be the state of being no more oriented toward either the ethnic or the receiving cultural, as opposed to being strongly oriented toward both cultures, which is conceptually possible. Thus, while this acculturation model represents an improvement over the assimilation perspective by recognizing that an individual may be equally oriented toward two cultures at once while not necessarily being marginalized. This approach fails to accommodate the situation where an individual may be strongly oriented toward each perspective.

The term “psychological acculturation” was coined by Graves (1967) to refer to change in individual psychology (within social context) as opposed to group change. Over time, interest increased in this social-psychological perspective (Padilla 1980). Psychological acculturation emphasizes personal agency (Cabassa 2003). With personal agency, it is supposed that an individual may maximize life chances by identifying with the most beneficial aspects of both the ethnic and the receiving cultures. In this revised conceptualization of “acculturation” (Laframboise et al 1993), scholars (Szapocznik 1980; Szapocznik and Kurtines 1980; Berry et al 1987) argue for two independent dimensions of orientation toward the host or receiving culture (e.g. American orientation) and toward culture of origin (e.g. ethnic identity). Given these two independent dimensions Ward (2001) has referred to this conceptualization and its measurement as “orthogonal.” In this model, an individual may choose to maintain his or her native cultural orientation while at the same time taking on aspects of the host culture as a matter of constrained preference or strategy.

The term “assimilation” is here understood to be the state of being highly oriented toward the host culture while being minimally oriented toward the native culture. The immigrant has abandoned the ethnic culture for that of the mainstream and has thus “melted” into the receiving culture. It is important to note that, from this perspective, assimilation is one possible result of the meeting of distinct cultures and not the end result of a determined process of taking on the patterns of the host culture. Because individuals may vary in strength of identification with both the ethnic and receiving cultures, different acculturative modes or types may be described based on the relative strength of orientation on each axis. With independent dimensions of orientation toward native and receiving cultures, biculturalism may be the state of being strongly oriented

toward both. Marginality is still possible through being weakly oriented toward both cultures. Here, an individual may choose a strategy of cultural orientation that may be maximally beneficial in terms of the reduction of acculturative stress, however it is recognized that agency and the success of a chosen strategy is constrained by personal, social, historical, and contextual factors (Kosics et al 2005).

Considering the assimilation approach and the typology approach, Laframboise and colleagues (1993) explain:

What differentiates the two models is that the assimilation approach emphasizes that individuals, their offspring, or their cultural group will eventually become full members of the majority group's culture and lose identification with their culture of origin. By contrast, the acculturation model implies that the individual, while becoming a competent participant in the majority culture, will always be identified as a member of the minority culture<sup>15</sup> (p. 397).

Rogler and colleagues (1991) have argued that estimation of the level of orientation toward the culture of origin should be separated from estimation of orientation toward the receiving culture. This argument was based on information gathered through focus groups that suggested that individuals do in fact vary in their strength of identification with both groups. It is arguable that no single research team has elaborated the typology model to allow the estimation of orientation towards both groups with more impact than J. W. Berry and colleagues (Berry et al 1987; Berry & Kim 1988). Berry's (1987) multidimensional model proposes a fourfold categorization schema that logically results from distinguishing high from low levels of orientation both toward the ethnic culture and the host culture<sup>16</sup>. In Berry's model, "integration" refers to a bicultural mode wherein an individual is highly oriented toward both the native and host culture.

It is hypothesized that integration is related to greater flexibility in managing social situations, which facilitates adaptation (de Domanico, Crawford, and De Wolfe

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<sup>15</sup> It is likely that visible ethnic minorities may never be fully assimilated and that phenotypical distinctions will be used to circumscribe the out-group so long as racism rooted in claims to scientifically verifiable differences across race/ethnic groups persists.

<sup>16</sup> While I am not able to create such an acculturation typology given data limitations, I mention Berry's approach in order to review findings demonstrating that biculturalism is most beneficial for adaptation. I will, however, include measures of acculturation that tap both orientation toward the US and ethnic orientation.

1994:198). Given the weight of evidence suggesting that biculturalism is beneficial (reviewed below), it appears that integration does provide greater flexibility in negotiating situations and meeting needs that benefits psychological well-being. An alternative, though related explanation is that a strong orientation to the host culture is itself enough to be protective regardless of the level of orientation toward the native culture. In the common circumstance where data do not allow for the creation of typologies due the lack of a comparable set of indicators tapping orientation toward the receiving culture as is available for ethnic orientation (i.e. enculturation), one compromise is to assess the independent effects of cultural orientation toward the ethnic and receiving cultures separately and test for independent contributions for mental health.

## CHAPTER FOUR

### EMPIRICAL PATTERNS OF ACCULTURATION AND DISTRESS/DEPRESSION

#### **Exposure to the US and Psychological Acculturation in Relation to Mental Health**

Research on the relationship between acculturation and Hispanic American mental health has produced some inconsistent results (Rogler, Cortes, and Malgady 1991), though the bulk of growing evidence suggests that higher levels of exposure to US culture and American orientation are associated with increases in depression and distress (Narrow et al 1990; Finch et al 2004; Thoman and Surís 2004; Bratter and Eschbach 2005; Ramos 2005; Alegría et al 2007). Indicators of acculturation commonly attempt to measure exposure to the US and/or degree of psychological acculturation (i.e. Americanization). Exposure to the US is generally measured by nativity status (US-born vs. foreign-born), generational status, or years in the US (for immigrants). Psychological acculturation is most commonly measured by language use, proficiency, or preference; social identity; and sometimes by level of preference for socializing with other members of one's ethnic group. While these are not the only dimensions of acculturation theorized to have an impact on cross-cultural adjustment, they are well-represented in the literature.

Most existing research on the Hispanic acculturation-mental health association has been conducted with Mexican Americans (e.g., Alderete, Vega, Kolody, and Aguilar-Axiola 2000), though there are an adequate number of studies considering Puerto Ricans and Cuban Americans to draw preliminary conclusions. In reviewing the empirical literature on the acculturation-mental health relationship, I will first consider studies employing a pan-ethnic Hispanic classification. I will then consider studies including Mexican Americans, followed by those including Puerto Ricans, and finally Cuban Americans. I then review a few studies, not specifically on the acculturation-depression relationship, that include Colombian Americans.

Considering Hispanic Americans as an umbrella group, Alegría and colleagues (2007), drawing on the NLAAS data, discovered "...a uniform trend in which overall

[lifetime] disorder rates were higher among Latinos proficient in English, than among Latinos with poor or fair English-language proficiency, the exceptions being depressive disorders among women...and anxiety disorders among men...” (p.71). Odds of overall psychiatric disorders were lower among all immigrant groups (irrespective of years in the US) than the US-born. In another study by Alegría (2007b) using the same data, men with good or excellent English language skills were at higher risk of past year depressive disorders than men with fair or poor skills and third generation men were at higher risk of having a past year depressive disorder than first generation men. A general pattern emerged suggesting that increased exposure to the US and being more highly proficient in English was associated with higher risk for disorder. Likewise, Bratter and Eschbach (2005), employing the NHIS, found that immigrants and those lacking in English proficiency reported lower past month psychological distress than the US-born and the more English-proficient. These relationships were found to persist after adjustments for a large variety of social status variables. Similarly, Ortega et al (2000), employing the NCS data, found that the acculturation items (nativity and language preference) were risk factors for any psychiatric disorder among Mexican Americans and “other Hispanics.”

While studies that employ the pan-ethnic classification may be useful to establish the general relationship between acculturation and mental health among Hispanics, they offer no information about how particular national origin groups may be similar or may differ in this relationship. This is so because pan-ethnic classifications likely conceal group differences that may emerge through differential community experiences or differing cultural practices or norms.

Many studies have concerned Mexican Americans in the acculturation-mental health relationship. For example, Neff and Hoppe (1993) assessed CES-D (Radloff 1977) distress among Mexican Americans in San Antonio, Texas by level of acculturation. The acculturation index consisted of language preference/nativity and was trichotomized to permit analyses of high, medium, and low levels of acculturation. The authors found that “the moderately and the least acculturated Mexican-American males had significantly higher levels of depression than did the highly acculturated Mexican-American males ...” (p.8). While speculations can be made about how community circumstances may influence the relationship under investigation, this influence may be

more thoroughly assessed by the inclusion of a comparison group. Because there was no other group for which acculturation was assessed, no comparisons can be made across groups in the acculturation-distress relationship in this community. In contrast, Finch and colleagues (2004), in a study of Mexican migrant farm workers in Fresno, California, found that more years in the US and better English language skills predicted higher levels of CES-D (Radloff 1977) distress. In terms of psychiatric disorder, Vega and colleagues (1998), also drawing on this sample of Mexican Americans in Fresno, estimated the lifetime prevalence of twelve CIDI-assessed psychiatric disorders. Nativity, language use, and years in the US were included as indicators of acculturation. The authors found that “the native-born lifetime rate for any disorder (48.1%) ... was twice that of immigrants (24.9%)” (p.774). The prevalence of major depression was lowest among immigrants (3.2 percent), higher among those in the US for 13 or more years (7.9 percent), and highest among the US-born (14.4 percent). A similar pattern emerged for dysthymia, with a greater proportion of native-born Mexican Americans (5.2 percent) reporting lifetime dysthymic disorder than either immigrants or those in the US for 13 or more years (both 1.6 percent). Furthermore, respondents who elected to complete the survey instrument in English were thirty percent more likely to have experienced a lifetime mood disorder than those who completed the survey in Spanish.

It thus appears that, greater exposure to the US and higher levels of acculturation are generally associated with decrements in mental health for Mexican Americans. Because these studies consider a particular national-origin group as opposed to an aggregation of groups, they offer more guidance in understanding the acculturation-mental health relationship, at least among Mexicans. This is because, a particular national-origin group may experience or express acculturation and/or distress differently than another group. Also, studies of particular Hispanic groups help to better understand this association because particular communities are identified in which particular groups reside which may influence experiences of acculturation and distress.

Similar findings have emerged for mainland Puerto Ricans. In a study of CES-D (Radloff 1977) distress among Puerto Ricans in the Northeast (HHANES sample), Ramos (2005) assessed the role of language preference/usage as an indicator of acculturation. Higher acculturated men reported higher levels of distress than the lower acculturated.

One limitation regarding the generalizability of this work is that it is not clear in what communities respondents reside within the in the Northeast. Thus, no speculation is possible about how community circumstances might impact both acculturation and distress. This negative acculturation-mental health relationship was also found in another major study including Puerto Ricans. Alegría et al (2007) reveal that risk for past year depressive disorders is increased by 70.0 percent among US-born Puerto Ricans compared to immigrants who arrived after age six in the NLAAS.

Several studies of the acculturation-mental health link have included Cuban Americans. Cuban American respondents in the HHANES who were born in the US were at higher risk (5.1 percent) for lifetime major depression than were the foreign-born (3.0 percent; Narrow et al 1990). Another study found that US-born Cuban Americans in Miami reported a higher mean distress level (9.9) than foreign-born Cuban Americans (8.6), though this difference was not statistically significant (Rodriguez-Hanely 2004). Rivera (2007), using the Transitions data (Turner and Gil 2002) investigated the link between acculturation and CES-D (Radloff 1977) psychological distress among a sample of young Hispanic adults in the Miami area. The index of acculturation included language usage, ethnic loyalty, and ethnic social relations. Higher levels of acculturation were associated with higher levels of distress both with and without controls for sociodemographic factors. Nativity status was not significantly associated with distress net of covariates. Non-Cuban Latinos did not significantly differ in depressive symptoms from Cuban Americans net of acculturation and other controls. Level of anxiety has also been found to be elevated among US-born Cuban American college students relative to their foreign-born peers (Casares 1999). While these studies support the conclusion that Cuban Americans experience declines in mental health with higher acculturation, there are some inconsistent findings in the literature.

Some studies of Cuban American mental health support the conclusion that higher levels of acculturation (i.e. US Americanization) is not associated with mental health or is salutary for health. Two studies demonstrated no association. In a young adult sample in South Florida, foreign-born Cubans reported equal prevalence of lifetime and twelve month major depression and dysthymia as US-born Cubans (Turner and Gil 1999). It should be noted that, while this study employed the same data as that conducted by

Rivera (2007) discussed above, that different outcomes were employed across these studies. Thus, no contradiction in findings is present. Acculturation did not appear to be associated with depression in another study in the same area. English language proficiency was not meaningfully related to depression among Cuban Americans in Miami (Alfaro-Chilelli 2001:120). Bratter and Eschbach (2005) report that US-born Cuban Americans had a lower mean level of distress (1.8) than immigrants residing in the US fifteen or more years (2.3), those in the US five to fifteen years (2.2), and those in the US less than five years (2.3). Also, English-speaking Cuban Americans reported nearly identical mean levels of distress (2.12) compared with non English-speaking Cuban Americans (2.07). It is not clear whether these are meaningful differences because tests of statistical significance were not provided.

One study appears to support the position that acculturation is protective for mental health. In a study of the role of acculturation in anxiety, Rivera-Sinclair (1997) collected data on a convenience sample of Cuban American men and women ages 18-90 years in the Washington, DC area. Surveys were administered in both Spanish and English by respondents' choice. Anxiety was assessed via a modified version of the State Anxiety Scale (Spielberger, González-Reigosa, and Martínez-Urrutia 1971). Time in the US was found to be negatively associated with anxiety.

Two other studies suggest a protective role of increased exposure to the US for Cuban Americans. Gil and Vega (1996) found that language and acculturation conflicts decreased with more years in the US among adolescents. Parents of these adolescents also experienced decreases in language conflicts with more years in the US. Interestingly, the relationship between years in the US and acculturation conflict was found to be curvilinear for parents, with low levels of conflict early after immigration, the highest levels in the three to ten years in the US interval, and low levels reemerging after residing in the US for 11 years or more. Another study suggests that Cuban Americans may be advantaged over Mexican Americans among those residing in the US from an early age. Alegría and colleagues (2007) found that Cuban Americans who were in the US as a child were advantaged over Mexican Americans who were in the US as a child in past year depressive disorders with adjustments for age and sex. Though some ambiguity

exists, the bulk of evidence suggests that increased exposure to the US and higher levels of acculturation are detrimental for Cuban American mental health.

Though limited, there is some evidence that a similar relationship exists between acculturation and mental health for Colombian Americans, such that higher levels of acculturation are associated with decrements in health. In a sample of Colombian immigrants in New York City 18 years of age and older, Meluk (2001) found that acculturative stress (measured by the Hispanic Stress Inventory; Cervantes, Padilla and Salgado de Snyder 1991) was detrimental to mental health (which was assessed with a composite measure of distress, anxiety, and subjective well-being). Similarly, in a study investigating ethnic group differences in alcohol use among young Hispanic men in New York City, higher levels of linguistic assimilation were found to be associated with risk for drinking among Colombians (Kail, Zayas, and Malgady 2000). I know of no research that directly assessed the acculturation-depression relationship among Colombian Americans. Moreover, the information available about Colombian Americans from which analogies may be drawn is limited to the New York City area. Given the near complete lack of information available on mental health and on the acculturation-mental health relationship for Colombian Americans living in the Miami area, an opportunity for advancing knowledge of this relationship exists by studying Colombians in Miami.

Taking these studies together, evidence suggests that more exposure to the US (e.g. being native born) and taking on the customs of the US (e.g. English language use/preference) are associated with more depression and/or psychological distress for Cuban and Colombian Americans as well as Mexican Americans and Puerto Ricans. However, little can be confidently stated about this relationship for Cuban Americans given inconsistencies in results or for Colombian Americans given a lack of available information. Despite theoretical reasons to conceptualize acculturation as a multidimensional construct that may include exposure variables as well as indicators of psychological incorporation (e.g., ethnic identity, American orientation, language use/preference, ethnic group social preference), few studies of Cuban American mental health include multiple indicators of psychological acculturation.

## The Protective Role of Biculturalism

Extensive cross-cultural, international research has tested the typology model and has demonstrated substantial support for its utility in a broad variety of contexts (Berry 1987). Given theoretical interest in whether biculturalism is a benefit or detriment to psychological well-being and ability to succeed, as well as interest in informing public policy that explicitly embraces multiculturalism (e.g., Canada, Italy, and to a limited extent, the U.S.), much attention has been given to Berry's (1980) integration (bicultural) mode of acculturation. Berry and colleagues (1987) presented a meta-analysis of several studies conducted in Canada that focused on many cultural groups, including groups that were characterized as immigrants, refugees, native peoples, ethnic groups, and sojourners. A consistent finding across the reviewed studies is that biculturalism is negatively associated with acculturation stress. In La Framboise and colleagues' (1993) review of literature, several studies are discussed that together provide evidence that biculturalism is beneficial for acquiring and maintaining effective relationships after immigration. Furthermore, Kosic (2002) found that biculturalism is beneficial for sociocultural adaptation, emotional disorders, and psychosomatic symptoms for Croatian and Polish immigrants to Italy.

In terms of Hispanic Americans, Bautista de Domanico and colleagues (1994) found that bicultural Mexican American youths had higher self-esteem, were better able to socialize in diverse settings, and had better psychological well-being than peers who strongly identified with either Mexican or US culture. Coatsworth and colleagues (2005) found that assimilated Hispanic youth in South Florida had more behavior problems than youth characterized by other acculturative types, including the bicultural. This research also investigated whether being highly identified with *any* culture is predictive of positive outcomes. When youth who were assimilated were combined with those who were bicultural higher levels of peer competence and support were observed as well as better academic performance compared to youths demonstrating adherence to other acculturative types. Moreover, Central Americans in Canada who are bicultural exhibit lower levels of psychological stress than highly assimilated individuals and individuals

who are weakly oriented to both their ethnic culture and the receiving culture (Dona and Berry 1994).

Several studies have considered biculturalism among Hispanic Americans in Miami. Szapocznik (1984) found that young Cuban Americans in Miami who were bicultural were better socially adjusted than those who were monocultural. Monocultural Cuban identity has been found to be associated with increased anxiety compared with individuals with a bi-cultural Cuban American identity (Rivera-Sinclair 1997). Coatsworth and colleagues (2005) found that bicultural Hispanic youth in Miami were better adjusted than youths who were characterized as other acculturation types.

It thus appears that being strongly oriented toward the receiving culture is more beneficial for mental health (assimilated) than being oriented toward neither (marginalized), though not as beneficial as being strongly oriented toward both the native and receiving cultures (bicultural) across a variety of minority or immigrant groups in a variety of geographical areas. It has been suggested that ethnic identity (enculturation) may act as a protective factor for mental health among Hispanic Americans (Herd and Grube, 1996; Mossakowski 2003), though it appears from the literature that American identity orientation may be beneficial as well. What is not clear is whether these factors are independently predictive of better mental health for Hispanic Americans net of exposure variables (e.g. years in the US) and other indicators of psychological acculturation (e.g. language preference, preference for socializing with other ethnic group members).

## CHAPTER FIVE

### EMPERICAL PATTERNS OF THE DISCRIMINATION-DISTRESS/DEPRESSION RELATIONSHIP

#### Introduction

Perceived ethnic discrimination is commonly understood to be a social stressor (Gil and Vega, 1996; Kessler, Mickelson, and Williams 1999; Williams, Neighbors, and Jackson 2003). As such, it is expected to be associated with compromised health in similar ways as other types of social stressors. There is some evidence that perceived discrimination (not necessarily limited to that based on race/ethnicity) accounts for roughly the same magnitude of mental health decrement as do other social stressors (Kessler, Mickelson, and Williams 1999).

Discrimination appears to have adverse consequences in many areas of health and well-being. There is a growing body of evidence suggesting that ethnic/racial discrimination is detrimental to both physical health and protective health behaviors (Krieger 2000; Harrell, Hall, and Taliaferro 2003; Williams, Neighbors, and Jackson 2003; Landrine et al 2006) as well as psychological well-being (Taylor and Turner 2002; Williams, Neighbors, and Jackson 2003; Bhui et al 2005; Jasinskaja-Lahti, Liebkind, and Perhoniemi 2006; Paradies 2006; Sellers et al 2006; Carter 2007). However, discrimination appears to have a more consistent impact on mental, rather than physical health (Williams, Neighbors, and Jackson 2003). In this review of the discrimination-mental health relationship, I will begin by considering literature conducted in countries other than the US and then focus on studies concerning African and Hispanic Americans in the US. My review of the discrimination-mental health relationship among Hispanic Americans will consider national-level studies as well as state and community studies organized by region. My purpose is to understand how Cuban and Colombian American mental health in Miami may be affected by experiences of ethnic discrimination.

## **An International View of the Discrimination-Health Relationship**

The detrimental impact of discrimination on mental health appears to hold for a variety of ethnic minority populations across a variety of national contexts. For example, in a study of immigrants (ages 18-65) in Finland, Jasinskaja-Lahti, Liebkind, and Perhoniemi (2006) investigated the role of perceived discrimination in general psychological distress (combined depression, anxiety, and somatic stress). Discrimination was positively related to distress for each of eleven immigrant groups analyzed net of a variety of social status and socioeconomic controls as well as proficiency in the Finnish language. In a study of workers in the UK, Kamaldeep and colleagues (2005) found that more experiences of racial/ethnic discrimination were associated with higher odds of MDD and anxiety disorder assessed via the Revised Clinical Interview Schedule (Lewis et al 1992). Noh et al (1999) found the same relationship among Southeast Asian Refugees in Canada, ages 18 years and older. Respondents who reported that they had experienced ethnic discrimination were significantly more depressed (Beiser and Fleming 1986) than those who did not report such experiences. These and other studies (e.g. Pernice and Brook 1996; Karlsen and Nazroo 2002) point to the universality of the negative impact of discrimination on mental health. Moreover, they reveal that the harmful impact of racial/ethnic discrimination can be observed in outcome measures of both psychological distress and psychiatric disorder.

### **The Prevalence of Perceived Discrimination and the Discrimination-Health Relationship in the US**

Racial and ethnic discrimination are commonly experienced in the US, especially among ethnic minority groups (Kessler, Mickelson, and Williams 1999). Kessler, Mickelson, and Williams (1999), assessed the prevalence of discrimination and the discrimination-mental health relationship in the US using data from the MacArthur Foundation Midlife Development in the United States (MIDUS) study. Respondents ranged in age from 25 to 74 years. Major lifetime discriminatory events and minor, day-to-day experiences of discrimination were assessed. Outcome measures included past-

month distress and past-year MDD (WHO-CIDI). Roughly 33 percent of respondents reported the occurrence of at least one of eleven major discriminatory experiences in their lifetime and 60.9 percent reported experiencing at least one of nine types of day-to-day discrimination (race/ethnic discrimination being one of these). Non-Hispanic white respondents reported significantly fewer experiences of major discrimination and day-to-day discrimination than either African Americans or an aggregated “other” ethnicity group. The most common reason cited for the experience of discrimination was race/ethnicity (37.1 percent). Both lifetime and day-to-day discrimination predicted increased likelihood of MDD and higher levels of distress. Perceived discrimination was associated with declines in health irrespective of the attribution cited (e.g. on the basis of race/ethnicity or gender). In a study conducted with a sample of young adults (18-23 years) in Miami, Turner and Avison (2003) investigate the exposure to a variety of social stressors, including major and day-to-day discrimination, among African Americans and Non-Hispanic whites. African Americans were more likely than non-Hispanic whites to experience both forms of discrimination as well as most other types of stressors and all stressors combined. This may be interpreted to suggest that relatively disadvantaged race/ethnic groups experience higher levels of exposure to potentially stressful circumstances, including ethnic discrimination.

Landrine and colleagues (2006) investigated the discrimination-distress relationship with a sample of US adults (ages 18-86 years) of a variety of race/ethnic backgrounds (non-Hispanic whites, Hispanic Americans, African Americans, Asian Americans, and “other” minority group members). The Hopkins Symptom Checklist-58 (Mattsson et al., 1969; Derogatis et al., 1971, 1994) was used to assess depression, among other health outcomes. Perceived discrimination was positively associated with depression for all race/ethnic groups. Collectively, these studies suggest that experiences of discrimination are common in the US, though these and other social stressors are more often experienced by ethnic minority individuals. Furthermore, major discriminatory events and daily experiences of discrimination appear to be detrimental to mental health (distress and disorder) in the US, irrespective of race/ethnicity and age range of groups considered.

## Studies Concerning African Americans

When particular race/ethnic groups have been considered, the majority of studies on the discrimination-mental health relationship in the US have been conducted on samples of African Americans (Araújo and Borrell 2006; Paradies 2006). Borrell et al (2006) studied the impact of the frequency/intensity of perceived racial discrimination on CES-D (Radloff 1977) distress among a sample of African Americans in the CARDIA study. Respondents ranged in age from 33 years to 45 years at the time of assessment. More perceived discrimination was associated with higher levels of psychological distress, a finding that persisted after adjustments for age, education, income, and skin color. In a study of African American adolescents from Iowa and Georgia, Brody et al (2006) investigate the association between racial discrimination and depressive symptoms over a five year period of time. Depression was measured with the DIS for Children, version four (Shaffer et al 1993). Increases in experiences of discrimination over time were associated with increases in later depressive symptoms with and without controls for SES.

Shulz et al (2006) investigated the discrimination-health relationship among African American women (ages 18 years and older) in Detroit also using a longitudinal design. Psychological distress was measured with an abbreviated version of the CES-D scale (Radloff 1977). Discrimination was positively associated with depressive symptoms at time one of measurement, a relationship that persisted net of age, education, and income. The authors also report that "...an increase in discrimination over time is associated with an increase in symptoms of depression over time" (p.1267).

In addition to social status variation in the exposure to social stressors (reported above), Turner and Avison (2003) and another investigation using the same data by Taylor and Turner (2002) assess the impact of discrimination on depressive symptomatology (CES-D; Radloff 1977) among African Americans and non-Hispanic white young adults. These data include measures of both day-to-day discrimination and lifetime major discrimination developed by Williams et al (1997). These studies differ however, in their particular approaches to indexing discrimination. While Turner and Avison (2003) include discriminatory events attributed to any one of a number of social

statuses, Taylor and Turner (2002) limit discriminatory events to those specifically attributed to race. In both studies, daily and major discrimination are positively associated with distress net of each other and social status variables. However, in the Turner and Avison investigation (2003), daily discrimination is independently predictive of higher distress net of several other categories of stress exposure and social status characteristics, Taylor and Turner investigation (2002) found no independent contribution of either measure of discrimination when limited to that attributed to race. Moreover, while Taylor and Turner (2002) accounted for an elevation in distress for African Americans relative to non-Hispanic whites with measures of racial discrimination, Turner and Avison (2003) did not account for this elevation with discrimination attributed to race and other social statuses. These studies and others (e.g. Sellers) together support the conclusion that perceived discrimination is associated with higher levels of depression among African Americans in the US and that the causal order goes from discrimination to distress and not the reverse. Moreover, this relationship appears to be robust, in that it persists net a variety of variables that may also influence levels of depression. Finally, racial discrimination appears to be particularly associated with distress and differences in distress across African Americans and non-Hispanic whites.

### **National Studies of the Discrimination-Mental Health Relationship among Hispanic Americans**

A substantial portion of Hispanic Americans experience ethnic discrimination and a substantial proportion perceive this as a problem that prevents success in the US (82.0 percent; National Survey on Latinos 2002). While a recent review of literature concerned with the discrimination-health relationship for Hispanic Americans noted a dearth of information on this subject (Araújo and Borrell 2006), several studies have been recently published. In a national sample of Hispanic Americans (NLAAS), Alegría and colleagues (2007b) found that frequency of perceived discrimination was associated with higher odds of past-year anxiety disorder, though there was no significant association with either past-year depressive or substance disorders (WMH-CIDI; Kessler and Ustun 2004). It may also be noted that Cuban Americans reported less frequent experiences of depression than Puerto Ricans, Mexican Americans, and other Hispanics with and

without adjustments for sex, age, nativity, and age of arrival for immigrants. However, significant group differences were only found without these adjustments and it is not clear which particular groups significantly differ from one another. Furthermore, immigrants who arrived in the US early in life (0-6 years old) reported significantly more frequent experiences of discrimination than those arriving later in life (age 7 or older). In another major study investigating the relationship between discrimination and general well-being, Ryff, Keyes, and Hughs (2003) found that “perceived discrimination was...a negative predictor of eudaimonic well-being, although such effects were gender-specific: it was women, both majority and minority, with high levels of discrimination in their daily lives whose sense of growth, mastery, autonomy, and self-acceptance was compromised” (p.275). This study was based on the MIDUS data among African American and non-Hispanic white US adults aged 25-74 years, supplemented with African Americans in New York and Mexican Americans in Chicago. Mexican Americans in Chicago reported significantly higher perceived discrimination scores than any other race/ethnic group. In a smaller national study of professional Hispanic American women (aggregated group of Mexican Americans, Puerto Ricans, Cuban Americans, and other Hispanic Americans), Amaro, Russo, and Johnson (1987) assessed the discrimination-distress relationship. Psychological distress was measured by an index created for the study by Zambrana (1987). A large majority (82.3 percent) of these women reported having experienced discrimination in their lifetime. Women who experienced discrimination reported higher distress than women who had not experienced discrimination, though this was significant only among married women.

Taking these studies together, it appears that national samples of Hispanic Americans are similar to both African Americans and international ethnic minorities in reporting mental health declines with more experiences of racial/ethnic discrimination. Moreover, within the broad “Hispanic” group, there are variations in levels of experiencing ethnic discrimination across national-origin groups. One difficulty in drawing conclusions from national studies is that it is difficult to contextualize the experience of ethnic discrimination and how community factors may play a role in the discrimination-distress relationship. A review of studies in various regions in the US may reveal variation across parts of the US in this relationship.

### **Studies Conducted in the West and Southwest**

In terms of studies concerning Hispanic Americans in the West and Southwest, Finch, Kolody, and Vega (2000) investigate the discrimination-distress (CES-D; Radloff 1977) association among an adult sample (ages 18-59) of Mexican Americans in Fresno, California. Perceived discrimination was found to be positively associated with psychological distress. Salgado de Snyder (1987) found higher CES-D (Radloff 1977) depression scores among Mexican immigrant women (ages 17-49 years who were married in Los Angeles) who had experienced recent discrimination than among women who had no such experiences. Similarly, Codina and Montavlo (1994) found that darker skin tone was associated with increased depression among US-born Mexican American males in five southwestern states and Chicago. It may be reasonably argued that this association between darker skin tone and higher distress belies discriminatory experiences based on phenotype. Generally speaking, the evidence supports the conclusion that Mexican Americans in the West and Southwest experience more psychological distress with more experiences of discrimination.

### **Studies Conducted in the Northeast**

In terms of Hispanic Americans in the Northeast, Gee et al (2006) investigated the roles of three types of discrimination (discrimination in achieving goals, anger response to racial/ethnic discrimination, and health care discrimination) in overall psychological well-being (Mental Component Summary subscale from the Medical Outcomes Study Short Form 12; Kosinski, Keller, and Ware 1997). The New Hampshire sample included individuals of African descent, foreign-born Mexican Americans, and other Hispanics. While a total sample age range was not provided, the mean ages of Mexican Americans and other Hispanics were 32.7 and 44.1 years, respectively. The authors report that each type of discrimination was associated with worse psychological well-being. Moreover, the association is more severe for immigrants with more exposure to the US (more years in residence). Krieger et al (2005) found that, among working class African Americans,

Hispanic Americans, and non-Hispanic whites in the greater Boston area, experiences of discrimination were associated with higher levels of psychological distress (K6 scale; Kessler et al 2002). Szalacha et al (2003) investigated the relationship among Puerto Rican children in the Boston area (grades 1-4; M=8.4 years of age). Depression was assessed through the Reynolds' Child Depression Scale (Reynolds 1989). Twelve percent of this sample reported having experienced ethnic discrimination. Children who reported experiencing discrimination reported significantly higher levels of depression than those who had not experienced discrimination. In another investigation (same publication), these authors considered the discrimination-depression relationship among a sample of adolescent (ages 13-14 years) Puerto Ricans in the Boston area. Roughly half of these adolescents reported having experienced discrimination and half indicated that they worried (anxiety) about being discriminated against. No significant findings emerged between experienced discrimination and discrimination anxiety. Contrada and colleagues (2001) examined the role of ethnic discrimination in past week psychological distress (Beck Depression Inventory; Beck, Ward, Mendelson, Mock, and Erbaugh 1961) among a sample of Northern New Jersey college students of diverse racial/ethnic backgrounds. Perceived ethnic discrimination was found to be positively associated with depressive symptoms with and without a large variety of control variables (gender, ethnicity, generic stress, SES, ethnic identity, and self-esteem).

Several studies of the discrimination-mental health relationship among Hispanic Americans were conducted in the New York area. The relationships between frequency of perceived ethnic discrimination by both adults and high school peers was assessed by Greene, Way, and Pahl (2006) in the discrimination-mental health relationship in a longitudinal study conducted in New York City. Depressive symptoms, the outcome variable, were assessed via the Children's Depression Inventory (Kovac 1985). Dominican American respondents reported higher levels of perceived ethnic discrimination at three of five measurement points than other Hispanic groups. However, Hispanic Americans other than Puerto Ricans were collapsed into a "Latino" group for multivariate analyses, disallowing further comparisons across national-origin groups. Perceived ethnic discrimination from both adults and peers was associated with higher depressive symptoms over time. One strength of this study is that the role of

discrimination in health is investigated net of ethnic identity, a concept often included as an indicator of acculturation.

Stuber et al (2003), in a study of low-income Latino and African American adults (18 years and older) in New York City, the discrimination-mental health association was assessed using a single item indicator of mental health<sup>17</sup>. Latinos were an aggregate group of Puerto Ricans, Dominican Americans, Mexican Americans, and other Latinos. A higher proportion of African American respondents reported experiences of racial discrimination (17.0 percent) than Latino respondents (8.0 percent). Poor mental health was more likely to be reported among respondents who perceived racial discrimination, though group comparisons in this relationship were not provided. It thus appears that Hispanic Americans in the Northeast of variety of national origin groups and across a variety of ages have mental health declines with more experiences of ethnic discrimination. Moreover, this relationship persists net a variety of factors found to be associated with Hispanic American mental health, including social status variables, SES, and indicators of acculturation.

### **Studies Conducted in the South**

In terms of Hispanic Americans in the South, those who report experiencing discrimination had more internalizing problems than those who did not report this experience among a sample of immigrant Latino (Mexican, South American, and Central American) adolescents in North Carolina (Smokowski and Bacallao 2007). Internalizing problems were measured via the Youth Self-Report (Achenbach 1991), which includes anxious/depressed, withdrawn/depressed, and somatic complaints subscales. The authors found that more frequent experiences of ethnic discrimination increased internalizing problems among adolescents with strong ethnic identity, US identity, or youths characterized as bicultural net a variety of indicators of social statuses, acculturation, acculturation conflict, and familialism. One strength of this study is that, in addition to assessing the role of perceived discrimination in health, several indicators of

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<sup>17</sup> “For how many days during the past 30 days was your mental health not good?”

acculturation were employed demonstrating that the role of discrimination in health is independent of these factors for this sample.

In a sample Hispanic Americans (ages 18-71 years; the largest groups including Cuban, Puerto Rican and Colombian Americans), in North Central Florida, Moradi and Risco (2006) assessed the discrimination-distress relationship. The Brief Symptom Inventory (BSI; Derogatis 1993) was used to assess current level of psychological distress. Ninety-one percent of respondents reported experiencing some ethnic discrimination. More frequent experiences of ethnic discrimination were associated with more psychological distress. This relationship was net of indicators of acculturation and enculturation (Latino/a enculturation and US acculturation), personal control/environmental mastery, and self-esteem. Thus, as in the Moradi and Risco (2006) investigation, it appears that perceived ethnic discrimination is a strong predictor of decreased mental health independent of acculturation and other factors that have also been demonstrated to be associated with psychological distress.

A few studies in this region drew samples from the Miami area. Gil and Vega (1996) found that more frequent experiences of ethnic discrimination was associated with lower self-esteem among Cuban adolescents in Miami net a variety of indicators of family SES, adolescent and family acculturation, and other family-related variables. Nicaraguan adolescents were also considered, though the relationship between discrimination and self-esteem was not significant for this group. Díaz et al (2001), investigated this relationship among gay and bi-sexual Hispanic American men (age 20-40 years) in Miami, Los Angeles, and New York who attended gay venues in those cities. Psychological distress was assessed with a scale developed for the study with items tapping the frequency of experiencing depression, anxiety, and suicidality. Discrimination was assessed through scales developed for the study concerned with both race/ethnicity and homophobia. Eighty percent of the sample had a sad or depressed mood in the past six months. Higher levels of discrimination attributed to race/ethnicity predicted higher levels of psychological distress. These studies together suggest that Cuban Americans and other Hispanics in Miami may be expected to respond to discrimination in ways similar to other race/ethnic groups across the US and abroad.

## Conclusion

This review of literature of the growing scholarship on the discrimination-mental health association for Hispanic Americans and other race/ethnic groups reveals a near universal experience of increases in psychological distress with higher frequency of experiencing race/ethnic discrimination. It is clear that this finding pertains to a variety of Hispanic groups inhabiting a variety of US contexts, including Miami. It is also evident that the detrimental effects of discrimination pertain net of a variety of social status, socioeconomic, and acculturation indicators for Hispanic Americans.

Given the clear public health concern that racial/ethnic discrimination represents in terms of mental health, further investigation into the impact of discrimination on health is warranted. In particular, few studies have investigated this relationship among two or more Hispanic American groups in the same community. Moreover, future studies of Hispanic mental health should include several dimensions of acculturation and an index of perceived ethnic discrimination to assess the independent contributions of these factors on the mental health of Hispanic Americans of different national origin groups. A community study of Cuban and Colombian adult mental health in Miami with these factors taken into account would advance understanding of the discrimination-health relationship as well as understanding of Hispanic American mental health more generally.

Taking into account this review of literature, and a review of the social circumstances of Cuban and Colombian immigrants in Miami (below), I expect to find that Cuban Americans report experiencing discrimination less frequently than Colombian Americans in Miami. This expectation is based on existing empirical evidence suggesting that Cubans living in Miami experience less discrimination than other Hispanic groups (Alegría et al 2007). Because of the consistent negative impact that discrimination has on mental health, I also expect that more frequent experiences of ethnic discrimination will be associated with higher levels of distress for both Cuban and Colombian Americans. However, because Cubans have reported being less likely than other Hispanic American groups to associate decreases in life chances with ethnic discrimination (National Latino Survey 2002), I expect distress among Cuban Americans

to be less influenced by ethnic discrimination than Colombian Americans. I will now turn to consider the circumstances under which Cuban and Colombian immigrants arrived in Miami and how these groups are socially situated in this community relative to one another. This will serve to provide an understanding social context which may shape both experiences of acculturation and ethnic discrimination and mental health.

## CHAPTER SIX

### HISTORICAL OVERVIEW: CUBAN AND COLOMBIAN IMMIGRANTS IN SOUTH FLORIDIA

#### Introduction

Understanding the immigration and demographic patterns of specific Latino subgroups is important for understanding their discrimination experiences and the impact it has on their mental health and life chances (Araújo and Borrell 2006:251).

Members of different ethnic groups have unique experiences as a result of distinct histories (e.g., voluntary vs. involuntary migration) and current sociocultural conditions (Green, Way, and Pahl 2006).

As these quotes observe, group characteristics and the social position of immigrant groups may condition experiences of acculturation and ethnic discrimination in the receiving community as well as mental health. Characteristics such as group solidarity or fragmentation may be associated with the strength of ethnic identity and preference for socializing with other ethnic group members (two dimensions of acculturation), and experiences of ethnic discrimination may vary by ethnic minority or majority status. Ethnic group experiences such as acculturation and discrimination may in turn be associated with levels of psychological distress. In this chapter, I consider Cuban and Colombian group characteristics and their relative social positions in Miami. I review patterns of migration and migrant characteristics that may differentiate these groups to inform research questions concerning group experiences of acculturation and ethnic discrimination and the relationships between these factors and mental health.

I argue that Cubans represent a unique case of group migration and incorporation in Miami. This is because Cubans arrived in Miami relatively early compared with other immigrant groups, in great numbers, in a short period of time, and were able to structurally assimilate in just a few decades (García 1996). Cubans, unlike other Hispanic groups in the area achieved cultural and political power to become a dominant group in Miami (Portes and Stepick 1993). Colombians, by contrast, arrived more recently and in fewer numbers. Moreover, despite high levels of Colombian education,

this group has not yet gained comparable social and political footholds. I further argue that experiences of acculturation and ethnic discrimination may differ across these groups due to group differences in group cohesiveness. While Cubans have generally demonstrated strong group solidarity, Colombians are a relatively socially fragmented group. Thus, Cubans may represent a privileged comparison group in Miami when investigating Hispanic mental health and the social factors associated with health.

This section will also compare and contrast the experiences of Cubans and Colombians in their respective relocation experiences to Miami and discuss how similarities and differences in their circumstances may translate into differences in acculturation and perceived ethnic discrimination upon arrival. I argue that despite equivalencies between groups in circumstances surrounding reasons for and patterns of migration and comparable socioeconomic statuses, Cubans might be expected to be advantaged in terms of social factors contributing to mental health. This expectation is grounded in the relative social advantage of Cubans in South Florida following from the inferred benefits of structural assimilation and the availability of resources for in-group organization and solidarity compared to Colombians.

To support this argument, I first review 2000 Census data on sociodemographic characteristics of Cubans and Colombians in Miami. Next, I consider historical and more proximal circumstances that differentiate these groups in terms of solidarity and fragmentation. Following this, I consider the antecedents of relative group social status in Miami. I conclude by providing justification for the inclusion of these particular groups in this study. I argue that the comparison these particular groups is worthy of investigation for their similarities and differences. These similarities and differences may inform hypotheses about how these groups may differ in ease of acculturation and experiences of ethnic discrimination, which may be in turn associated with differences in psychological distress.

### **Cubans and Colombians in Miami**

According to the US Census, 2.3 million people resided in Miami-Dade County in the year 2000 (US Bureau of the Census 2000). Of these, 29 percent (650,601) identified

as being of Cuban descent and 3 percent (70,066) identified as being of Colombian descent. Cubans represent a numerical majority of any race or ethnic group in the County and Colombians represent the second largest Hispanic ethnic group by a small margin<sup>18</sup>. It is likely not simply numerical majority/minority status that explains any group differences in health, but that other factors serve to systematically differentiate social groups in health. Indeed, a substantial body of sociological literature has accumulated explaining differences in health across social statuses, such as race/ethnicity (Pearlin 1989; Turner and Lloyd 1999; Turner and Gil 2002). One of the most enduring explanatory factors in the majority/minority-health or race/ethnicity-health relationships is social class.

### **Socioeconomic Status**

Socioeconomic status (SES) is a frequently-used index of social class and is often indicated by educational attainment and income (Williams and Collins 1995). These factors have been consistently associated with health and social status differentials in health (Holzer et al 1986; Ross and Wu 1995; Williams and Collins 1995; Lillie-Blanton et al 1996; Reynolds and Ross 1998; Muntaner et al 2004). As such, it is important to consider group differences across Cubans and Colombians in Miami in terms of education and income.

In general, most Cubans and Colombians living in Miami are well-educated and non-poor. Among the population 25 years and older, 57 percent of Cubans and 76 percent of Colombians have attained at least a high school diploma<sup>19</sup>. Of this group, 18 percent of Cubans and 24 percent of Colombians have earned a bachelor's degree or

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<sup>18</sup> Nicaraguans are the third largest Hispanic subgroup with a population of 69,257.

<sup>19</sup> Note that in the general Miami-Dade population, including Cubans and Colombians, 70 percent are estimated to have attained a high school diploma. Thus, by this measure, Cubans have under-achieved and Colombians have over-achieved on this educational milestone compared to general population.

higher<sup>20</sup>. While Colombians are relatively advantaged in terms of education, they appear to be relatively disadvantaged in terms of income compared to Cubans. Cubans had a higher per capita income (\$18,600) in the year 2000 than did Colombians (\$15,700)<sup>21</sup>. While Cubans and Colombians have roughly the same median household incomes (\$33,400 and \$33,500, respectively)<sup>22</sup>, Cubans have a slightly higher median family income (\$39,000) than do Colombians (\$35,000)<sup>23</sup>. Finally, the large majority of both groups live above the poverty line, though there is a lower proportion of Cubans below the poverty line (16 percent) than Colombians (22 percent)<sup>24</sup>. The socioeconomic characteristics of these two ethnic groups reveal some differences, but overall, Colombians and Cubans are roughly equal in terms of SES. Nonetheless, it will be necessary to statistically control for SES in comparing the social and physical health of Cubans and Colombians in Miami to ensure that any group differences in outcomes observed or variance explained by acculturation and ethnic discrimination are net of the effects of SES. In addition, it will be necessary to control on gender and age which have repeatedly been shown to be associated with psychological distress (Dohrenwend and Dohrenwend 1976; Kessler et al 1993; Kessler et al 1994; Mirowsky 1996; Mirowsky and Ross 1995; Rosenfield 1999). I now consider the sociodemographic makeup of Cubans and Colombians in Miami.

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<sup>20</sup> Again, at this educational milestone, Colombians are similar to the general population, wherein 22 percent have achieved a bachelor's degree, though Cubans appear relatively under-educated compared to the general population at this level.

<sup>21</sup> The general population estimate for per capita income is roughly \$19,000. While Cubans are closer to the general population average, Colombians are on average disadvantaged compared to both Cubans and the general population on this measure.

<sup>22</sup> The population average is roughly \$36,000.

<sup>23</sup> The population average is roughly \$40,000.

<sup>24</sup> The population average is 18 percent.

## **Sociodemographic Characteristics**

In terms of sociodemographic characteristics, 52 percent of Cubans in the area are female, compared to 56 percent of Colombians. While the proportions of Cubans and Colombians 18 years or older are similar (84 percent and 81 percent, respectively), there is a greater proportion of Cubans among those who are 65 years or older compared to Colombians (22 percent and 7 percent, respectively). Furthermore, Cubans have a higher median age (44 years) than Colombians (36 years). There are high proportions of immigrants in both groups, with 88 percent of Colombians and 80 percent of Cubans being foreign-born. These differences are not surprising in light of migration histories and tenure in Miami, as will be discussed below. Given proportional differences across these groups in gender and age, I will statistically control on these factors to gain a clear picture of the ethnic group-distress relationship net of these potentially confounding predictors of distress. Because my investigation is limited to immigrants, I provide group figures on nativity only for illustrative purposes as I will include the number of years in the US as an indicator of acculturation.

### **Migration to Miami: A General Overview of Reasons for Emigration, Waves of Migration, and Migrant Characteristics**

#### **Introduction**

There has been substantial growth in the Cuban population of Miami since the 1950s. Proximity to the peninsula, familiar climate and architecture, and the presence of Spanish-English bilinguals have been cited as reasons drawing the earliest Cuban arrivals to Miami (García 1996; Portes and Stepick 1993). Prior to the 1959 Cuban Revolution, Miami was a growing resort town, where affluent Cubans could enjoy frequent trips for business, or leisure and shopping. Some maintained a second residence in South Florida. An estimated 200,000 Cubans resided in the US just prior to the Revolution, with the majority residing in Miami (Ruiz 1994). The size of this group increased over the next four decades with waves of immigration tied to social, economic, and political unrest under Cuban political leader Fidel Castro's totalitarian communist regime, as well as for

family reunification. By the early 1990's, roughly 564,000 Cubans resided in what was then called "Dade County," constituting nearly a third of the county population (US Bureau of the Census 1993), and, as noted, the population exceeded 650,000 by the year 2000 (US Bureau of the Census 2000)<sup>25</sup>.

Colombians began to become established in South Florida more recently than Cubans. Their presence has grown since the late 1970s, though the accuracy of a population count is difficult to establish due to the substantial presence of undocumented immigrants (Collier 2004; Guarnizo and Diaz 1999). Some estimate that as many as 40-50 percent of Colombians in Florida are undocumented (Collier and Gamarra 2001). The presence of an undocumented subpopulation is in part due to the perceived dangers of return in light of politically-motivated violence (Colon 1999) in combination with a general lack of official US recognition of the dangers of return and political push factors that conditioned emigration (Collier 2004). Recognition of these factors would allow for political refugee status in the US. Colombia, like Cuba, has experienced social, economic, and political unrest for decades. Collier and Gamarra (2001) characterize the situation:

Colombia is in crisis. An undeclared civil war, encompassing wide-spread guerrilla and drug-related violence, combined with economic recession during the late 1990s, has brought turmoil to this South American state. Colombia's political and economic instability has resulted in the displacement of tens of thousands of Colombian citizens from their home communities (p.3).

There are many reasons cited in the literature for emigration from Colombia, including opportunities associated with drug trafficking to the US and elsewhere, seeking to escape violence associated with guerilla conflict, hopelessness about the future of the country, discontent with elected officials, search for employment and/or desire for better economic opportunities, and desire to join a relative (Guarnizo and Díaz 1999:399; Collier and Gamarra 2001; Collier 2004). Colombians began to arrive in large numbers in the US in the late 1980's and early 1990's. The US Census counted 53,600 Colombians in Dade county in 1990 (US Bureau of the Census 1990), with an increase of over 15,000 by 2000 (US Bureau of the Census 2000). However, because of the

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<sup>25</sup> Dade County was renamed "Miami-Dade County" by the 2000 Census.

presumed existence of a large undocumented population, these figures might be treated as conservative estimates.

Thus, there are sizable groups of both Colombians and Cubans in Miami, many of whom exited their respective homelands for comparable reasons. In light of similar reasons for immigration, and similar socioeconomic statuses across groups, a key to understanding how these groups are situated relative to one another is in understanding each group's migration experience and the implication that these experiences may have for group solidarity or fragmentation.

Beginning with the motivations for immigration, the Cuban experience can be characterized as one in which most circumstances promoted group solidarity and a strengthening of ethnic identity. Numerous subsequent events further supported the cohesiveness of this group. It is through this solidarity and working together, coupled with support from the US government, that Cubans were able to develop a cultural, economic, and political stronghold in Miami. This, coupled with their high numerical representation, have made Cubans the majority group. Colombians, on the other hand, may be characterized as a relatively fragmented ethnic group, generally lacking social or political power in Miami. In the sections to follow, I present an historical overview of group migration patterns such that I might elaborate on the circumstances leading Cubans to 1) have strong group solidarity and strong ethnic identity and 2) be the dominant social group. Throughout, I note similarities and differences in the Colombian experience to highlight the reasons for their relative fragmentation and minority status. Based upon these observations, I develop research questions from these key social factors—group solidarity/fragmentation and ethnic majority/minority status—that I anticipate will predict better mental health among Cubans compared to Colombians.

### **Cubans Americans: Waves of Migration and the Building of Solidarity**

Further details waves of migration may illustrate the origins of group solidarity and fragmentation. Toward this end, I draw primarily from the authoritative social histories of Cuban Americans authored by Portes and Stepick (1993) and García (1996) to weave a narrative of Cuban migration and the formation of group identity. Cubans

arrived in Miami in three discernable waves. The initial wave was largely in anticipation of and reaction to the 1959 Cuban Revolution and continued through 1962 (García 1996). The first wave arriving in south Florida was nearly monolithic in their opposition to Castro and to communism in general. Mainstream US media applauded the early arrivals' anti-communist values and perseverance, though local tensions were felt by working class natives (García 1996). Many felt that Cubans were unjustifiably afforded welfare opportunities not equally available to natives. Others felt a cultural distance through language and/or modes of political expression, interpreted as a refusal to assimilate. Still others felt trapped in the middle of a war that was not their own (García 1996:28-30). These emigrés generally expected that they would soon return to the island, believing that Castro's power would be short-lived. Therefore, assimilation was generally not their goal. Rather, the immediate goal was to influence events on the island while maintaining a living and contributing to their host country while in exile.

While there was a nearly single-minded disapproval of Castro among the emigrés, there was much disagreement about what to do about it. The exiles were divided on how to best remove Castro and to transform their homeland into a more agreeable state. Opinions ranged from lobbying for peaceful negotiations between the US and the island, to the formation of paramilitary groups to invade and overthrow Castro.

The CIA backed one paramilitary brigade with financing and training and recruited among Cuban exiles in Miami. This brigade of exiles landed at the Bay of Pigs and Girón Beach in Cuba between April 17-19 1961. The brigade was ill-equipped in terms of supplies, information, and support and was swiftly shut down by the Cuban military. Roughly 120 brigade soldiers were killed and some 1,125 were captured and imprisoned (García 1996:32). The Miami Cuban community rallied, imploring President Kennedy to intervene on behalf of the prisoners of war. After rounds of negotiations with the Cuban exile community, Castro agreed to accept ransom for the prisoners in the form of essential goods, which were donated by the Red Cross and several private US organizations. Over time, Castro freed all but a few brigade members and, in a surprise move, he also allowed family members of these exiles to emigrate to the US via US ships and planes carrying ransom goods. The brigade prisoners of war returned to a hero's welcome, with some 40,000 exiles gathering at The Miami Orange Bowl to celebrate

their conviction and bravery. This is one of many instances where the exile community can be witnessed pulling together for *la causa*, that is, for ending Castro's communist regime and returning the island to a more agreeable form of government.

A second wave of migration occurred following shortly after the failed Bay of Pigs invasion. Another 297,000 Cubans arrived in the US during the "Freedom Flights" between 1965 and 1973 (García 1996:43). This group of arrivals was welcomed not only by their friends and family, but by US policy changes as well. The 1965 Immigration and Naturalization Act removed priorities by race/ethnicity and the 1966 Cuban Adjustment Act allowed for Cubans who resided in the US for at least two years to apply for permanent residency. In addition, family members of Cubans already in the US were granted admission to the country without the otherwise required red tape for an immigrant visa (García 1996:43). However, many locals did not provide as warm a welcome. Local tensions grew with other native-born ethnic groups who increasingly felt that the provisions afforded the Cuban arrivals through social welfare programs were unjust and that the competition for local jobs with foreigners was unfair (Portes and Stepick 1993). So, while the first wave faced some antipathy rooted in perceived occupational competition with native groups, these feelings of resentment began to simmer just beneath the surface as the Freedom Flights progressed and some native Miamians were calling for an end to the flights nearing their conclusion (García 1996).

The last major wave of emigration consisted of those who were pushed out during the 1980 Mariél exodus (Portes and Stepick 1993; Ruiz 1994:71). Following a Cuban economic downturn in the late 1970s through the beginning of 1980, many citizens grew increasingly dissatisfied with Cuban government leadership. As a result, an estimated 10,000 Cuban citizens stormed the Peruvian embassy seeking political asylum (García 1996). Castro, embarrassed by this spectacle and seeking to demonstrate his liberal exit policy (Portes and Stepick 1993:21-22), opened the port of Mariél for their departure and invited anyone else who wished to emigrate to leave as well (García 1996; Portes and Stepick 1993). Family and friends from the Miami exile community chartered boats to rescue their loved ones, but often transported whomever the Cuban government charged them with. Those seeking refuge crossed many segments of Cuban society including "...students, housewives, factory and construction workers, writers, and even government

bureaucrats” (García 1996:55). However, Castro also arranged for patients in mental hospitals and prisoners to exit alongside those seeking political asylum. As such, this wave was characterized as consisting of the least desirable elements of the Cuban population, called *gusanos* or worms by Castro (García 1996) and/or “...the scum of the country – antisocials, homosexuals, drug addicts, and gamblers...” (Portes and Stepick 1993:21). These disparagements were echoed in the mainstream US press, perhaps most notably by the *Miami Herald* newspaper (Portes and Stepick 1993) despite the fact that 80 percent of the roughly 125,000 refugees had no criminal history, that some committed “crimes” that were not recognized in the US or committed petty offences, or that less than four percent were felons (García 1996:65). Nonetheless, stigma and discrimination resulted (Stepick et al 2003:40).

Unlike earlier Cuban arrivals who were largely thought to be a model immigrant group, the *Marielitos* faced stigma and discrimination from both the mainstream US and from compatriots. Because natives by and large did not distinguish between *Marielitos* and other Cuban exiles, earlier arrivals sought to distance themselves from *Marielitos* for a short time (García 1996:46). However, this in-group fragmentation would soon be transformed into fuel for a strong Cuban-American identity (Portes and Stepick 1993), as will be detailed below. What was more lasting were local tensions with Miami natives concerning stigma and perceived market competition and equity of the allocation of social welfare resources (García 1996). Natives now added stigma to their dissatisfaction with the continuing arrival of Cubans.

Since the Mariél exodus, individuals have continued to flee the island to Miami, risking personal safety in makeshift rafts often organized in flotillas. These migrants, known as the “*Balseros*” (i.e. rafters) fled Cuba largely due to an economic downturn following the collapse of the Soviet Union who previously provided economic stability for Cuba. As noted, the Cuban population in Miami numbered roughly 564,000 in 1990 (US Bureau of the Census 1990), a figure that increased from roughly 407,000 a decade before (Miami Department of Planning and Zoning 2003). While the majority of this increase is due to Mariél arrivals, with an estimated 100,000 *Mariélitos* thought to settle or resettle in south Florida during the early 1980’s, some of the increase is attributable to the *Balseros*. According to the United States Coast Guard, some 5,800 *Balseros*

managed to reach safety in the United States from 1985 to 1992 (Pedraza 1996) and a total of 50,172 *Balseros* were interdicted by the US Coastguard from 1983 through 1999, with a peak occurring in 1994 (US Coastguard 2007). The case of Elián González in November 1999 is perhaps prototypical of the desperation of the *Balseros* as well as the solidarity of the Cuban exile community and differences of opinion with other local race/ethnic groups.

Five-year-old Elián González, along with his mother and twelve others set out in a small boat from Cuba in November 1999 bound for Florida. The boat capsized and sank at sea. Of the fourteen passengers, only Elián and two others survived the crossing; the three survivors were picked up by two fishermen off the Florida coast while floating on an inner tube. The fishermen handed them over to the US Coastguard. A highly public legal and ethical debate ensued over whether Elián should be returned to his father in communist Cuba, or if he should remain under the custody of Elián's paternal great uncle and his daughter and remain in the US, in accordance with his deceased mother's wishes. For many, Elián became a symbol for the desperation of the *Balseros* who would endure great risk and hardship to escape Castro's totalitarian Cuba as well as a symbol for underdeveloped and strained US-Cuba relations and growing inter-ethnic tensions in South Florida. A late November 1999 article in the Miami Herald picked up on this matter early in the debate exclaiming that Elián is "a boy, not a symbol," urging lawmakers to do what's best for Elián (Miami Herald 1999:8B Nov 30). Showing extraordinary solidarity, eighty-eight percent of Cubans polled in South Florida in December 1999 believed that Elián should remain in the US, while only five percent believed he should be returned (Miami Herald 1999). However, this same poll revealed ethnic group differences in opinion on the issue. Only thirty-four percent of non-Hispanic whites, thirty-one percent of non-Hispanic blacks, and forty-seven percent of non-Cuban Hispanics believed Elián should remain in the US (Miami Herald 1999). Elián was returned to Cuba on June 28, 2000 by order of Attorney General Janet Reno.

The Elián González case was an international issue centered on south Florida's Cuban exile community that is prototypical of many social issues building for decades around the emigrés. As an illustration, a database search of FirstSearch Newspaper Abstracts limited to the years 1999-2001 yielded 1,594 newspaper items whose subjects

were devoted to the Elián story. A search of Google News over the same time frame returned 1,370 newspaper articles published in the Miami Herald alone on the matter. At the core of many of these articles are discussions of Cuban immigration policy, the strength of the Miami Cuban exile lobby, and the negotiation of a bicultural Cuban-American identity. The widespread interest in these topics reflects the social impact of waves of Cuban migration across four decades.

While several factors in the history of Cuban migration may have resulted in group fragmentation, the group remained cohesive. Cuban emigrés, from the earliest wave through the most recent, may have internalized Castro's depiction of them as traitors and *gusanos*. Instead, the group was brought together by a single-minded opposition to Castro despite a multitude of opinions within the group on how to best affect change on the island. In this vein, while a military invasion of the island was clearly on the extreme side of the possible options for change, representing a minority position of emigrés, brigadiers returning after the failed Bay of Pigs invasion were widely greeted as heroes of *la causa*. Also, whereas group fragmentation momentarily resulted from depictions of the *Marielitos* as criminals and deviants largely owing to mainstream US media, the Cuban emigré community quickly banded together to reject these depictions of their group and replaced these images with reminders of how Cuban emigrés were largely responsible for the transformation of a small vacation and retirement community to a major US metropolis regarded as the gateway to Latin American Economy (detailed below). Lastly, the Elian Gonzales case may be iconic of solidarity which grew with time within the emigré community. Despite differences of opinion with their non-Cuban neighbors, the emigré community banded together in near unanimous agreement that Elian should remain in the US and be raised as a free individual in a democratic society. These are but a few moments in the history of Cubans in Miami that reflect strong group solidarity among this immigrant group.

The Cuban emigrés in Miami not only retained, but also strengthened their sense of *Cubanidad* (or proud Cuban identity) and negotiated a strong and positive sense of being an American (Portes 1984). Several factors enabled the development of this strong bi-cultural identity. Early entrants believed that they would soon return to the island, anticipating the demise of Castro (García 1996:14). As such, their oppositional identity

as Cubans who would return and right the wrongs of the totalitarian regime was solidly cast in the group's self-understanding. Over time, as Castro remained in power, they also "...developed strong emotional ties to the country that gave them refuge. As they bought homes, paid taxes, attended PTA meetings, and participated in civic affairs, they developed ties to Florida and the United States in spite of their original intentions" (García 1996:5). Miami Cubans retained Spanish while learning or improving their English. They transformed their collective identity as political exiles to a proud US ethnic group – Cuban-American (Portes and Stepick 1993). In the process, group solidarity, rooted in opposition to Castro, was strengthened through the successful defense of group character and solidarity came to characterize the Cuban-American ethnic identity.

### **Colombians: Waves of Migration and the Exacerbation of Fragmentation**

Most US Colombian immigrants arrived from the cities of Cali or Pereira (Guarnizo and Diaz 1999). In both of these Colombian cities, drug traffickers had a substantial influence on the local economies and employed significant numbers of individuals (Guarnizo and Diaz 1999). Guarnizo and Diaz (1999:399) cite drug trafficking as one of three main factors conditioning Colombian migration to the US along with "...the cumulative effect of a migration process that started in the post-World War II period..." and economic restructuring arising from neo-liberal reforms aimed to curtail the drug business.

Colombian migration to Miami, like that of Cubans, occurred in three discernable waves. The first wave was precipitated by civil war (*La Violencia*), which lasted from 1948-1957 (Collier and Gamarra 2001; US Department of State 2007). This wave of migrants sought to escape political violence or sought better economic opportunity in the US during and after the war. By and large, this wave consisted of individuals of the lower and lower-middle classes during the war, though included more individuals from the middle, upper-middle, and upper classes from the end of the war through the late 1970s (Collier and Gamarra 2001). However, according to Collier and Gamarra (2001), "a negligible number of [this first wave of] migrants remained in South Florida..." The

Miami-Dade County Department of Planning and Zoning counted 19,000 persons of Colombian descent in Dade County in 1980 (Miami-Dade County Department of Planning and Zoning 2003).

Beginning in the late 1970s and continuing through to the late 1980s, Colombians migrated to the US (and elsewhere) largely to escape narco-terrorism or to participate in the drug trade, despite a healthy economy in Colombia (Collier and Gamarra 2001). This second wave consisted of many social classes, though it included more individuals of the higher classes than the first wave (Collier and Gamarra 2001; Guarnizo and Diaz 1999). The US Census counted some 53,600 Colombians in Dade county in 1990 (US Bureau of the Census 1990). Some, unknown number, of these migrants were tied to the growing international drug trade (Collier and Gamarra 2001), primarily involving cocaine. During the cocaine boom of the 1980s, increasing numbers of Colombians were taking *viajecitos*, or trips to smuggle drugs or import cash derived illegally; many of these remained abroad (Guarnizo and Diaz 1999: 401). During this period, many others returned to face a general stereotyping of migrants in Colombia as individuals who will cross any ethical principle for financial gain (Guarnizo and Diaz 1999:402). As of the year 2000, Colombia remained the largest center of cocaine production; an estimated 136,200 hectares of cocaine were being produced in the country (US Drug Enforcement Administration 2001), most of which is shipped to the US. An estimated 200,000 Colombians were involved in the cultivation, production and trafficking of cocaine in the year 2004 (Public Broadcasting System 2004), after coca production waned from its peak. While it is unclear how many Colombians in Miami were involved in the drug trade, social stigma resulted against the entire group of immigrants from the mainstream US. This stigma also exacerbated existing in-group fragmentation based on regional cultures, class origins, and ethnicity (Guarnizo and Diaz 1999). Many migrants involved in legitimate occupations became suspicious of unfamiliar compatriots and sought to disassociate themselves from negative stereotypes and distance themselves from potential danger (Collier and Gamarra 2001). Guarnizo and Diaz (1999: 403) characterize the social impact of participation in the drug trade by some Colombians:

The expansion of drug trafficking [from the mid 1980s through the mid 1990s] has brought about not only the incorporation of a larger population into the migration process, but has also created an environment plagued by *desconfianza*, mistrust, and social fragmentation among migrants, as well as widespread stigmatization and discrimination against Colombians in the United States.

Drug-related violence, widely covered by the news media, cast a great shadow over the Colombian community in Miami. By way of illustration, the Dadeland Mall Massacre occurred on July 11, 1979 when two men were murdered in broad daylight in a feud between Colombian cocaine lords. Such events became iconic images of Colombian immigrants in the minds of many Americans, as many stories mentioning Colombians in the press concerned the drug trade. The drug trade had a substantial effect on South Florida. According to the US Drug Enforcement Agency (2007), “by 1979, the South Florida illegal drug trade was the state's biggest industry and was said to be worth \$10 billion a year wholesale.” More Colombians in this second wave remained in South Florida than in the preceding wave as Miami grew in Latin influence, largely due to the rise of the local economy.

A third wave, beginning in the early 1990's and continuing to the present, largely consisted of the affluent who had the means to escape violent territorial battles and declining economic opportunities in Colombia (Bérubé 2005; Collier and Gamarra 2001). This economic downturn was primarily due to neoliberal reforms and contraction of the drug business following the incarceration of major Colombian drug lords (Guarnizo and Diaz 1999:400). Within this wave, a surge of migration occurred in the years 1999 and 2000 in response to further increases in paramilitary conflict and economic downturns in Colombia. Although these difficulties had persisted for several decades, they were heightened under the Pastrana administration (1998-2000; Bureau of Western Hemisphere Affairs 2007). Colombia's most educated began emigrating *en masse* in the mid 1980s, though their rates of departure increased through this period, leading some to characterize the exodus as a “brain drain” (Collier 2004; Rosselli, Otero, and Maza 2001). However, migrants also became more heterogeneous during the 1990s, increasingly including the working class and the unemployed (Guarnizo and Diaz 1999). While there was a decrease in Colombian drug production and trafficking during this period, the industry remained a central issue in Colombia and Colombia-US relations. A

search of Google News Archives for “Colombian” and “drug” limited to the Miami Herald between the years 1990 and 1999 yields 1,660 news items. This is evidence that this last wave of Colombian migrants continued to be confronted with negative images of their group due to the historical and ongoing problem of drugs in Colombia and in the US.

Colombian group fragmentation in Miami has thus been influenced by historical international developments and resulting stigma associated with the Colombian drug trade from both within and outside of the group. While Cubans in Miami were able to successfully negotiate a proud Cuban American bi-cultural identity, demonstrating substantial solidarity, Colombians’ existing fragmentation appears to have increased due to wariness and suspicion on the part of Colombians towards other unfamiliar members of their ethnic group. The difference in group solidarity/fragmentation may hold important clues to how Cuban and Colombian immigrants may differently experience adaptation to Miami (as I measure through several indicators of acculturation) and experiences of ethnic discrimination.

Cultural and psychological adaptation for immigrant groups may be elevated or suppressed by the group’s level of solidarity or fragmentation. An immigrant group that has successfully rejected stigma and its potential to fragment or perhaps even succeed at strengthening group solidarity in the face of stigma will likely be more resilient to the demands of a new environment than would a socially fragmented group. Levels of commonly-investigated dimension of acculturation such as ethnic and US identities, preference for the Spanish language, and the preference for socializing with members of one’s ethnic group may differ across two groups where one demonstrates solidarity and the other fragmentation. Cubans and Colombians in Miami may be two such groups. Cubans may have more opportunity to feel a strong and proud Cuban identity at the same time as being a proud contributing member of US society given group solidarity. Colombians by contrast, may be limited in the extent to which one may feel or express pride in one’s national heritage and may feel limited in ability to identify with a host country that attaches stigma to the individual based on the actions of a minority of Colombian immigrants. Likewise, solidarity/fragmentation may differentiate groups in the experience of ethnic discrimination. Here, it is likely that Cubans are, on average,

protected from experiences of discrimination due not only to being the numerical majority in the area, but also due to having a strong group bond that may buffer the effects of experiences of discrimination based on ethnicity. Since experiences of acculturation and discrimination have been demonstrated to be associated with psychological distress, these groups may differ in distress due to the mediating or moderating effects of these factors in the relationship between social group and distress.

### **Relative Social Status: Economic, Political, and Social Dimensions**

#### **Cubans: The Ethnic Majority**

As outlined above, there was already a substantial Cuban population in Miami by the time Colombians began to establish a presence. By the year 2000, the ratio of Cubans to Colombians in Miami was roughly 11:1<sup>26</sup>. As such, the Cuban people and culture are the most visible of Hispanic or other groups. The major Cuban ethnic enclave, “Little Havana,” where frequent public celebrations of Cuban culture and history occur, has the second largest concentration of people of Cuban origin outside of Havana, Cuba (García 1996). However, there are several Cuban enclaves located throughout Miami. Moreover, Cuban businesses are spread throughout the city, blurring the boundaries of the Cuban enclave (Portes and Stepick 1993).

According to Portes and Stepick (1993), there are three requirements for the development of an ethnic economic enclave: a stable market for ethnic goods and services, social network access to inexpensive labor in the ethnic community, and capital. These authors argue that the first two of these requirements were accommodated in Miami by waves of Cuban emigration tied to sociopolitical events on the island. For Cubans, after the first “entrepreneurial” class came to Miami, successive waves arrived representing “...average education and occupational status below those of the preceding wave” (Portes and Stepick 1993:145). This provided both increases in market demand for ethnic goods and services, as well as a fresh supply of labor willing to work for low

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<sup>26</sup> Even using the high-end of estimate of the proportion of undocumented Colombians, Cubans would outnumber Colombians by a ratio of roughly 5:1.

wages. Because early Cubans were frequently denied business loans through mainstream banking institutions, start-up capital was frequently garnered through “character loans,” or “extending credit on the basis of personal reputation” (Portes and Stepick 1993:132). Whereas a traditional American bank would scrutinize a business plan to determine eligibility for a loan, Cuban bankers in Latin American-owned banks would base eligibility on an applicant’s former business reputation in Cuba as well as their reputation within the tight-knit exile community. This practice produced loans of \$10,000 to \$30,000 which would enable a business start-up (Portes and Stepick 1993).

Underlying the rise of the Cuban economic enclave was group solidarity, as well as middle-class values and an entrepreneurial spirit (García 1996). Cubans would patronize other Cuban-owned businesses and preferred other co-nationals as business associates (Portes and Stepick 1993). Business owners would give preference to hiring other Cubans, who would work long hours for a low wage in return for preferential opportunities. Workers would also benefit from informal apprenticeships, where they would learn to operate a business and later, many became entrepreneurs themselves (Portes and Stepick 1993). The best predictor of self-employment in the late 1970s was former employment in a Cuban-owned business (Portes and Stepick 1993:1460). Solidarity was thus reproduced and intertwined with the rise of the Cuban economy.

The Cuban economy in Miami grew at a swift pace, moving from “a means of personal survival to achieving a position of influence in the local economy” in just two decades (Portes and Stepick 1993:145). There were just a few Cuban restaurants scattered throughout Miami in 1962. Early blue-collar workers included militants on the CIA payroll, women working in garment factories transplanted from New York, and skilled tradespeople in the construction business. White-collared workers would soon be recognized for their skills as well. Major US companies interested in operating in Latin America found a qualified pool of Spanish-speaking professionals and white-collared workers among Cuban emigrés. However, over time, emigrés increasingly worked within their ethnic economic enclave. According to Portes and Stepick (1993:146), “in 1976, 39 percent of the refugees...were employed in Cuban-owned firms (including the self-employed). By 1979, the figure had increased to 49 percent...” There were an estimated 30,366 Cuban-owned firms in the US in 1977, most of them in Miami (Portes

and Stepick 1993). While numerous Cuban-owned small businesses cropped up throughout Miami, in what may be the typical of small ethnic business, some Cubans began multi-million dollar operations with connections at the highest levels of government (Portes and Stepick 1993:125). By the mid 1980s, “six of the ten largest home builders in Dade were Cuban-owned...” (Portes and Stepick 1993:134). The rise of the ethnic economic enclave and the movement of Cuban professionals and business owners into the mainstream economy allowed for the influence needed to make swift political gains.

Cuban political gains were the result of three related factors: (1) mobilization in response to perceived ethnic discrimination following the successful 1980 English-only referendum and stigma attached to the Mariél event, (2) calcification of the idea that return to the island was not soon forthcoming, and (3) economic gains allowing for influence and campaign contributions.

While Cubans in Miami largely identified as political exiles prior to 1980, stigma and discrimination associated with Mariél and native hostilities reflected through the English-only referendum transformed their identification to an American ethnic minority group (Portes 1984). Subsequent to this, it became common to self-identify as “Cuban American.” However, this minority perspective was short-lived, as it was replaced by a discourse of the Cuban immigrant success story (Portes and Stepick 1993), and it was generally with this pride of group accomplishment that one identified as Cuban American. As the prospect of their return to their homeland became more unlikely, Cuban Americans saw themselves as staunch defenders of American values, given a lived sociopolitical history exemplifying the dangers of a non-democratic and capitalistic political system (Portes and Stepick 1993). Cuban Americans thus organized to combat suggestions of undesirability and to ensure that the group’s economic and political ends were kept in focus and were seen as demonstrations of Americanism. Economic gains allowed for political organization and influence. As an example of their successful political mobilization, The Cuban American National Foundation was extremely successful in influencing US policy toward Cuba (Kiger 1997). García (1996:8) succinctly explains the political success of Cubans by the early 1990s: “By 1992, Cubans dominated Miami’s city commission; the city and county managers were Cuban; ten of

twenty-eight seats occupied by the Dade County delegation in the state legislature were held by Cubans; Cubans had been elected mayor of several cities, including Miami; and one emigré had been elected to the U.S. House of Representatives.” In 2004, the Los Angeles Times reported that Cubans had retained political dominance in the area, reporting that:

“...of the more than 1 million registered Latino voters in Florida, as many as half may still be Cuban American. All three Latinos in the state Senate are Cuban American; of the 14 members of the Hispanic Caucus in Florida's House of Representatives, 11 are Cuban American...[and]... the three Florida Latinos in the U.S. House of Representatives are Cuban Americans” (LA Times June 28, 2004).

### **Colombians: An Ethnic Minority Group**

Colombians in South Florida are disempowered relative to Cubans across economic, political, and social dimensions (Collier 2004). The main explanatory factor for the relative disadvantage of Colombians is social fragmentation. According to Guarnizo and Diaz (1999):

...group solidarity among Colombians, a crucial component of entrepreneurial success...is class based (horizontal solidarity), rather than ethno-nationally-based (vertical solidarity). However, the mistrust and exclusion generated by the stigma of drugs, regionalism, and racism, prevent even horizontal solidarity from expanding. This process results in high levels of social fragmentation that impede the formation of larger economic, political, and socio-cultural transnational ventures and regroupings.

In terms of economic mobility, many Colombians dropped in socio-economic status after arriving in Miami due to difficulties finding employment (Collier 2004). Much of this is attributed to an inability to receive the Temporary Protected Status afforded to other Latin American migrant groups escaping socio-political violence, or residency visas or work visas. Social security numbers, which most employers require, cannot be obtained without such resident statuses. Another difficulty securing employment is related to cultural norms and in-group suspicions. Since it is a cultural

norm in Colombia to attain work through tight-knit social networks of friends and family, and given the exacerbation of existing social fragmentation in Miami due to the participation of some in the drug trade, many Colombians are both unskilled in job interviewing and lack the in-group social connections to secure a job through informal means (Collier and Gamarra 2001). Many professionals lacked licenses recognized in the US to practice their professions and many of these lacked the English language skills to apply for a new license in the US. Moreover, many Colombian migrants to Miami found it exceedingly difficult to find employment or other assistance within the Cuban enclave where Spanish is generally the language of business (Collier 2004).

Collier and Gamarra (2001) describe the occupations of those Colombians who had attained employment, differentiated by social class prior to migration. The lower and lower-middle classes tend to be undocumented and work in manufacturing, service and agriculture. The middle, upper-middle, and upper classes of the first and second waves of immigration largely work in professional occupations, businesses, and educational institutions. Finally, the middle, upper-middle, and upper classes of the third wave are often investors, trained professionals working several menial jobs to make ends meet, transnational businesspeople who continue to operate their businesses in Colombia, and the upper class who do not necessarily require employment to maintain their lifestyle.

In general, many Colombians may have stressful experiences of adaptation to their new environment in terms of attaining and maintaining work. Of those in the lower classes who attain work, they are frequently undocumented, and thus are frequently not protected by employment regulations in agriculture or the factory. Of those in the middle and upper classes, many experience downward social mobility, working beneath their skill levels, sometimes in several menial occupations. The aggregate result of these difficulties is that the group has not yet attained the economic health that would have been more likely if not for group fragmentation, obstacles to attaining residency due to US immigration policy, and difficulties integrating into the established Latin economy.

Colombian migrants in Miami have also faced many difficulties that preclude the social mobility of the group as a whole. While the primary pull factor that later Colombian migrants cite for moving to South Florida is to join family and friends with the expectation of social support upon arrival (Collier 2004), many times new migrants

have been frustrated by a lack of support by their host family in finding employment and attaining information about acquiring US resident status. This is especially difficult because Colombian migrants by and large lack the sense of pride in their national origin and tend to rely on only their closest family and friends (Collier 2004). They thus often lack extensive social networks and do not live in ethnic enclaves in South Florida (Collier and Gamarra 2001). As such, Colombians have not made much of a mark in the social life of Miami. Collier and Gamarra (2001:11) explain: “socially, the impact of Colombian migration [in Miami] is weak...for Colombians assimilate quickly into a South Florida population characterized by social and ethnic divisions and lacking social trust-conditions similar to those that Colombians left behind in their home state.” Thus, fragmentation not only has played a major role in precluding economic incorporation, but also contributes to a lack of social influence. However, Collier and Gamarra (2001) also warn:

The weakness of Colombian social capital does not mean that Colombians are completely anti-social. They come together for events involving Colombian national sports teams (soccer, etc.) in South Florida, as well as in response to natural disasters...and at the annual July 20 Colombian Independence Day celebrations. They also join selected religious and business groups (mainly with other Colombians) (p. 16).

Despite these iconic examples of national pride and group assistance, Colombians in Miami have not forged social strategies that successfully raise their presence in the area. Unlike Cubans, whose strong solidarity has optimized conditions to raise the group from a temporary exile identity to a strong Cuban American identity, Colombians remain divided, and what likely follows, is an inability to effectively organize to raise the social status of the group.

Colombians in the US are not very politically active (Collier and Gamarra 2001). “Only 70,000 Colombians in Florida, out of an estimated statewide population of 458,000 have become US citizens and only 23,000 are registered to vote in the United States” (Collier and Gamarra 2001:14). By the year 2001, only three Colombians had run for office in South Florida (Collier and Gamarra 2001). Two of these Colombian candidates ran against each other and eventually lost to a Cuban American candidate. The general

lack of political participation by Colombians in Miami, and in their homeland for that matter, may reflect a lack of confidence in the political system both in Miami and Colombia. While Colombians in Miami have formed a number of service organizations, primarily to aid in the resettlement of newcomers, they are largely ineffectual due to limited resources, membership restrictions based on social classes or networks, overlapping of membership, and inter-agency competition (Collier and Gamarra 2001).

It thus appears that Colombian group fragmentation is implicated in a social status paralysis beyond factors that are out of the immediate control of the group, such as relative group size in the area. It appears that, this group fragmentation has led to a persistent minority status, especially compared to Cuban Americans, that is manifested in relative social, economic, and political disadvantage.

This disadvantage relative to Cubans likely translates into group differences in experiences of acculturation and ethnic discrimination. For example, Colombians may be less likely to strongly identify with either an ethnic (nationalistic) identity or an American identity due to persistent in-group fragmentation and lack of access to US resources compared to Cubans who appear to strongly identify as both Cuban and American. Also, Colombians may be less inclined to socialize with others from their ethnic group than Cubans given relative fragmentation/solidarity<sup>27</sup>. Finally, given the described relative economic, social, and political disadvantage of Colombians compared to Cubans in Miami, and the Cuban numeric majority, it is likely that Colombians would report a higher frequency of ethnic discrimination compared to Cubans in the area. Both differences in experiences of acculturation and ethnic discrimination may, in turn, differentiate these groups in terms of psychological distress. Here, it may be the case that Colombians, as the socially disadvantaged group, may report higher levels of psychological distress than Cubans, a relationship that may be mediated or moderated by social factors such as acculturation and ethnic discrimination.

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<sup>27</sup> While preference for the Spanish language is one of the most widely-used indicators of acculturation for Hispanic immigrant groups, it is unclear whether there might be a group difference in Miami, where Spanish is commonly used both socially and professionally.

## Summary and Conclusion

This review of the migration patterns of Cubans and Colombians to Miami has served to generate research questions regarding how these groups may differ in experiences of acculturation and ethnic discrimination (outlined in the following chapter). Social factors may be associated with psychological distress as risk or protective factors. This review has also revealed other notable group similarities and differences that point to why these particular groups are interesting in their comparison of social factors associated with mental health.

In terms of similarities, waves of immigration were largely tied to socio-political circumstances; both groups emigrated to escape political persecution or violence and repression. Both groups also faced stigma and discrimination upon arrival due to some portion of each being involved in illicit activity, or at least perceived to have been involved. However, whereas Cubans were able to successfully defend and recast their group image, Colombians appear to continue to suffer the negative effects of stigma. These groups were also similar in the general ordering of the arrivals across social strata, with the upper classes generally preceding the lower classes. For Cubans, each successive wave of migration generally consisted in lower socioeconomic standing than the preceding wave. For Colombians, the higher classes arrived and remained in Miami from the 1970s through the 1980s, followed by a wave including more of the highly educated while increasingly including the lower classes throughout the 1990s. By the year 2000, both groups were highly heterogeneous in terms of social class. However, a review of Census 2000 figures reveals that while Colombians are on average more represented than Cubans in higher levels of education, Cubans are slightly better off in terms of income. Nonetheless, both groups appear to be comparable in socioeconomic status, taking these factors together, and are relatively well-off in this regard compared to other immigrant groups in Miami and compared with other Hispanic immigrant groups throughout the US.

In terms of differences, Cubans were already quite established in the area by the time Colombians began to establish a presence and by the year 2000, representing the largest Hispanic ethnic group and holding a strong social and political presence. Also,

whereas Cubans were instrumentally aided in resettlement through immigration policy, Colombians have not enjoyed equal support and many fear deportation. Lastly, while previous waves of Cubans rallied behind their compatriots showing great group solidarity for *la causa*, Colombians have not demonstrated similar levels of group cohesion. However, as Guarnizo and Diaz (1999:404) warn, one should be cautious in interpreting the Colombian group as entirely lacking solidarity. Principles such as solidarity and reciprocity continue to be highly valued social resources. The fragmenting effect of regional and class identities, and their exacerbation by the involvement of illicit activity by some have had the effect of availing these social resources to a close network of friends and relatives.

These two Latin American immigrant groups thus represent an interesting comparison of mental health and associated social factors. Despite similarities often found to impact mental health, such as socioeconomic status and reasons for migration, these groups are also importantly different in social solidarity/fragmentation and relative group advantage in the area. Moreover, Miami itself represents an interesting quasi-natural laboratory in which to compare these two Hispanic groups in a study of mental health. This is because, Miami presents a rare context in which to study Hispanic immigrant mental health given a large presence of Hispanic and other immigrants and that the Spanish language is commonly used in both social and professional situations. This study will thus serve to advance research on Hispanic immigrant health and associated factors by comparing social factors affecting psychological distress in a context unlike that of where the bulk of Hispanic health data has been collected (i.e., California, New York, Texas). This will provide further information about the universality of the relationships between acculturation and mental health and ethnic discrimination and mental health among Hispanic immigrant groups in the US. Moreover, the proposed study will advance the field by studying two relatively understudied Hispanic American groups. While a handful of community studies and one recent national study (NLAAS) have considered Cuban American mental health, there is a near total absence of scholarly information about US Colombians (Guarnizo and Diaz 1999). The proposed study will thus advance the field of Hispanic American/immigrant mental health in several important respects.

## CHAPTER SEVEN

### RESEARCH QUESTIONS

#### **Descriptive Analysis (Presented in Chapter 9)**

1. Are indicators of acculturation and perceived ethnic discrimination significantly correlated with distress among Cuban and Colombian immigrants in Miami?
2. Are Colombian Americans significantly more distressed than Cuban Americans on average?
3. Do these groups significantly differ in mean level of acculturation (five dimensions will be considered) and perceived ethnic discrimination?
4. What proportions of Cuban and Colombian immigrants in South Florida reach the threshold for significant depressive symptomatology?
5. Are women more distressed than men within these immigrant groups?

#### **Multivariate Analysis (Presented in Chapter 10)**

1. Do social status variables (sex, age, SES) explain group differences in depressive symptoms observed<sup>28</sup>?
2. Can any of five indicators of acculturation explain any group difference in distress observed net of social status variables?
3. Which, if any, of the five indicators of acculturation are independently associated with distress net of each other and social status variables?
4. Can perceived ethnic discrimination explain any group difference in distress observed net of social status variables?
5. Is perceived ethnic discrimination independently predictive of distress net of social status variables and indicators of acculturation?

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<sup>28</sup> All multivariate models will control for difficulties with functional activities due to the sampling procedures discussed above.

6. Are the effects of social status variables, indicators of acculturation, or perceived ethnic discrimination differentially predictive of distress across ethnic groups?

## CHAPTER EIGHT

### METHOD

I analyze data from wave one of the *Physical Challenge and Health* study (Turner, Lloyd, and Taylor 2006). This is a two-wave panel study of community-residing adults that focuses on the associations between physical disability and DSM-IV psychiatric and substance use disorders. Data were collected in Miami-Dade County, Florida. The primary sampling unit was the square-mile block of which there were 100 randomly selected from the county<sup>29</sup> containing 206,234 households. A random sample of 10,000 of these households was screened door to door and via telephone from May through November 2000. The goal was to identify 1000 respondents with a physical limitation and 1000 without limitation matched on age (18 years or older), sex, race/ethnicity, and area of residence. Physical limitations were assessed by screening questions to establish disability status that targeted “limitations in normatively expected activities” (Turner, Lloyd, and Taylor 2006:215). Household screenings assessed whether *any* adult in the household possessed a physical limitation. Fifty percent of the sample were women. Non-Hispanic whites, African Americans, Cuban Americans, and non-Cuban Hispanics each represented 25 percent of the sample. An interview success rate of 82 percent was obtained. Computer-assisted interviews were conducted in either English or Spanish<sup>30</sup> (respondent’s choice) by trained interviewers who were largely bilingual. Wave one interviews took place in 2000-2001. The final sample size was 1986. Of these, 559 respondents confirmed the presence of a physical limitation of 900 screened as having a limitation (roughly 28 percent of the sample). The national prevalence of disability across all age groups in 1992 was estimated to be 15 percent (LaPlante and Carlson 1996:6). Thus, by design, this sample over-represents physically

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<sup>29</sup> These blocks were selected from 404 blocks that contained 100 non-commercial residences or more.

<sup>30</sup> The Spanish version was translated from English and back translated and reviewed by a multi-ethnic group of Hispanic team members to ensure that the translation was suitable across Hispanic national groups.

challenged adults in South Florida. Thus, my multivariate analyses will statistically control for limitations in functional activities. The sample ranges in age from 18 to 93 years. However, because the study was designed to over-sample adults with physical limitations and because physical limitations increase with age (LaPlante and Carlson 1996:6), the sample has a higher median age than does the general population of the county (59 versus 36 years; US Bureau of the Census 2000).

This investigation will be limited to Cuban and Colombian immigrant respondents. Ethnic classification was determined by respondents' self-report as foreign-born Cuban or foreign-born Colombian. Three respondents selected an "other" write-in option for ethnicity and provided an ambiguous response. In these cases, I coded these respondents as "Cuban" or "Colombian" *vis-à-vis* birthplace of the respondent. Analyses have identified 373 immigrants of Cuban descent and 78 of Colombian descent with complete data on study variables<sup>31</sup>. Thus, the study from which I draw provides a sample of each national origin group that is adequate for multivariate analyses.

## Measures

Depressive Symptoms: Depressive symptomatology was measured using the 20-item version of the Center for Epidemiologic Studies Depression Scale (CES-D), a widely-used and reliable index of depressive symptomatology (Radloff 1977). This scale has been validated for use with Hispanic Americans (Roberts, Rhoades, and Vernon 1990). Respondents were asked how often in the last month they experienced a list of feelings and experiences indicative of depressed mood. Four measures of positive affect were reverse coded and all items were then summed resulting in a scale ranging from 20-80. Twenty was then deducted from index scores to produce a range of zero to 60 in order to be comparable with previous research. Higher values of this measure represent the presence of more frequent past month depressive symptoms. The internal reliability of this depressive symptoms scale among my study sample is .90 (Cronbach's Alpha statistic).

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<sup>31</sup> This, roughly 5:1 ratio, corresponds with Census 2000 estimates of population values for these groups, as discussed above.

Significant Depressive Symptomatology: Significant depressive symptomatology is a dichotomous indicator where a CES-D score of 16 or greater is coded “1” and scores lower than 16 are coded “0.” This threshold was originally described as an “arbitrary” cut point for significant depressive symptoms by the author of the instrument (Radloff 1977:393). However, as noted above, empirical evidence suggests that this is a meaningful marker of clinical significance as well as risk for mortality. Level of depressive symptoms may therefore be meaningfully distinguished at this threshold. In the interest of providing information that is relevant for public health efforts, I will provide group proportions of meeting this criterion.

Perceived Ethnic Discrimination: A three item index of perceived discrimination (Vega et al 1993) –specifically referring to discrimination based on being of Latin origin – will be included in analyses. These three items include (1) “how often do people dislike you because you are Hispanic (Latin)?” (2) “how often are you treated unfairly because you are Hispanic (Latin)?” and (3) “how often have you seen friends treated badly because they are Hispanic (Latin)?” These items were set on a four point Likert scale of frequency with one representing “never” and four representing “always.” It is important to note that these items are asking about frequency of ethnic discrimination, getting at how rarely or commonly this stressful circumstance was experienced. Items will be summed resulting in a scale ranging from 3 to 12. Higher values on the scale represent more frequent experiences of ethnic discrimination. The internal reliability of this scale is .78 among this sample.

It should be noted that there are two other discrimination scales available in the data set that were not selected for use. These scales, created by Williams et al (1997), were designed to tap major discrimination and day to day discrimination. Preliminary analyses revealed that only 283 cases of the total sample of 1986 reported experiencing *any* one of seven events attributed to discrimination based on ethnicity, race, skin color, accent, limited Spanish proficiency, or limited English proficiency. Thus, multivariate analyses would not be able to be conducted across ethnic groups given small cell sizes. Analyses also revealed that the day to day discrimination scale would not be as useful as the scale described above concerning discrimination based on Hispanic heritage for several reasons. First, the great majority of Cuban and Colombian respondents reported

that they *never* experience any one of nine character assaults, resulting in little variation in the variable. Second, when day to day discrimination was substituted for discrimination based on Hispanic heritage in the full OLS model (described below) predicting distress, the net relationship was stronger for discrimination based on Hispanic heritage. Third, when both indicators of discrimination were included in the final model, discrimination based on Hispanic heritage was independently associated with distress net of all covariates, though day to day discrimination was not. Finally, the decision was made to employ the measure of discrimination based on Hispanic heritage because this measure has been previously used in some of the most widely-cited scholarly investigations into discrimination and Hispanic American mental health (Vega et al 1993; Finch, Kolody, and Vega 1999).

Acculturation: Five indicators<sup>32</sup> of acculturation will be constructed from a well-known and widely-used set of items developed by Gil and Vega (1996). Indicators will include years in the US, strength of ethnic identity, strength of American orientation, preference for the Spanish language, and preference for associating with others from one's ethnic group. Years in the US ranges from 2 to 72 among the relevant sample.

A scale of strength of ethnic identity was constructed from four items: (1) "you have a strong sense of yourself as a member of your ethnic group" (2) "your ethnic heritage is important in your life" (3) "you are proud of your ethnic heritage" and (4) "your ethnic group had a lot to do with who you are today." These items were set in a seven point Likert-type response scale with "strongly agree" anchored at one and "strongly disagree" at point seven. The four items were reverse coded and summed. The resulting scale was then standardized. Higher values on this scale represent stronger ethnic identity. The internal reliability of this scale is .76.

American orientation is measured by the single item: "you consider yourself to be American." This item was set in a four point Likert scale of agreement with "agree a lot" at point one and "disagree a lot" at point four. This item was reverse coded such that higher scores in the one to four range reflect stronger American orientation. While a

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<sup>32</sup> It should be noted that I am unable to utilize five acculturative stress items because of high proportions of non-response. Only 248 of 457 Cuban respondents and 55 of 90 Colombian respondents provided data on these questions.

single item measure of this social-psychological construct is less than ideal, I will nonetheless include this indicator of acculturation given the evidence presented above that orientation to the receiving community is independent from ethnic orientation or identity. One limitation in these data is that I am unable to construct a psychological acculturation typology given the available measures or assess multiple dimensions of American orientation. I will nonetheless include this indicator of American Orientation to investigate the independent contribution of this identity to the extent possible.

Preference for the Spanish language is constructed from five items. These include (1) “what language do you prefer to speak?” (2) “what language do (did) you prefer to speak at school?” (3) “what language do you speak with friends?” (4) “in what language are the magazines you read?” and (5) “in general, what language are the movies, TV and radio programs you like to watch and listen to the most?” Response choices were cast in a five-point Likert scale such that “Spanish all the time” was coded “1” and “English all the time” was coded “5”. All items were reverse coded, summed, and standardized. Higher scores on this item reflect stronger preference for the Spanish language. The internal reliability of this scale is .76.

In-group social preference was constructed from six items. These items include: (1) “you identify with other people from your ethnic group,” (2) “most of your close friends are from your own ethnic group,” (3) “you are comfortable in social situations where others are present from your ethnic group,” (4) “your ethnic background plays a big part in how you interact with others,” (5) “you prefer to date people from your ethnic group,” and (6) “your values, attitudes, and behaviors are shared by most members of your ethnic group”. These items were set in a seven point Likert-type response scale with “strongly agree” anchored at one and “strongly disagree” at point seven. Items were reverse coded, summed, and standardized. Higher scores on this measure reflect higher preference for associating with others from one’s ethnic group. The internal reliability of this scale is .82.

Sociodemographics/Controls: Sociodemographic variables will include functional activity difficulties, gender, age, and socioeconomic status. The scale of functional limitations is included due to the planned over-representation of individuals possessing a physical limitation in the study from which I draw and evidence that

physical limitations are associated with declines in mental health (Turner, Lloyd, and Taylor 2006). Seven survey items tapped *difficulties performing functional activities*, which were adapted from several sources (Roscoe and Breslau 1966; Nagi 1976; Fries et al 1980). These items asked if respondents were able to (1) “reach up and get a 5 pound object (such as a bag of sugar) from just above your head,” (2) “bend down to pick up an object (like a piece of clothing) from the floor,” (3) “turn faucets on and off,” (4) “walk a quarter of a mile,” (5) “stoop or crouch down,” (6) “lift 10 pounds,” and (7) “sit for more than two hours.” Items were set in a four point scale including “easily” (coded 1), “with some difficulty” (coded 2), “with much difficulty” (coded 3), and “unable to do” (coded 4). One was subtracted from each score and items were summed resulting in a scale range of 0 to 21, with higher scores representing greater difficulties performing activities. The internal reliability of this scale is .89.

*Gender* is coded “1” for female. *Age* is measured continuously, in years. A composite *SES* score was based on income level, occupational prestige, and educational attainment. Scores on these three dimensions were summed, divided by the number of status dimensions on which data were available, and standardized. Higher scores represent higher levels of SES.

## **Method**

All data analyses are conducted using the STATA statistical software package, version 9.2 (StataCorp 2006). The first phase of analyses (Chapter 9) will examine descriptive statistics for all study variables. I have computed a correlation matrix with *p* values indicating statistical significance (see Table 2 below). I have also produced two tables of descriptive statistics. The first of these (Table 3) provides full sample means (with standard deviations) or proportions, where applicable, as well as group-specific means (with adjusted standard errors due to designed clustering) and proportions with indications of statistical significance across groups for all study variables. The second (Table 4) presents proportions of Cubans and Colombians reporting significant distress within immigrant group by the presence or absence of difficulties performing functional activities. I provide the information contained in Table 4 for two reasons. First, the data

provide an opportunity to examine how depression may vary by physical challenge within Hispanic immigrant groups for which little information is currently available. Thus, this table is provided to add to public health information. Second, this information provides an empirical rationale for controlling on difficulties performing functional activities in multivariate analyses. A final descriptive analysis estimates levels of depressive symptomatology within immigrant group by gender, with gender contrasts within groups. I provide this information for reasons similar to those justifying the inclusion of Table 4. First, because studies consistently demonstrate that women present higher levels of depressive symptoms than men and because no information currently exists about gender differences in depression among Colombian Americans, I explore the possibility of variation in distress by gender. I also provide these estimates as public health information as well as for the purpose of providing an empirical rationale for controlling on gender in multivariate analyses.

Multivariate analyses (Chapter 10) will employ OLS regression using the STATA survey module (svy:) to adjust standard errors for clustering. This clustering is due to the sample selection technique that matched a non-disabled individual residing within the same square mile block as a respondent screened as disabled. Thus, the square mile block will be specified as the primary sampling unit in all multivariate analyses. Table 5 presents coefficients from OLS regression of depressive symptoms on sociodemographics, acculturation, and perceived ethnic discrimination. Models are designed to address the six multivariate research questions specified above. Interaction terms were created between ethnic group and all study variables to assess the final research question regarding the possible differential effect of acculturation and/or ethnic discrimination across immigrant groups in terms of distress. All models control on level of difficulty in performing functional activities.

Figures 1 through 5 are conceptual models of the relationships assessed in this study. Figure 1 illustrates the assessment of direct effects of sociodemographics, five dimensions of acculturation, and perceived ethnic discrimination on depressive symptoms. Figure 2 illustrates the assessment of mediating effects of five dimensions of acculturation in the relationship between ethnic group and depressive symptoms. In mediational analyses, I am assessing whether any of five acculturation variables can

attenuate or account for any significant relationships observed between ethnic group and psychological distress either separately or in concert. Figure 3 illustrates the assessment of moderating effects of five dimensions of acculturation across immigrant groups in the prediction of distress. Here, I am interested in whether Cuban and Colombian immigrants are differently affected by any of the acculturation variables in terms of distress. Thus, Figures 2 and 3 represent competing hypotheses of what may be underlying any group differences in distress. On the one hand, I may be able to explain any group differences in distress through the assessment of mediating affects. On the other hand, group differences in the experience or expression of distress may occur only at certain levels of indicators of acculturation. I take the same approach with regards to the relationship between ethnic discrimination and distress. Figure 4 depicts the assessment of perceived ethnic discrimination as a mediator in the relationship between ethnic group and depressive symptoms. Finally, Figure 5 represents the assessment of perceived ethnic discrimination as a moderating factor in the relationship between ethnic groups and psychological distress.

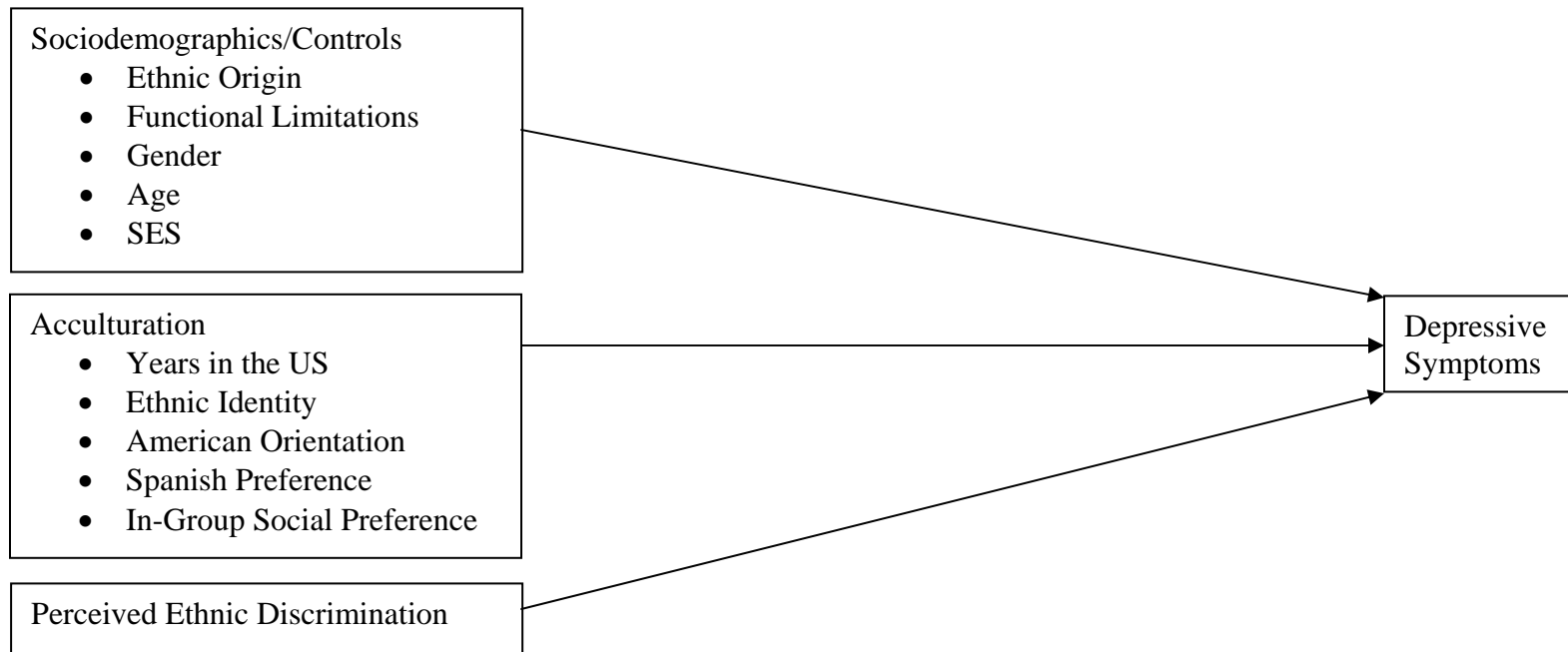


Figure 1. Conceptual Model: Assessing Direct Effects of Sociodemographics, Dimensions of Acculturation, and Perceived Ethnic Discrimination on Depressive Symptoms

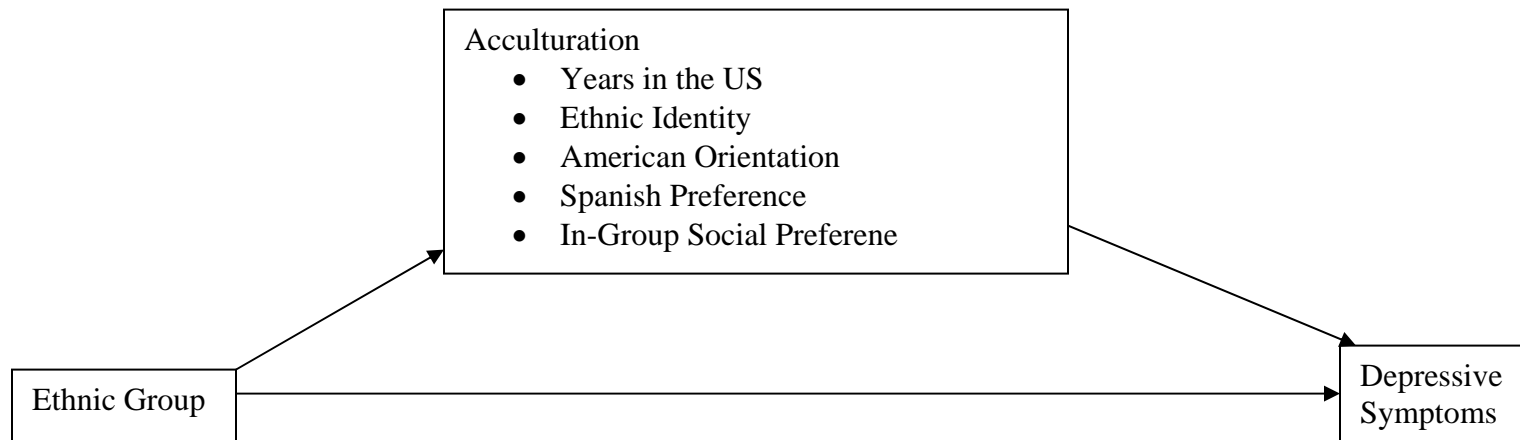


Figure 2. Conceptual Model: Indicators of Acculturation Mediating the Relationship between Ethnicity and Depressive Symptoms

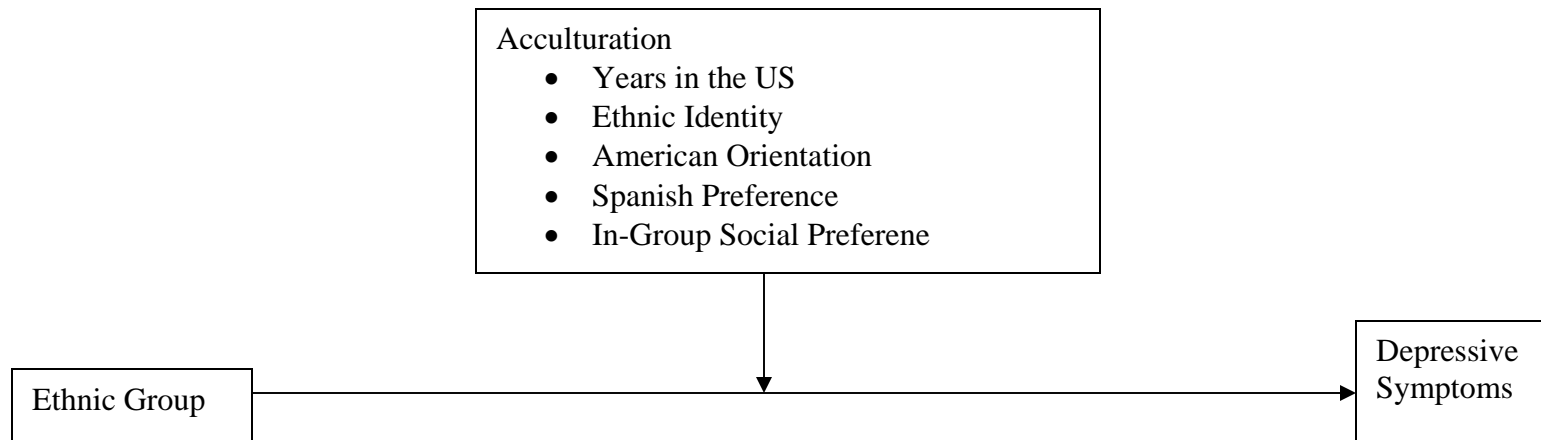


Figure 3. Conceptual Model: Indicators of Acculturation Moderating the Relationship between Ethnicity and Depressive Symptoms

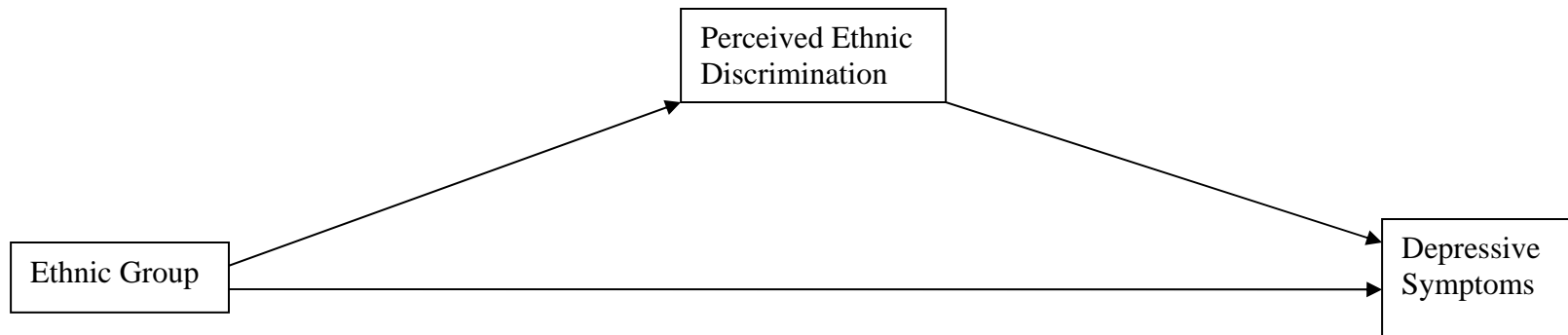


Figure 4. Conceptual Model: Perceived Ethnic Discrimination Mediating the Relationship between Ethnicity and Depressive Symptoms

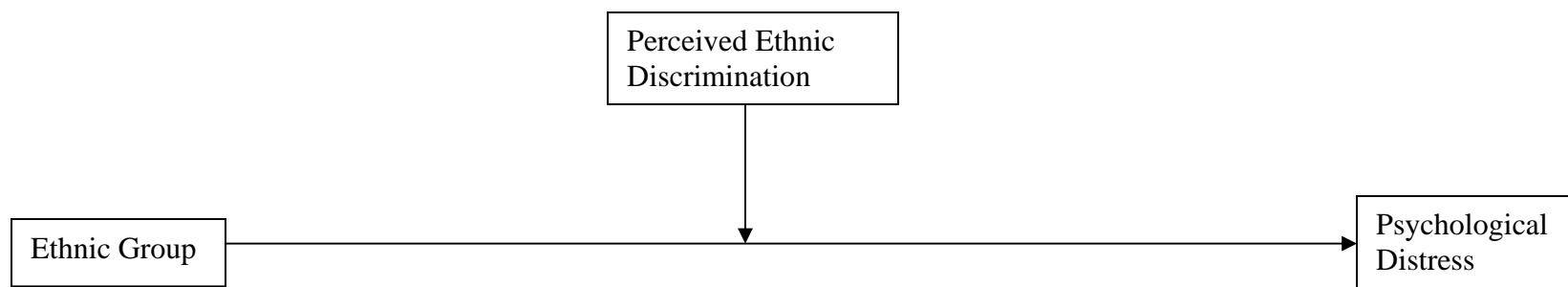


Figure 5. Conceptual Model: Perceived Ethnic Discrimination Moderating the Relationship between Ethnicity and Depressive Symptoms

## CHAPTER NINE

### DESCRIPTIVE RESULTS

I first investigate whether indicators of acculturation and ethnic discrimination are significantly correlated with distress among Cuban and Colombian immigrants in Miami. Table 2 reports Pearson's correlations across all study variables. Years in the US, ethnic identity, and American orientation are all negatively associated with depressive symptomatology at the 95 percent confidence level or better. In-group social preference/loyalty is also negatively associated with distress ( $p < .10$ ). Preference for the Spanish language is not significantly correlated with psychological distress. Perceived ethnic discrimination is positively associated with depressive symptomatology ( $p < .001$ ). Thus, four of five indicators of acculturation and perceived ethnic discrimination are associated with level of psychological distress among Hispanic immigrants in Miami, at least at the zero order.

Table 3 reports the mean or percent (where applicable) for all study variables for the full sample and for Cuban and Colombian immigrants separately. My first central concern here is whether Colombian immigrants are significantly more distressed than Cuban immigrants on average. Colombians report a significantly ( $p < .05$ ) higher mean level of distress (17.45) than do Cubans (13.82). It is noteworthy that the mean level of distress among Colombians surpasses the standard threshold for clinically significant depressive symptoms among individuals ( $CES-D \geq 16$ ).

The next four rows of Table 3 report descriptive statistics on difficulties with functional activities and social status variables. The groups do not substantially differ in their level of difficulty experienced performing functional activities. The Colombian group contains a higher proportion (58.97 percent) of women than does the Cuban group (50.13 percent). Colombians are also significantly ( $p < .001$ ) younger on average (50.65 years) than are Cubans (59.17 years). Finally, Colombians report higher levels of SES than do Cubans.

My second central interest in this descriptive analysis is whether Cuban and Colombian immigrants significantly differ in levels of acculturation and perceived ethnic

discrimination. In terms of the five indicators of acculturation, the groups differ significantly in two of five dimensions. Colombians report significantly ( $p < .001$ ) less exposure to the US (19.03 years) than do Cubans (26.57 years) on average. This is not surprising given the group patterns of migration discussed above, with Cubans arriving in Miami earlier than Colombians. Colombian immigrants also report significantly ( $p < .01$ ) lower American orientation (2.80) than do Cuban immigrants (3.10). This may be a function of relatively less time to become psychologically assimilated in terms of group identity. Inspection of the correlation between these factors in Table 2 supports this explanation given a significant positive association between number of years in the US and American orientation. Colombian and Cuban immigrants do not significantly differ in mean strength of ethnic identity, preference for the Spanish language or preference for socializing with members from within one's ethnic group. Table 3 also reports mean levels of perceived discrimination for the entire sample and within immigrant groups.

No significant group differences are observed in perceived discrimination. Therefore, Cuban and Colombian immigrants appear to be more similar than dissimilar in post-migration psychosocial factors commonly associated with Hispanic American mental health, though group differences do exist in average number of years in the US and American orientation.

Another central concern in descriptive analysis is estimating what proportions of these immigrant groups reach the threshold for significant levels of depressive symptoms. The last row in Table 3 reports the proportions of respondents that report clinically significant depressive symptomatology (CES-D  $\geq 16$ ) as well as tests for statistically significant differences across groups. Colombian immigrants are more likely to report significant depressive symptomatology (44.44 percent) than are Cuban immigrants (35.66 percent;  $p < .10$ ). Thus, a substantial portion of both groups may be at risk for clinically-significant depression. Due to the sampling strategy of the parent study, I also investigated proportions of CES-D caseness within each immigrant group, stratified by the presence of functional activity difficulties. Respondents reporting no difficulties performing functional activities were examined separately from those reporting any difficulty.

Table 2. Correlation Matrix, All Study Variables<sup>1</sup>

|  | 1                   | 2                   | 3                   | 4                   | 5                   | 6                   | 7                   |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| 1 Colombian                            | 1.000<br>(---)      |                     |                     |                     |                     |                     |                     |
| 2 Activity<br>Limitations              | -0.0377<br>(0.4240) | 1.000<br>(---)      |                     |                     |                     |                     |                     |
| 3 Female                               | 0.0878<br>(0.0625)  | 0.1652<br>(0.0004)  | 1.000<br>(---)      |                     |                     |                     |                     |
| 4 Age                                  | -0.1840<br>(0.0001) | 0.3235<br>(0.0000)  | 0.0803<br>(0.0886)  | 1.000<br>(---)      |                     |                     |                     |
| 5 SES <sup>z</sup>                     | 0.1112<br>(0.0182)  | -0.2367<br>(0.0000) | -0.0661<br>(0.1611) | 0.3505<br>(0.0000)  | 1.000<br>(---)      |                     |                     |
| 6 Years in US                          | -0.1972<br>(0.0000) | 0.1290<br>(0.1290)  | -0.0275<br>(0.5608) | 0.4517<br>(0.0000)  | 0.0310<br>(0.5118)  | 1.000<br>(---)      |                     |
| 7 Ethnic<br>Identity <sup>z</sup>      | -0.0461<br>(0.3287) | -0.0665<br>(0.1588) | -0.0115<br>(0.8083) | 0.0186<br>(0.694)   | -0.0580<br>(0.2190) | 0.0093<br>(0.8435)  | 1.000<br>(---)      |
| 8 American<br>Orientation              | -0.0849<br>(0.0716) | 0.0402<br>(0.3947)  | 0.0267<br>(0.5720)  | 0.1139<br>(0.0155)  | 0.1019<br>(0.0305)  | 0.2983<br>(0.0000)  | 0.1555<br>(0.0009)  |
| 9 Spanish<br>Preference <sup>z</sup>   | -0.0047<br>(0.9213) | 0.1322<br>(0.0049)  | 0.1129<br>(0.0165)  | 0.4542<br>(0.0000)  | -0.5545<br>(0.0000) | -0.1209<br>(0.0102) | 0.2029<br>(0.0000)  |
| 10 In-Group<br>Preference <sup>z</sup> | -0.0379<br>(0.4219) | 0.0101<br>(0.8314)  | -0.0141<br>(0.7657) | 0.1316<br>(0.0051)  | -0.1290<br>(0.0061) | -0.0406<br>(0.3899) | 0.6774<br>(0.0000)  |
| 11 Perceived<br>Discrimination         | 0.0398<br>(0.3991)  | 0.1163<br>(0.0135)  | -0.0038<br>(0.9361) | -0.1601<br>(0.0006) | 0.1385<br>(0.0032)  | -0.1037<br>(0.0277) | -0.2963<br>(0.0000) |
| 12 Depressive<br>Symptoms              | 0.1184<br>(0.0118)  | 0.3188<br>(0.0000)  | 0.0901<br>(0.0560)  | 0.0016<br>(0.9728)  | -0.1525<br>(0.0012) | -0.1021<br>(0.0301) | -0.2688<br>(0.0000) |

Notes: 1=Unadjusted coefficients; z=Standardized measure, *p* value in parentheses

Table 2. - Continued

|                                     | 8        | 9        | 10       | 11       | 12    |
|-------------------------------------|----------|----------|----------|----------|-------|
| 1 Colombian                         |          |          |          |          |       |
| 2 Activity Limitations              |          |          |          |          |       |
| 3 Female                            |          |          |          |          |       |
| 4 Age                               |          |          |          |          |       |
| 5 SES <sup>z</sup>                  |          |          |          |          |       |
| 6 Years in US                       |          |          |          |          |       |
| 7 Ethnic Identity <sup>z</sup>      |          |          |          |          |       |
| 8 American                          | 1.000    |          |          |          |       |
| Orientation                         | (---)    |          |          |          |       |
| 9 Spanish Preference <sup>z</sup>   | -0.1147  | 1.000    |          |          |       |
|                                     | (0.0148) | (---)    |          |          |       |
| 10 In-Group Preference <sup>z</sup> | 0.0068   | 0.2827   | 1.000    |          |       |
|                                     | (0.8852) | (0.0000) | (---)    |          |       |
| 11 Perceived Discrimination         | -0.2253  | -0.2633  | -0.1609  | 1.000    |       |
|                                     | (0.0000) | (0.0000) | (0.0006) | (---)    |       |
| 12 Depressive Symptoms              | -0.2290  | 0.0183   | -0.0781  | 0.4125   | 1.000 |
|                                     | (0.0000) | (0.6988) | (0.0976) | (0.0000) | (---) |

Table 3. Descriptive Statistics with Mean (**SD** or Taylor Linearized Standard Error) or Percent

|   | <b>Full Sample</b><br>(N=451) | <b>Cuban</b><br>(N=373) | <b>Colombian</b><br>(N=78)  |
|---|-------------------------------|-------------------------|-----------------------------|
| <b>Depressive Symptomatology</b>              | 14.44<br><b>(11.28)</b>       | 13.82<br>(0.50)         | 17.45*<br>(1.46)            |
| <b>Activity Limitations</b>                   | 3.23<br><b>(4.60)</b>         | 3.34<br>(0.33)          | 2.70<br>(0.45)              |
| <b>Female</b>                                 | 52.66%                        | 50.13%                  | 58.97% <sup>+</sup>         |
| <b>Age</b>                                    | 57.70<br><b>(15.95)</b>       | 59.17<br>(1.16)         | 50.65***<br>(1.69)          |
| <b>SES<sup>z</sup></b>                        | 0.00<br><b>(1.00)</b>         | -0.03<br>(0.06)         | 0.17 <sup>+</sup><br>(0.09) |
| <b>Years in the US</b>                        | 25.26<br><b>(13.49)</b>       | 26.57<br>(1.01)         | 19.03***<br>(1.44)          |
| <b>Ethnic I.D.<sup>z</sup></b>                | 0.00<br><b>(1.00)</b>         | 0.02<br>(0.05)          | -0.07<br>(0.09)             |
| <b>American Orientation</b>                   | 3.05<br><b>(1.10)</b>         | 3.10<br>(0.07)          | 2.80**<br>(0.10)            |
| <b>Spanish Preference<sup>z</sup></b>         | 0.00<br><b>(1.00)</b>         | -0.01<br>(0.08)         | 0.03<br>(0.10)              |
| <b>In-Group Social Preference<sup>z</sup></b> | 0.00<br><b>(1.00)</b>         | 0.03<br>(0.05)          | -0.12<br>(0.10)             |
| <b>Perceived Discrimination</b>               | 4.97<br><b>(2.11)</b>         | 4.94<br>(0.08)          | 5.16<br>(0.23)              |
| <b>Clinically Significant Distress</b>        | 37.69%                        | 35.66%                  | 47.44% <sup>+</sup>         |

Notes: <sup>+</sup>= Significantly different than Cubans at  $p < .10$ ,  
<sup>\*</sup>=Significantly different than Cubans at  $p < .05$ ,  
<sup>\*\*</sup>=Significantly different than Cubans at  $p < .01$ ,  
<sup>\*\*\*</sup>=Significantly different than Cubans at  $p < .001$ ,  
<sup>z</sup>=Standardized measure.

Table 4. Proportions of Cubans and Colombians Reporting Clinically Significant Distress within Group by the Presence or Absence of Difficulties Performing Functional Activities

|                      | No Difficulties with Activities |        |           | Some Difficulties with Activities |        |           |
|----------------------|---------------------------------|--------|-----------|-----------------------------------|--------|-----------|
|                      | Total Sample                    | Cuban  | Colombian | Total Sample                      | Cuban  | Colombian |
| Significant Distress | 27.27%                          | 23.95% | 40.48%*   | 46.69%                            | 45.15% | 55.55%    |

Note: \*=Significantly different than Cubans within functional activity status at  $p < .05$ .

In the total sample, 27 percent of immigrants without any difficulty present significant levels of depressive symptoms compared to roughly 47 percent of those reporting some difficulty performing activities. In terms of group comparisons among those reporting no difficulties, close to one quarter (24.5 percent) of Cubans and 41 percent of Colombians were significantly depressed, with Colombians being at significantly higher risk than Cubans ( $p < .05$ ). Among those with some functional limitation, 45 percent of Cuban and 56 percent of Colombian immigrants were significantly distressed, though groups did not significantly differ in this activity status category. Thus, in terms of clinically significant depressive symptoms, Colombians are disadvantaged relative to Cubans, though only among respondents reporting no difficulties with functional activities.

Given the consistent finding that women are more distressed than men and because little is known about social status variation in distress among Colombians, I assessed the presence of gender effects. In the total sample, women reported a significantly higher ( $p < .05$ ) mean distress score (15.43) than men (13.40), as expected based on the literature. However, this female elevation in distress was found only to pertain to the Cuban subsample in group-specific analyses (not shown). Among Cuban immigrants, women report a significantly ( $p < .01$ ) higher mean level of distress (14.93) than do men (12.69), as expected. Unexpectedly, Colombian women report roughly equal mean levels of distress as Colombian men (17.20 and 17.93, respectively). This analysis points to the importance of statistically adjusting for gender effects in multivariate analyses of distress across immigrant groups.

To summarize these findings, correlational analysis reveals that four of five indicators of acculturation and perceived ethnic discrimination are associated with level of psychological distress among Hispanic immigrants in Miami. It appears that these factors matter for Hispanic immigrant mental health, even in the unique context of Miami. Bivariate analysis has demonstrated that Colombian immigrants are significantly more distressed on average than are Cuban immigrants in this sample. Colombian immigrants also appear to be at an elevated risk for significant levels of depressive symptomatology relative to Cuban immigrants.

In terms of the predictors central to this investigation, these immigrant groups do not significantly differ in ethnic identity, preference for the Spanish language, in-group

social preference, or perceived ethnic discrimination. These similarities may reflect roughly equal social experiences in the local environment for these Hispanic immigrant groups along these dimensions. However, Cuban immigrants have been in the US longer on average than Colombians and report higher mean levels of American orientation. Thus, Cubans may be more assimilated to US culture in Miami compared to Colombians, though groups are equally maintaining orientation to their cultures of origin.

Two other considerations were investigated due to the characteristics of this sample and the lack of available information about the mental health of Colombian Americans. The first considered the impact of the presence or absence of difficulties with functional activities on significant depressive symptoms. While the presence of difficulties is associated with greater proportions of respondents meeting criterion for clinically significant symptoms among the entire sample and among Cubans and Colombians separately, the significant elevation of risk for Colombians over Cubans only appears to pertain to those without any activity difficulties. It may thus be the case that physical limitations are experienced as somewhat equally distressing across these immigrant groups and serves as a leveler of distress. This difference across groups by physical limitation may be important in multivariate analyses that will assess mediating and moderating roles of this and other variables in the relationship between ethnic category and distress.

While these findings advance current understanding of Hispanic immigrant mental health in South Florida by providing an assessment of Colombian depression and a comparison of their depression with that of Cubans, it is not clear how social status considerations, dimensions of acculturation, and perceived discrimination may work in tandem in the prediction of psychological distress. In particular, it is of central interest to assess which of these factors are independently associated with distress. Moreover, given the observed elevation of distress among Colombian Americans relative to Cuban Americans, it is of interest to examine whether any of five indicators of acculturation or perceived ethnic discrimination may explain this higher level of distress. Another interest relative to this group difference in distress is whether these same factors may differentially affect distress across groups. In order to attend to these considerations, I now turn to the presentation of multivariate analyses.

## CHAPTER TEN

### RESULTS FROM MULTIVARIATE ANALYSES

I began multivariate analyses by ruling out the presence of problems with collinearity. To assess the existence of multicollinearity across independent variables with high correlation coefficients (e.g. in-group social preference and ethnic identity), I performed a test of collinearity using the *coldiag2* function in STATA 9, which is consistent with the diagnostic procedures of Harkness (Belsley, Kuh, and Welsch 1980). While Belsley, Kuh, and Welsch (1980) suggest that collinearity likely exists across a set of variables if a condition number is produced that exceeds 30.0 in this diagnostic method, study variables produced a condition number of 21.7, indicating that collinearity will not be a major influence in the results presented below. Moreover, condition indexes across particular variables fell well beneath their point of concern (i.e. the highest condition index was 12.53).

Table 6 presents OLS coefficients of depressive symptomatology regressed on social status variables, five indicators of acculturation, and perceived discrimination attributed to being Latino. Based on descriptive findings, difficulties in the performance of functional activities are controlled in all models as were gender, age, and SES in models two and after. Model one reveals that Colombian immigrants are more distressed than are Cuban immigrants on average with functional activity difficulties controlled. Moreover, coefficients for activity limitations across all models reveal the detrimental impact of these limitations on distress net of a host of social status, acculturation, and discrimination considerations.

Model two introduces sociodemographic considerations and assesses whether social status variables (sex, age, SES) explain the Colombian disadvantage in distress relative to Cubans observed. While being older and having higher SES are associated with significantly lower distress, females are not found to differ from males in distress net of other variables in this or any other model. This is a noteworthy finding given the consistent finding that women are more distressed than men.

Table 5. Coefficients from OLS Regression of Depressive Symptoms on Sociodemographics, Acculturation, and Perceived Ethnic Discrimination

|   | (1)                 | (2)                 | (3)                 | (4)                 | (5)                 | (6)                 | (7)                 | (8)                 | (9)                 | (10)                | (11)                |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| Colombian <sup>1</sup>                  | 3.996**<br>(1.477)  | 3.638*<br>(1.492)   | 3.344*<br>(1.570)   | 3.342*<br>(1.495)   | 3.129*<br>(1.497)   | 3.850*<br>(1.507)   | 3.624*<br>(1.510)   | 2.986<br>(1.552)    | 3.617*<br>(1.441)   | 3.067*<br>(1.492)   | -4.336<br>(3.302)   |
| Activity Limits                         | 0.793**<br>(0.107)  | 0.809**<br>(0.116)  | 0.813**<br>(0.114)  | 0.754**<br>(0.119)  | 0.822**<br>(0.110)  | 0.793**<br>(0.118)  | 0.800**<br>(0.117)  | 0.755**<br>(0.112)  | 0.609**<br>(0.109)  | 0.619**<br>(0.104)  | 0.618**<br>(0.103)  |
| Female <sup>2</sup>                     |                     | 0.607<br>(0.806)    | 0.527<br>(0.806)    | 0.612<br>(0.762)    | 0.745<br>(0.816)    | 0.703<br>(0.805)    | 0.569<br>(0.778)    | 0.844<br>(0.775)    | 0.744<br>(0.816)    | 0.812<br>(0.794)    | 0.910<br>(0.816)    |
| Age                                     |                     | -0.093*<br>(0.037)  | -0.066<br>(0.041)   | -0.090*<br>(0.038)  | -0.071<br>(0.038)   | -0.077<br>(0.040)   | -0.087*<br>(0.038)  | -0.058<br>(0.049)   | -0.042<br>(0.037)   | -0.049<br>(0.045)   | -0.057<br>(0.045)   |
| SES <sup>Z</sup>                        |                     | -1.488**<br>(0.530) | -1.293**<br>(0.487) | -1.683**<br>(0.510) | -1.077*<br>(0.507)  | -1.852**<br>(0.551) | -1.578**<br>(0.545) | -1.508**<br>(0.520) | -2.032**<br>(0.423) | -1.688**<br>(0.457) | -1.582**<br>(0.449) |
| Years in the US                         |                     |                     | -0.065<br>(0.047)   |                     |                     |                     |                     | -0.026<br>(0.056)   |                     | -0.006<br>(0.049)   | 0.002<br>(0.050)    |
| Ethnic Identity <sup>Z</sup>            |                     |                     |                     | -2.811**<br>(0.576) |                     |                     |                     | -3.475**<br>(0.713) |                     | -2.510**<br>(0.567) | -2.491**<br>(0.595) |
| American Orientation                    |                     |                     |                     |                     | -2.181**<br>(0.382) |                     |                     | -1.657**<br>(0.399) |                     | -1.002*<br>(0.430)  | -1.426**<br>(0.425) |
| Spanish Preference <sup>Z</sup>         |                     |                     |                     |                     | -0.780              |                     | -0.718<br>(0.578)   |                     | 0.178               | 0.262<br>(0.600)    |                     |
| In-Group Social Preference <sup>Z</sup> |                     |                     |                     |                     |                     |                     | -0.885<br>(0.474)   | 1.613**<br>(0.576)  |                     | 1.263*<br>(0.493)   | 1.360**<br>(0.510)  |
| Perceived Discrimination                |                     |                     |                     |                     |                     |                     |                     |                     | 2.107**<br>(0.196)  | 1.722**<br>(0.208)  | 1.730**<br>(0.206)  |
| Colombian*American Orientation          |                     |                     |                     |                     |                     |                     |                     |                     |                     |                     | 2.559*<br>(1.058)   |
| Constant                                | 11.235**<br>(0.541) | 16.304**<br>(2.122) | 16.422**<br>(2.086) | 16.362**<br>(2.139) | 21.624**<br>(2.147) | 15.327**<br>(2.299) | 15.997**<br>(2.152) | 20.125**<br>(2.305) | 3.463<br>(2.499)    | 8.977**<br>(2.563)  | 10.471**<br>(2.505) |
| Observations                            | 451                 | 451                 | 451                 | 451                 | 451                 | 451                 | 451                 | 451                 | 451                 | 451                 | 451                 |
| R-squared                               | 0.12                | 0.14                | 0.15                | 0.20                | 0.19                | 0.14                | 0.15                | 0.24                | 0.29                | 0.33                | 0.33                |

Notes: 1=Cuban is reference category; 2=Male is reference category; Z=standardized measure; adjusted standard errors in parentheses.

\* $p < .05$ ; \*\* $p < .01$  (two-tailed tests)

It may be that, given the finding presented above that the female elevation in distress only pertains to Cuban immigrants, the effects of gender may be washed out in multivariate analysis including Colombians for whom no gender differences are present. Exploration of this possibility is beyond the scope of the present investigation. On a final note pertaining to this model, the combination of social status variables and difficulties with functional activities do not explain the Colombian disadvantage in psychological distress.

Models three through seven introduce five dimensions of acculturation, each net of ethnic group, difficulties with functional activities, and social status variables. Here, I investigate whether any of five indicators of acculturation explain any the Colombian disadvantage in distress observed net of social status variables. Of the five indicators, ethnic identity (Model Four) and American orientation (Model Five) are significantly predictive of distress net of model covariates. Higher levels of both ethnic identity and American orientation are each associated with lower levels of psychological distress. However, no single indicator of acculturation explains the Colombian disadvantage in distress relative to Cubans.

In Model 8, I investigate whether any of the five indicators of acculturation are independently associated with distress net of each other and social status variables. Three of five indicators of acculturation are found to be independently associated with psychological distress. While higher levels of the social identity variables (ethnic identity and American orientation) are associated with decreases in distress net of other factors controlled, higher in-group social preference is associated with increases in distress net of other factors. The combination of these factors attenuates the Colombian disadvantage in distress relative to Cubans, with roughly 18 percent of the relationship in Model 2 accounted for. It should be noted that the direction of the relationship between in-group social preference and distress changed from negative to positive from Model 7 to Model 8. While, the relationship was not significant in Model 7, this change may indicate that the association between in-group social preference and distress would be different in a world where these respondents did not differ in other dimensions of acculturation or social status considerations.

Model 9 considers whether perceived ethnic discrimination is independently predictive of distress net of social status variables. More frequent experiences of ethnic discrimination are associated with higher levels of psychological distress net of social status variables. Perceived ethnic discrimination does not however, explain the elevated levels of distress among Colombian immigrants relative to Cuban immigrants.

In the full model (Model 10), I assess the independent associations between all study variables and depressive symptomatology. Being of Colombian origin, having more difficulties performing functional activities, and having higher preference for socializing within one's ethnic group are all independently associated with higher psychological distress. Higher SES, stronger ethnic identity, and stronger identification as an American are all independently associated with lower levels of psychological distress. These variables taken together do not account for the Colombian disadvantage in psychological distress relative to Cubans.

As suggested in Chapter 6, Cubans and Colombians may be differentially affected by varying levels of the five indicators of acculturation or perceived ethnic discrimination in terms of distress. As such, I test potential moderating influences of the independent variables by interacting ethnic group and the five indicators of acculturation as well as ethnic group and perceived ethnic discrimination. Only American orientation appears to differentially matter for distress across immigrant groups. The addition of the multiplicative term statistically improves model fit ( $F= 5.85; p < 0.05$ ) when added to Model 10 variables (see Model 11). Figure 6 illustrates this differential relationship. Cuban immigrants report fewer depressive symptoms, on average, with higher levels of American orientation. However, the opposite is predicted for Colombian immigrants. For Colombians, higher levels of American orientation are predictive of higher average distress scores. At the highest level of American orientation, Colombians are roughly six points higher on the CES-D scale than are Cubans on average. It is noteworthy that, on average, Colombians at the highest levels of American orientation surpass the threshold for significant depressive symptoms while those at the lowest level do not. In sum, multivariate analysis reveals that some dimensions of acculturation and ethnic discrimination are associated with depressive symptomatology among these immigrant groups net of social status characteristics and difficulties performing functional activities.

Moreover, of the indicators of acculturation, ethnic identity, American orientation, and in-group social preference are independently associated with distress. In addition, perceived ethnic discrimination is independently and positively associated with distress. Finally, a differential effect of strength of American orientation across groups was observed. Thus, while the combination of dimensions of acculturation attenuates the relationship between ethnic group and distress, moderation appears to be the better explanation of group differences in distress. That is to say, the magnitude of the relationship between ethnic group and distress differs by level of American orientation.

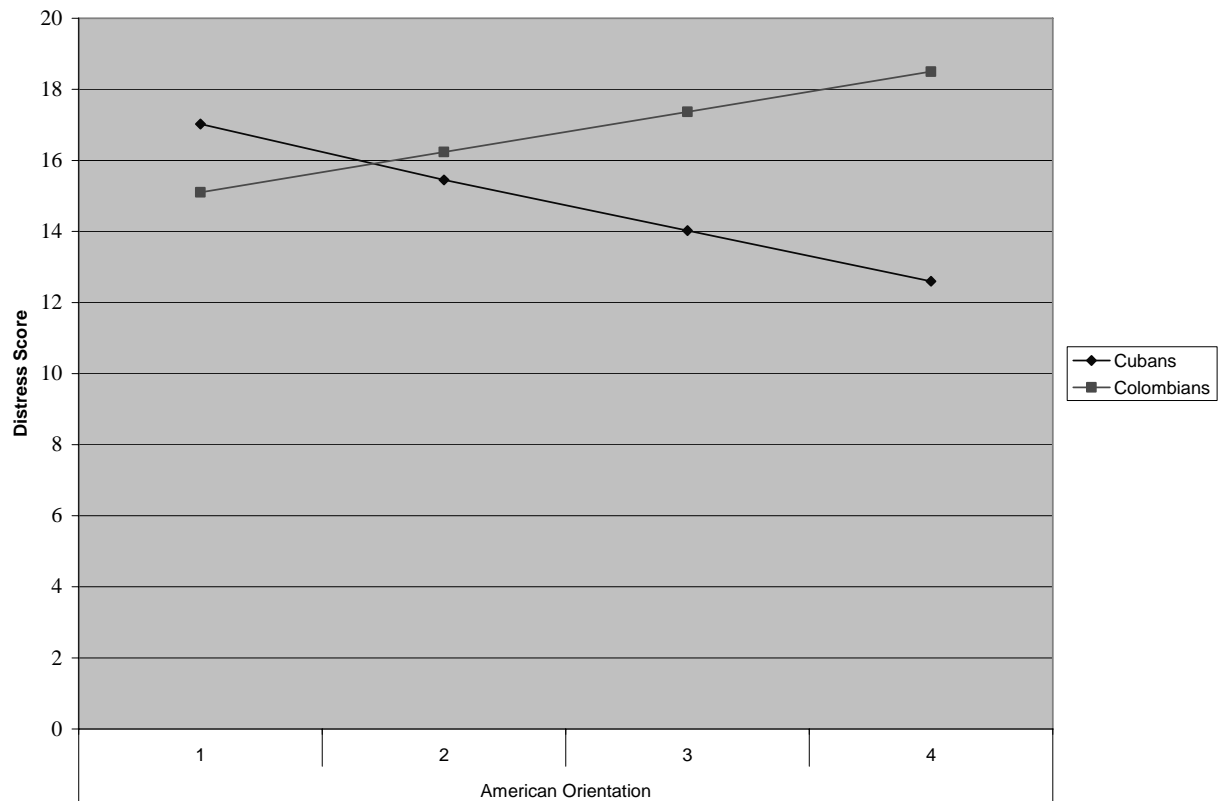


Figure 6. Depressive Symptoms by American Orientation (Separately by Immigrant Group)

## **CHAPTER ELEVEN**

### **DISCUSSION**

#### **Summary of Findings**

Based on findings presented here, it appears that Cuban and Colombian immigrants in Miami are more similar than dissimilar in the reporting of acculturation and perceived ethnic discrimination. In descriptive analysis, I found that these groups did not significantly differ in mean levels of ethnic identity, preference for the Spanish language, in-group social preference, or perceived ethnic discrimination. However, Cuban immigrants have been in the US longer and report stronger American orientation than Colombian immigrants on average. Moreover, Colombians have higher mean levels of psychological distress and a higher likelihood of meeting the criterion for significant depressive symptomatology than Cubans. In multivariate analyses, I investigated the independent roles of acculturation and perceived ethnic discrimination in relation to distress, net of social status characteristics and difficulties with functional activities.

Regression analysis revealed that several dimensions of acculturation were related to psychological distress. In particular, higher levels of the two social identity measures were associated with distress net of social status variables and independently of all other factors considered. However, the role of social identity differs across groups. While having a higher levels of ethnic identity appears to be protective against distress for both groups, having a stronger American orientation is detrimental for Colombian mental health though beneficial for Cubans. Stronger preference for socializing with others from within one's ethnic group is associated with higher levels of distress across groups. Number of years in the US and preference for the Spanish language were not associated with psychological distress. More frequent experiences of ethnic discrimination are associated with increases in depressive symptomatology net of all other factors considered in this study. Finally, all five dimensions of acculturation considered together attenuated the immigrant group difference in distress to a small degree. Finally, it

appears that moderation as opposed to mediation better explains how these groups are differentiated in terms of psychological distress.

### **Interpretation of Results**

The current findings should be interpreted with an understanding of community characteristics in Miami. Cuban immigrants arrived earlier in Miami *en masse* than did Colombian immigrants. Thus, it not surprising that Cubans report higher average number of years in the US than do Colombians in this sample. Years in the US is often used in the Hispanic mental health literature as a measure of exposure to US culture (Marín, Organista, and Chun 2003). With greater exposure to the US, the classic assimilation view suggest, the more indistinguishable the immigrant will become from the receiving culture. The fact that Cuban immigrants report significantly higher mean levels of American orientation than Colombian immigrants appears to support this position. However, as I have argued, Miami is a rare social environment for Hispanic immigrants given its strong Latin influence. This strong Latin influence, it may be reasoned, should be reflected in how Hispanic immigrants acculturate in this environment and experience ethnic discrimination. It may be that number of years in the Miami is not meaningfully associated with Hispanic immigrant mental health because of this strong Latin influence.

The lack of significant mean group differences in three of the five dimensions of acculturation may be attributed to the presence of many ethnic minority and immigrant groups co-existing in Miami. Given this and the strong Latin presence in this community, Hispanic immigrant groups may be less pressured to abandon their original cultural and/or psychological characteristics than they would be in other less multicultural environs. Given group fragmentation among Colombians (Collier 2004) and the solidarity of Cubans (Portes and Stepick 1993) discussed in the literature, we may have expected Cubans to report stronger ethnic identity than Colombians. However, these groups did not significantly differ in strength of ethnic identity. This may be because Miami fosters strong ethnic identity rooted in any national origin.

One possible explanation for the low average level of American orientation among Colombians relative to Cubans may be found in patterns of official incorporation.

As reviewed above, while many Cuban immigrants were assisted in their resettlement by naturalization legislation, and large proportions of Cubans are politically involved, a great proportion of Colombian immigrants remain undocumented and few are involved in the political process. While it is not clear what factors are involved in respondents' assessment of their level of American orientation given the single item indicator employed, legal incorporation and political participation may be an important component. If this is the case, the lower American orientation scores of Colombians relative to Cubans may be a reflection of historical patterns of structural incorporation into the US and Miami.

Given that the literature suggests that higher acculturation is, on the one hand, associated with decrements in Hispanic American health and that strongly identifying with either the ethnic or receiving cultures is more beneficial for mental health than being weakly oriented toward both, there was some reason to suppose that these groups may either benefit or suffer from stronger American orientation. The finding that Cubans do benefit from higher levels of American orientation may be reflective of the unique context of Miami for Cuban immigrants. Perhaps Cubans have the resources to take advantage of the benefits of being an American and the means to participate in American life in ways that are salutary for mental health. The detrimental effect of stronger American orientation among Colombians may be reflective of some cognitive dissonance resulting in distress among Colombians who on the one hand have experienced unwelcoming receptions to the US and to Miami and nonetheless feel strongly oriented as an American on the other hand. The finding that these groups are differentially affected by stronger levels of American orientation points to a future research opportunity into the "Hispanic mental health paradox" which describes the common finding that increased exposure to the US and higher psychological acculturation is associated with decrements in mental health.

This investigation has also provided further empirical evidence that acculturation occurs on at least two separate dimensions. Because ethnic and American identities were independently associated with psychological distress in this study, it is important to avoid including these and other dimensions of acculturation in the same index. To do so would be to unnecessarily lose information about the role of acculturation in Hispanic

immigrant health. These group identities represent separate and important factors in psychological acculturation for Hispanic immigrants that matter for mental health. Furthermore, in the case of American orientation, this independent factor was differentially associated with mental health across groups while ethnic identity was not, giving further evidence of the importance of investigating social identity orientations separately.

Language use/preference has previously been found to be an important predictor of Hispanic mental health (Vega et al 1998; Ortega et al 2000; Alegría et al 2007). In the current study, preference for the Spanish language had no influence of distress net of social status variables. This may be because many individuals speak Spanish in Miami and so the preference for Spanish or lack thereof is relatively inconsequential for psychological adjustment in Miami compared with other locales without such a strong Latin influence. Moreover, these immigrant groups did not significantly differ in their preference for the Spanish language. Preference for the Spanish language may thus not be a meaningful marker of Hispanic immigrant acculturation in this context and is thus not serving as the meaningful correlate of mental health commonly observed.

While my reading of the relative social position of these two groups in Miami suggested that Colombians may experience more discrimination than Cubans in this context, Colombian and Cuban immigrants did not differ in the frequency of experiences of ethnic discrimination. This too may speak to the unique context of Miami and the visibility of Latin cultures. Perhaps Colombians are enjoying ethnic relations friendly to all Hispanic groups pioneered in the area by earlier-arriving Cubans. Another explanation is that those who discriminate against Hispanic Americans are treating these groups with a pan-ethnic classification mindset. Nonetheless, for those Cuban and Colombian immigrants who do experience more frequent ethnic discrimination, decrements in health are present. Thus, even in a context such as Miami, which is characterized by a strong Latin influence, some Latina/os experience discrimination based on being Latin and these experiences are detrimental to mental health. Furthermore, these observations hold for two immigrant groups who are relatively advantaged in SES compared with other Hispanic immigrant groups. This is evidence

that ethnic discrimination may be a somewhat universal experience among Hispanics in the US and that its effects are uniformly damaging.

### **Strengths and Limitations**

In my opinion, this study adds to the understanding of Hispanic American mental health in several respects. First, I have focused on Cuban immigrants, who are the third largest Hispanic American group, though lesser studied than Mexican Americans and Puerto Ricans in the social epidemiology of mental health literature. I have also focused on Colombian immigrants, for whom information is nearly completely lacking in terms of mental health and associated social factors. These groups are of particular interest given similar conditions for migration and both being relatively high in SES, compared to the most frequently studied Hispanic American groups (i.e. Mexican Americans and Puerto Ricans). Given these group characteristics, and the strong Latin influence in Miami, one may reasonably suspect that these groups in this context may not be as affected in mental health by acculturation and ethnic discrimination as that observed in the literature. However, acculturation and ethnic discrimination do importantly matter for the psychological well-being for these relatively privileged groups in this atypical context. It may be argued that experiences of acculturation and discrimination may be more universal as they relate to mental health for Hispanic Americans than previously known.

A second strength of this study is the employment of several indicators of acculturation in the prediction of distress. While most studies concerning Hispanic American mental health employ only indicators of exposure to the receiving culture (years in the US, generational status), and some employ a composite scale of acculturation incorporating several dimensions, the current study demonstrates the independent roles of three of five dimensions of acculturation. Further evidence of the importance of investigating separate dimensions of acculturation was presented in these findings. While in-group social preference was found to be positively related to distress, ethnic identity was found to be negatively related to distress. Should these dimensions of acculturation been indexed into the same composite acculturation measure, these

dimensions would have been working against each other and their unique contributions to mental health would surely have been overlooked.

A final strength of this study is the explicit consideration given to the historical experiences of the immigrant groups considered as well as their social context. Such an understanding aided in the formulation of research questions and guided the interpretation of findings. Thus, in addition to understandings about Hispanic immigrant health garnered from the empirical literature, a reading of social history importantly guided this investigation.

This investigation also contained limitations. One limitation of this study may be found in the measurement of acculturation employed, despite its strength commented on above. While employing several dimensions of acculturation is preferable to the approach taken in many other studies, a more complete assessment of American orientation and/or orientation to culture of Miami in particular would be ideal. In particular, it would be useful to more fully capture variation in Americanism as a social identity. For example, the bidimensional model proposed by Berry (1997) advocates the separate measurement of cultural ties with both the cultural of origin and the receiving culture. The inclusion of matching questions on each dimension would provide equal opportunity to report identification with both across a variety of considerations. Only a single item indicator of American orientation was available for the current analyses, though the single item proved to be a robust predictor of psychological distress. A more complete battery of questions on this dimension would serve to isolate various components of American orientation such as preference for socializing with US natives, English language preference, or mainstream media preference.

Another limitation to be noted is the generalizability of the findings presented here. Because Miami is unique in its Latin influence, it is not clear how these immigrant groups inhabiting other communities would compare in the associations between acculturation and distress and discrimination and distress. Because these groups do not co-exist in any numbers outside Miami and in the New York/New Jersey area, an opportunity exists to compare these results with a similar sample in the Northeast. The newly-released National Latino and Asian American study data (Alegría et al 2006) may be capable of attending to such a community comparison in social experiences associated

with Hispanic immigrant mental health. However, while the NLAAS contains several indicators of exposure to US culture as well as a language proficiency measure, it does not contain multiple indicators of both ethnic and American psychological acculturation discussed as ideal above. Similarly, these findings may not be generalized to other Hispanic ethnic groups. Future research is needed to attend to this limitation.

A final limitation to be noted is the use of cross-sectional data, disallowing any inferences to be made in terms of temporal ordering. It may be the case that highly distressed individuals are more likely to perceive discrimination than the lesser distressed. Similarly, it may be the case that Colombians who are more distressed are less likely to report high levels of American orientation. While a second wave of data is available in the *Physical Challenge and Health* study, both waves were not employed given a significant reduction in statistical power using the full range of variables considered here across time. Following respondents over time would facilitate a better understanding of whether acculturation and discrimination lead to distress, or the reverse. A future study with these data might reduce the number of considerations employed here to take advantage of the opportunity to investigate the central concerns of this study over time.

### **Implications for Future Research**

In the future, studies in the social epidemiology of Hispanic American mental health could be improved in several respects. First, investigators should prioritize not only collecting large enough samples of the three largest Hispanic American groups, but also smaller ethnic groups in two or more community settings to enable comparisons of the roles of acculturation and ethnic discrimination in mental health across groups in different social contexts. This may serve to further help identify the community contexts that drive social factors associated with mental health. Second, research would do well to conduct longitudinal analyses on the social factors in migration and incorporation that may pertain to psychological well-being. Ideally, research would follow respondents from their countries of origin to their areas of migration and collect extensive data on how social factors at several points in time as well as in different geographical/social

contexts may be related to mental health. Perhaps there are particularly sensitive periods in the lifecourse when acculturation and discrimination have an elevated or reduced influence on mental health. Such possibilities should be explored. Finally, the measurement of both acculturation and perceived ethnic discrimination may be improved in future studies. As mentioned above, more extensive data tapping the multidimensionality of both ethnic and US orientations would serve to identify which factors involved in each are independently associated with mental health. Also, the social epidemiology of Hispanic American mental health could be advanced by including indices of ethnic discrimination that are able to ascribe discriminatory experiences to national origin, when such occurrences arise. As the field continues to establish the heterogeneity inhering within the pan-ethnic category “Hispanic” in terms of distress and disorder, we will need to continue to take appropriate steps to identify how such heterogeneity arises in the social environment.

## APPENDIX A: FSU HUMAN SUBJECTS APPROVAL LETTER



Office of the Vice President For Research  
Human Subjects Committee  
Tallahassee, Florida 32306-2742  
(850) 644-8633 · FAX (850) 644-4392

### APPROVAL MEMORANDUM

Date: 10/18/2006

To:

**Andrew Cislo**  
Center for Demography and Population Health, Florida State University, 601 Bellamy Bldg.  
Tallahassee, FL 32306-2240

Dept.: **SOCIOLOGY**

From: **Thomas L. Jacobson, Chair**

A handwritten signature in black ink, appearing to read "Thomas Jacobson".

Re: **Use of Human Subjects in Research**  
**Hispanic Mental Health in South Florida: Considering Acculturation and Ethnic Discrimination**

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on **10/11/2006**. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by **10/10/2007** you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. The principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: John Taylor  
HSC No. 2006.0875

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## BIOGRAPHICAL SKETCH

Andrew M. Cislo

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### EDUCATION

- Expected September 2007                      **Doctor of Philosophy**, Sociology  
Florida State University, Tallahassee, FL  
*Dissertation*: “Psychological Distress Among Cuban and Colombian Immigrants in Miami: Considering the Roles of Acculturation and Ethnic Discrimination”  
*Committee*: Professor John Taylor (chair), R. Jay Turner, Donald Lloyd, Rebecca Miles  
*Qualifying Exam*: Mental Health  
*Minor Area*: Social Psychology
- July 2006                                      **Master of Science**, Sociology  
Florida State University, Tallahassee, FL  
*Masters Paper*: “Ethnic Identity and Self-Esteem: Contrasting Cuban and Nicaraguan Young Adults”  
*Committee*: Professor R. Jay Turner (chair), Jill Quadagno, John Reynolds, Donald Lloyd
- December 2001                              **Bachelor of Arts** (honors), Philosophy (major)  
French (minor)  
Northeastern Illinois University, Chicago, IL  
*Honor’s Paper*: “The Fractal Nature of Language”  
*Honor’s Program Mentor*: Dragan Milovanovic

### PUBLICATIONS AND PRESENTATIONS

#### Publications:

- Cislo, Andrew M.** UNDER REVIEW “Ethnic Identity and Self-Esteem: Contrasting Cuban and Nicaraguan Young Adults.” *Hispanic Journal of Behavioral Sciences*.
- R. Jay Turner, **Andrew M. Cislo**, A. Henry Eliassen, and Mathew D. Gayman, RESUBMITTED WITH REVISIONS “The Social and Developmental Origins of Perceived Social Support.” *Journal of Health and Social Behavior*.
- Fulton, Bradley R., Perry Edelman, Daniel Kuhn, and **Andrew M. Cislo**. 2006. “Observing Quality of Life in Dementia (OQOLD): A New Tool for Improving Dementia Care Practice.” *Seniors Housing and Care Journal*, 14(1):79-84.
- Shank, Richard, Mathew D. Gayman, and **Andrew M. Cislo**. 2006. “Filmed Images of HIV/AIDS, 2001-2005: An Annotated List of Documentary and Feature Films.” in *Teaching the Sociology of HIV/AIDS: Syllabi, Lectures, and Other Resources for Instructors and Students*, 3rd ed. Carrie E. Foote-Ardah and Eric R. Wright, eds. American Sociological Association, Washington, D.C.

Keane, William L., **Andrew M. Cislo**, and Bradley R. Fulton. 2003. "Free-Standing Dementia Properties: A Survey-Based Overview of Dementia-Dedicated Assisted Living." *Seniors Housing & Care Journal*, 41-54.

Keane, William L., **Andrew M. Cislo**, and Bradley R. Fulton. 2003. "Defining the Dementia Market." *Assisted Living Today*, 10(9), 14-17.

**Cislo, Andrew M.** 1999. "Chaos, Category Construction, and Obscenity." *Red Feather Archives of Non-Linear Socio-Dynamics* Aug.:028.  
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**Cislo, Andrew M.** 1996. "Order Out of Disorder: The Vision of Heraclitus." *Humanity & Society*, 20(1):19-40.

Papers in Progress:

Cislo, Andrew M. "Depressive Symptomatology among Cuban and Columbian Immigrants in Miami: Considering the Roles of Acculturation and Ethnic Discrimination."

Presentations:

Cislo, Andrew M. 2006. "Ethnic Identity and Self-Esteem: Contrasting Cuban and Nicaraguan Young Adults." Presented at the annual meeting of the American Sociological Association, August 12, Montreal, Canada.

Cislo, Andrew M. 2006. "Depression among Cuban and Colombian Adults: Considering Acculturation and Ethnic Discrimination." Presented at the annual meeting of the American Sociological Association, August 11, Montreal, Canada.

Cislo, Andrew M. 2006. "Depression among Adult Immigrants of Cuban, Colombian, and other Hispanic Origins." Presented at the annual meeting of the Southern Sociological Association, March 25, 2006, New Orleans, LA.

Cislo, Andrew M. 2005. "Hispanic Subgroup Comparisons of the Correlates of Ethnic Identity." Presented at the annual meeting of the American Sociological Association, August 13, Philadelphia, PA.

Cislo, Andrew M., Mathew D. Gayman, and A. Henry Eliassen. 2005. "Origins of Social Support from Adolescence to Young Adulthood." Presented at the annual meeting of the Southern Sociological Association, April Charolette, NC.

Fulton, Bradley R., Perry Edelman, and Andrew M. Cislo. 2004. "Dementia-Specific Observational Procedures: Measuring Quality of Care/Life and Assessing the Use of Space in Care Settings." Presented at the annual meeting of the American Society on Aging, April, San Francisco, CA.

Cislo, Andrew M., Breonte S. Guy, Michiko Iwasaki, and Raza Mirza. 2003. "A Case for Collaboration in Ethnic Minority Aging Research." Presented at the annual meeting of the American Psychological Association, August, Toronto, Canada.

- Keane, William L., and Andrew M. Cislo. 2003. "Assisted Living and Dementia Care: What's Working and What's Ahead." Presented at the annual meeting of the Assisted Living Federation of America, April, Phoenix, AZ.
- Hollinger-Smith, Linda, Betsie Sassen, Nancy-Mella-Oliver, John Vicik, and Andrew M. Cislo. 2003. "Measuring Quality-of-Life Outcomes Across a Spectrum of Long-Term Care Services for Older Adults: Findings from Cycle Two." Presented at the annual joint conference of the National Council on Aging and the American Society on Aging, March, Chicago, IL.
- Cislo, Andrew M. 2002. "Knowing the Person." Presented at the annual meeting of the Pioneer Network, August, Oak Brook, IL.
- Cislo, Andrew M. 2002. "From Being to Becoming." Presented at the annual meeting of the Pioneer Network, August, Oak Brook, IL.
- Hollinger-Smith, Linda and Andrew M. Cislo. 2001. "Measuring Quality-of-Life Outcomes that Cross a Spectrum of Services for Seniors." Presented at the annual meeting of the Gerontological Society of America, November, Chicago, IL.
- Cislo, Andrew M. 1997. "New Directions in Critical Criminology." Presented at the lead roundtable at the annual meeting of the Academy of Criminal Justice Sciences, November, Louisville, KY.
- Cislo, Andrew M. 1996. "The Fractal Nature of Language." Presented at the annual meeting of the American Society of Criminology, February, Chicago, IL.

Service Work:

Discussant: Ethnicity/Social Identity roundtable. American Sociological Association annual meetings, August, 2007.

Vice President Sociology Graduate Student Union 2004-2005.

Reviewer: Mather Institute on Aging Institutional Review Board 2001-2003

**AWARDS**

August 2004-August 2007. American Sociological Association/NIMH Minority Fellowship Program for training in mental health research.

July 2002. American Psychological Association/NIMH Minority Aging Network in Psychology (MANIP) training fellowship.

1996, 1997, and 1998. Northeastern Illinois University: Full honors merit scholarship.

1995. Northeastern Illinois University: Part-time honors merit scholarship.

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## **PROFESSIONAL EXPERIENCE**

August 2004-Present. *Research Assistant*. Florida State University, Tallahassee, FL with Drs. R. Jay Turner and John Taylor. Areas of Inquiry: Mental health, Hispanic American mental health, social stress, social epidemiology, acculturation and ethnic identity, and personal and social resources.

August 2003-August 2004. *Research Assistant*. Florida State University, Tallahassee, FL with Dr. Melonie Heron. Area of Inquiry: Immigrant health.

December 2001-July 2003. *Research Associate*. Mather Institute on Aging, Evanston, IL with Dr. Linda Hollinger-Smith. Areas of Inquiry: Quality of life for persons with dementia, culture change in long-term care settings, dementia care in assisted living communities.

August 2001-December 2001. *Research Assistant*. Mather Institute on Aging, Evanston, IL with Dr. Linda Hollinger-Smith. Areas of Inquiry: Quality of life in community centers, independent living, assisted living, and skilled nursing institutions.

October 2000-August 2001. *Administrative Assistant*. Morse Institute for Geriatric Research and Training, West Palm Beach, FL with Dr. Alan Sadowsky.

## **TEACHING**

Summer 2006. *Race and Minority Relations*. Florida State University – Department of Sociology.

## **PROFESSIONAL SOCIETIES**

American Sociological Association  
Section Memberships: Mental Health, Latino/a Sociology, Medical Sociology  
Southern Sociological Society

## **RELEVANT VOLUNTEER EXPERIENCE**

2002-2003 Senior Connections, Evanston, IL – Friendly visiting with homebound senior.

## **RESEARCH INTERESTS**

Latino/a Sociology  
Immigration and Acculturation  
Mental Health  
Social Psychology  
Aging and the Life Course  
Social Stress