Depression and anxiety symptoms, acculturation, depression stigma and psychological help-seeking among Russian-speaking skilled immigrants

Alla Demutska, GradDip, PostGradDip

School of Psychology and Psychiatry

Faculty of Medicine, Nursing and Health Sciences

Monash University, Melbourne, Australia

Submitted in partial fulfilment of the degree of

Doctor of Psychology (Clinical)

2012

Table of Contents

List of Tables

Chapter 5

Chapter 6

Chapter 7

List of Figures

Chapter 2

Abstract

Immigrants constitute 24 percent of the Australian population, with skilled immigration becoming the fastest growing migration stream in Australia. Nonetheless, epidemiological data and systematic research of this population is lacking. Most recent Russian-speaking immigrants coming from the Former Soviet Union (FSU) have arrived to Australia on the skilled immigrant program, and there is also a lack of research on this particular cultural group. Skilled immigrants are expected to adapt better than many other groups for several factors, including better English proficiency, younger age, better physical and mental health due to strict visa requirements, and better professional prospects. However, previous studies with immigrants showed that this group often have more mental health issues than the host population. In particular, previous research with Russian-speaking immigrants indicated that they had difficulties with adaptation in host countries, and typically had high levels of mental health problems compared to the host and other immigrant groups. Hence, it is important to investigate the specifics of acculturation in this group and research factors impeding or facilitating the process of acculturation. There is also a lack of information about the help seeking attitudes and depression stigma in FSU immigrants living in Australia. It may be expected that FSU immigrants, like other immigrant groups, are reluctant to present for professional psychological help for mental health problems such as depression. The research conducted and presented in this thesis is a series of empirical investigations linked to these research aims. The research aims were mostly exploratory because little research has been conducted with this specific group in the Australian context.

Sixty five Russian-speaking immigrants, 65 Russian speaking non-immigrants and 63 Anglo-Australians were recruited through social clubs, community web forums and web groups, churches, schools, and universities. All participants completed online questionnaires which

included the Centre for Epidemiologic Studies Depression Scale, the State-Trait Anxiety Inventory, Interpersonal Support Evaluation List, Perceived Stress Scale, Depression Stigma Scale, Attitudes toward Seeking Mental Health Services Scale and socio-demographic questions. Russian-speaking immigrants completed additional socio-demographic questions and the Language, Identity and Behaviour (LIB) scales to measure acculturation, and the Demands of Immigration scale to measure immigration stress.

In the first study of the thesis, we looked into the mental health of Russian-speaking skilled immigrants to Australia. We compared levels of depressive and anxiety symptoms in this group with a Russian-speaking sample living in the FSU and an Anglo-Australian sample. Results indicated that the immigrant group scored significantly lower on the depression and anxiety measures than the two comparative groups. Although demographic differences between three groups were observed, they did not account for the differences in depressive and anxiety symptoms.

In the second study of the thesis, we explored relationships between measures of Russian and Australian acculturation and immigration stress and whether Russian immigrants endorse a bidimensional acculturation model. The sub-sample consisting only of immigrants from the FSU living in Australia was selected. Results indicated that that immigration stress was related to retaining of Russian culture and a decrease in Australian acculturation, after controlling for socio-demographic factors. No association between the Russian and Australian dimensions of acculturation was found which supports the notion that acculturation can occur independently along both host and native dimensions**.** Limitations and future directions are discussed.

In the third study of the thesis, depression stigma and psychological help-seeking attitudes were compared in immigrants from the FSU living in Australia, a Russian-speaking sample living in the FSU, and an Anglo-Australian sample. Results indicated that the Russian-

speaking immigrants were more likely to have more perceived stigma, and less personal stigma than the Australian sample. Anglo-Australians were found to be higher on Psychological Openness and Help-seeking Propensity subscales, than Russian immigrants, while Russian non-immigrants and Russian immigrants did not differ from each other on these measures. No relationship between acculturation factors, depression stigma and psychological help-seeking was found in the present study.

Taken together, the findings indicate that Russian-speaking skilled immigrants may have a different trajectory of adaptation compared to many other immigrant groups. Limitations and implications are discussed.

General Declaration

Monash University

Monash Research Graduate School

Declaration for thesis based or partially based on conjointly published or unpublished work

General Declaration

In accordance with Monash University Doctorate Regulation 17/ Doctor of Philosophy and Master of Philosophy (MPhil) regulations the following declarations are made:

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes three unpublished publications submitted to peer reviewed journals. The core theme of the thesis is psychological adaptation and acculturation of Russian-speaking immigrants in Australia. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the School of Psychology and Psychiatry, and principal supervisor Doctor Litza A. Kiropoulos. Professor

Lenore Manderson was added as an associate supervisor from January 2012. She provided support for the write-up of the thesis chapters other than papers submitted for publication.

[The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.]

In the case of 5, 6, and 7 my contribution to the work involved the following:

Thesis chapter	Publication title	Publication status	Nature and extent of candidate's contribution
Chapter 5, Paper 1	Depressive and anxiety symptoms in Russian-speaking skilled immigrants from the Former Soviet Union (FSU) living in Australia: a comparison with Anglo-Australians and former Soviet Union native group	Submitted	Participation in design, formulation of ideas, data analyses and securing ethics approval; review of appropriate literature; review of materials; recruitment of participants; data collection; and writing of papers. Supervisor provided input into design, formulation of ideas, data analyses, securing ethics approval, and several manuscript drafts. 70%
Chapter 6, Paper 2	Predictors of acculturation in skilled immigrants from the Former Soviet Union (FSU) living in Australia	Submitted	Participation in design, formulation of ideas, data analyses and securing ethics approval; review of appropriate literature; review of materials; recruitment of participants; data

			collection; and writing of papers. Supervisor provided input into design, formulation of ideas, data analyses, securing ethics approval, and several manuscript drafts. 70%
Chapter 7, Paper 3	Depression stigma and psychological help-seeking attitudes in Russian-speaking skilled immigrants from the Former Soviet Union (FSU) living in Australia: a comparison with Anglo-Australians and a Russian-speaking non-immigrant group	Submitted	Participation in design, formulation of ideas, data analyses and securing ethics approval; review of appropriate literature; review of materials; recruitment of participants; data collection; and writing of papers. Supervisor provided input into design, formulation of ideas, data analyses, securing ethics approval, and several manuscript drafts. 70%

I have renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Signed: ……

Date: ……

Acknowledgements

I would like to thank my supervisor, Dr Litza Kiropolous, for her help and guidance from the start to the finish of my project. She was always available when I needed help and was quick in providing feedback and her knowledge and expertise in the area of my research was appreciated. I would like also to thank Litza for the long hours she spent helping me with my thesis. I would like to thank Professor Lenore Manderson, who joined my project towards the end, and whose energy, knowledge, resourcefulness, and understanding of my needs helped me to submit my work. I greatly appreciated the novel approaches Lenore suggested to help me solving my difficulties.

I would like to thank Dr Kathryn Gilson, who was a great help at the start of the project before she went on maternity leave. I thank Emeritus Professor Kim Ng and John Taffe, who helped me with their knowledge of statistics. I believe I am now much more able to do statistical analysis and understand statistics in depth. Without their help I would not be able to move forward.

I would like to thank the Department of Psychology for all the advice, guidance in difficult times, and administrative support. In particular, I would like to thank Dr Sabura Allen, Dr Kate Gould, Dr Dana Wong and Susan Knight. I would like to thank MRGS for their prompt reply with all my questions.

I would like to thank my friends and my boyfriend, who were very supportive and understating during my periods of frustration and anxiety. I would like to thank my fellow students from the doctorate course for our chats. Also thank you to the staff and postgraduate students working under Professor Manderson's guidance, who welcomed me so warmly. I felt

very accepted and the energy of the group helped me to continue my writing during the difficult times.

I would like to thank my technical support team, in particular Indu Balasubramaniam, who helped me with uploading my questionaries on-line. I would like to thank Olga Nikitina, Natalia Polulyakh and Anna Ivanova for their assistance with translation of the questionnaires. Also I would like to thank all my participants and those who helped me to find participants, in particular, the Russian-Ethnic Representative in Australia.

Notice 1

Under the Copyright Act 1968, this thesis must be used only under the normal conditions of scholarly fair dealing. In particular no results or conclusions should be extracted from it, nor should it be copied or closely paraphrased in whole or in part without the written consent of the author. Proper written acknowledgement should be made for any assistance obtained from this thesis.

Notice 2

I certify that I have made all reasonable efforts to secure copyright permissions for third-party content included in this thesis and have not knowingly added copyright content to my work without the owner's permission.

PART I

INTRODUCTION

Chapter 1

Thesis Outline and Background

Immigrants are an important population to study due to their numbers worldwide. A quarter of the Australian population is foreign-born, which makes it particularly important to understand how immigrants acculturate to the Australian context. While large groups, such as immigrants from China, have been extensively studied, many of the smaller groups, such as Russian-speaking immigrants, have not been widely researched in Australia. The newer groups of immigrants, such as skilled immigrants, have not been studied widely as well, though this group is the fastest growing immigration stream in Australia. In the current thesis I am focusing on psychological adaptation and acculturation of Russian-speaking skilled immigrants living in Australia. This thesis comprises eight chapters organised into four parts, and consists of three articles submitted for publication in peer reviewed journals.

Part I is comprised of two chapters. In this chapter, I provided a brief overview of the history of immigration and particularly of skilled immigration to Australia, and a history of Russian-speaking immigrants to Australia. In chapter 2, I present a review of the literature focusing on acculturation, and compare and contrast frameworks for understanding acculturation. I discuss the outcomes of acculturation, specifically in relation to mental health outcomes, depression, stigma and psychological help-seeking attitudes. Although I review studies with different immigrant groups in countries such as the US, Israel, Canada, and Australia, I particularly attend to studies with Russian-speaking immigrants, and their acculturation and adaptation trajectories. Factors found to play a role in the mental health and acculturation of immigrants are considered. I conclude this chapter with an overview of stigma towards people with mental illness and patterns of psychological help-seeking within immigrants internationally and in Australia. There is an unavoidable overlap between this literature review and the introductions to the three articles, submitted for publication.

In Part II of the thesis, I present the study design. In chapter 3, I present the research aims and rationale for this thesis. The gaps in the existing literature are summarised and outlined in this chapter. In chapter 4, I describe the procedures, materials, and participants of the study. The decision was made to include an expanded methodology section for several reasons. None of the method sections of the articles included in the thesis reflects the entire methodology of the study. I therefore provide the reader with the overall methodology, providing a description of all three groups and all questionnaires. I also explain the procedures in detail, as partially described in the three articles. Due to limitations in the length of the articles, I was restricted in the amount of detail I could provide in the method sections. I acknowledge unavoidable repetitions in this section of the thesis and in the method sections of the articles.

Part III consists of empirical papers, each comprising a separate chapter of the thesis. In Chapter 5, I address the first aim of the thesis, where the levels of depression and anxiety symptoms in Russian-speaking skilled immigrants in Australia are compared to non-immigrants living in the FSU, and an Anglo-Australian group, while controlling for socio-demographic and other factors. In Chapter 6, I examine acculturation, assessed separately for both Russian and Australian dimensions, in Russian-speaking skilled immigrants living in Australia, and its relationship with immigration stress. In Chapter 7, I aim to compare psychological help-seeking attitudes and stigma towards depression in Russian-speaking immigrants living in Australia, with Russian-speaking non-immigrants living in the FSU, and an Anglo-Australian group, while controlling for age, gender, and education.

In Part IV, I present an integrated discussion, with an overview of the main findings of this thesis, and a summary from the implications arising of the papers. I also outline the limitations and present future research directions.

History of Immigration to Australia

Globally, the number of immigrants has steadily increased for decades, from approximately 156 million in 1990 to 214 million in 2010; currently 3.1% of the world's population are immigrants (United Nations, 2009). Immigrants are typically distinguished from refugees and sojourners on two main parameters. Immigrants are often motivated by so-called 'pull' rather than 'push' factors, contrary to people who are refugees or asylum seekers. 'Pull' factors can include political, economic, social and other reasons. Typically, immigrants' main reasons to immigrate are economic, and they have high achievement motivation (Boneva & Frieze, 2001; Ward, Bochner, & Furnham, 2001).

Immigration has been an important part of Australia's past and present. Since 1901, when the first immigration policy, the so-called 'White Australia Policy', was introduced, many changes have occurred. The White Australia Policy was devised to restrict the number of non-Caucasian immigrants, especially Chinese immigrants (Evans, 2001; Sang & Ward, 2006). Although cultural groups, including people from China, were already living in Australia, most immigrants arriving at that time were British citizens, assisted to come by both Australia and Britain (Sang & Ward, 2006). The White Australia Policy continued until 1973, after the Labor Party came to power and the new government followed Canada in adopting non-discriminatory immigration policies (Jordens, 2001).

The major immigrant influx to Australia occurred after Second World War, mostly from Europe. When non-British assisted immigrants, mostly of European origin, started to arrive in 1947, around 90% of population were of Anglo-Celtic background (Jordens, 2001). From the 1960s, non-European immigrants were accepted into Australia on the basis of their qualifications and suitability (Sang & Ward, 2006). Notably immigrants from Turkey and Lebanon were accepted to Australia in the late 1960s, and thereafter migrants came from an increasingly diverse number of source countries. This was accelerated with the end of Vietnam War in 1972, when Australia began to accept large numbers of Vietnamese and

Vietnamese-Chinese refugees who fled from Vietnam. Since then, immigration has added to half of the population growth in Australia, with immigrants influencing political, economical and cultural aspects of society (Collins, 2008). Increasing diversity of immigrants and their growing numbers was accompanied by some controversy, and this has continued in recent decades. This is illustrated by the Blainey debate and Pauline Hanson's popularity in the late 1990s, when they and others continued to argue for a Western European if not Anglo-Celtic Australia. Overall, immigration waves in Australia have tended to fluctuate depending on the state of the economy, with fewer people being accepted during economically difficult times (Sang & Ward, 2006).

In the last 40 years, Australia has adopted the policy of multiculturalism. Yet a number of authors argue that there has been little support for cultural pluralism by the population (Betts, 1991; Holton, 1997). Immigrants have been accused of causing many economic problems, such as unemployment, inflation, and foreign debt (Collins, 2008). Goot (1993) showed that most Australians support 'a fair go' for all community members. The support was strongest among the younger generation, and, among those born in Asia or Europe. However, almost half of the respondents believed immigrants deprive Australians of jobs and that they receive too much help from the government (Goot, 1993). Similarly, in a study by Ho and colleagues (1994), most Australian-born respondents supported multiculturalism, but when questioned about specific multicultural policies and services, assimilationist attitudes became more salient. For example, there was more support for English language courses for immigrants than for the services helping immigrants to maintain their original culture (Ho et al., 1994). In a more recent study it was shown that multiculturalism in Australia is well accepted, with fewer immigrants reporting cases of racism (The IPSOS Mackay Report, 2010). Several factors, such as economic growth and availability of jobs, were found to influence public opinion on immigration and immigrants. In this study, survey respondents from Australia also were more likely to favour skilled immigration compared to other

immigration streams. Most respondents supported multiculturalism, even though assimilation was viewed as an important component of immigrant adaptation into multicultural society.

To understand the phenomenon of acculturation better, Van Oudenhoven, Van der Zee and Bakker (2002) (cited in Van Oudenhoven, 2006) compared the experience of acculturation in a culturally homogeneous group of Frisian immigrants in Australia, Canada, and the US. In the US and Canada, most Frisian immigrants preferred to integrate into the host culture, adopting but not assimilating into the host culture while maintaining their original culture. In Australia, immigrants equally endorsed integration, assimilation, or marginalization (rejecting the host culture) strategies. In general, Frisian immigrants were less successful in adapting to the way of life in Australia than they were in the US or Canada. They displayed lower levels of satisfaction with life and higher levels of physical problems. The authors explained the difference in the outcomes by the differences in immigration policies in three countries, with Australia having the strongest assimilation tendencies (van Oudenhoven, 2006).

Currently, immigrants from over 200 different cultures and countries constitute 29% of the Australian population, and in 41% of the population, at least one parent is foreign born (Australian Bureau of Statistics [ABS], 2011a, 2011b), a proportion considerably higher than in other countries with substantial immigrant populations, such as the USA or Canada (Sang & Ward, 2006). Overseas migration was responsible for 51% of population growth in 2005-2006 in Australia. The five largest foreign-born groups were from the UK (5.3% of the population), New Zealand (2.4%), China (1.7%), India (1.5%) and Italy (1.0%), with other groups constituting 1% or less (ABS, 2011b). One in three recent immigrants to Australia is from an Asian background (Collins, 2008). Most immigrants come to settle to New South Wales and Victoria, principally to the capital cities, and two thirds of recent immigrants and temporary residents were employed at the time of the survey (ABS, 2011b, 2011c).

Skilled immigration to Australia

Public opinion has often been negative towards new immigrants. As suggested above, historically and still today, immigrants are often perceived as a cause of many economic problems, such as unemployment, inflation, or foreign debt (Collins, 2008). As a result, since the 1990s, the Australian government has focused on skilled migration, attracting immigrants with education and qualifications relevant to the Australian economy to address labour shortages (Collins, 2008). From 1985 to 1997, the largest proportion of immigrants arrived on the Family Stream (those selected on the basis of their family relationship, with no requirements for occupational skills or knowledge of language) (Linacre, 2007). Since then, family stream has been cut substantially, and the skilled immigrant stream has received more visa quotas (Collins, 2008; Jupp, 2001).

In recent years, the annual number of skilled immigrants has increased, from 24 000 in 1996-7 to 92 000 in 2005–06, making this category the largest amongst other permanent visa categories in Australia (Linacre, 2007). Skilled immigration is based on a point system, depending on profession, English proficiency, and work experience. The skilled immigration criteria are adjusted on a regular basis, with changes to qualification requirements to reflect labour market needs. Currently, successful skilled migration visa category applicants to Australia have to meet stringent criteria, including being under 45 years of age and of good health, proficient in English, and possessing the qualifications which are currently in demand in Australia (Department of Immigration and Citizenship [DIAC], 2008). Skilled immigrants are eligible to some benefits upon arrival, such as Medicare; however, they are not eligible for welfare support during the first two years on arrival, despite problems with employability during this time (Jupp, 2001). Though skilled immigrants possess required qualifications, often their educational qualifications and employment from their native country are not recognised by employers (Collins, 2008). Downward status mobility and underemployment

are consequently common at the early stages of immigration (Collins, 2008; Jayasuriya, Lang, & Fielding, 1992).

Russian-speaking immigrants to Australia

It is difficult to estimate the number of Russian-speaking immigrants worldwide. Vishnevskiy and Zaychonkovskaya (1991) claimed that up to 15 million people left the USSR during the Soviet era, but the break-up of the Soviet Union became a trigger for the further mass migration of Russian-speaking people. According to the Demographic Yearbook of Russia for 1999, the majority of immigrants have settled in the US, Israel, Canada, Germany, and Finland. According to the 2006 Australian Census, Russian ancestry was claimed by more than 67, 000 people living in Australia, and the Russian speaking population in Australia, the majority coming from the FSU, exceeds 35, 000 people (ABS, 2008). This comprises 0.16% of the Australian population.

Russian-speaking immigrants are a heterogeneous group, both in terms of their immigration pathways and ethnicity. During the Soviet era, a 'Russification' policy was endorsed – the compulsory study of Russian language, Russian and Soviet literature, and history at schools. Consequently, Russian language became the main language used in most of the FSU republics, and different nationalities and minority groups adopted Russian-Soviet culture. In this thesis, I use 'Russian-speaking' as an umbrella term for immigrants from FSU due to their shared history, traditions and values, even though not all immigrants in this study would identify as having a 'Russian' ethnic identity or nationality.

There have been several waves of immigrants from Russia and the FSU to Australia. At the beginning of the 19th century, the first Russians visited Australia on exploratory ships, and the first Russian settler to Australia was a convict (Govor, 1997; Museum Victoria, n.d.). Russian travellers, scholars and experts started to visit Australia more often from the mid to end of the 19th century, among them the famous traveller and anthropologist Nikolai

Miklouho-Maclay, who also lived in Australia for some time (Govor, 1997). By the end of 19th century there was an established community in Australia, with 1,172 settled by 1891 in Melbourne (Christa, 2001; Museum Victoria, n.d.). The first revolution in Russia, in 1905, brought some highly educated people to Australia, some falling into the category of exiles, opposing tsarism in Russia, while others arriving as settlers (Christa, 2001; Museum Victoria, n.d.). After the revolution of 1917, many so-called white Russians, who opposed the communist regime, arrived in Australia. They formed communities, cultural organisations and churches, and their presence became increasingly visible (Christa, 2001). The major immigration from FSU occurred after the Second World War, however. Many were displaced persons: prisoners of war and escapees, who could not return to the USSR because of the fear of persecution (Christa, 2001). Russian Jews, often mistreated in the USSR, were allowed to exit USSR in the 1970s, and while the majority migrated to Israel, many arrived in Australia (Christa, 2001). The latest wave of Russian-speaking immigrants, skilled immigrants, started to arrive after the collapse of the Soviet Union in 1991. Unlike earlier immigrants who were often persecuted or selectively discriminated against in the Soviet Union (Christa, 2001; Museum Victoria, n.d.), most skilled immigrants made it their choice to immigrate and were not directly threatened by the political regime.

Though plenty of Census or Department of Immigration data for skilled immigrants and for Russian Federation-born immigrants exist, no data are readily available specifically for Russian-speaking skilled immigrants from the FSU. The 2006 Census (most recent data) showed that within Australia, the majority of Russian Federation-born immigrants lived in New South Wales and Victoria, with these immigrants identifying as Jewish, Russian, or Ukrainian ancestry (DIAC, n.d.). Most of them were well educated. Those who were employed typically worked as professionals (DIAC, 2010). A recent report on skilled immigrants showed that majority had good English; half of them were employed full-time, and the majority of those were employed as professionals (ABS, 2010).

As highlighted above, research on immigrants and their acculturation is extremely important in the Australian context given the number of immigrants in Australia. In the next section I look into the phenomenon of acculturation and psychological adaptation of immigrants, with the emphasis on Russian-speaking skilled immigrants, and also I consider factors related to acculturation of this group. I also look into depression stigma and psychological help-seeking of Russian-speaking skilled immigrants.

Chapter 2

Literature review

Acculturation of skilled immigrants is a phenomenon that needs particular attention, given the paucity of research with this population, currently largest within other visa categories in Australia. Below I provide an overview of the history and current theories in the field of acculturation research, and of past research conducted with various immigrant groups.

The first use of the term 'acculturation' can be traced back to 1880, to John Powell, at the time the director of Bureau of Ethnography in Washington (Oxford English Dictionary, 2011; Rudmin, 2003b). Acculturation studies were first conducted by anthropologists among Native Americans, and the use of the term acculturation at that time implied a transition from 'savagery' to 'civilization' in the context of a growing interest in evolution and change (Rudmin, 2003b; Winthrop, 1991). First models of acculturation, developed within sociology, such as Park's theory in 1914 focusing on the acculturation of immigrants in the US, started to appear in the early 1900s and reflected the increase in immigration to the US at the time (Padilla & Perez, 2003). Since the 1930s, anthropological studies of acculturation have expanded beyond US borders (Madianos, 2010; Sayegh & Lasry, 1993; Winthrop, 1991). After World War II, when immigration substantially increased, the field of acculturation research began to develop exponentially, and acculturation studies started to focus on the immigrant groups residing in host societies, particularly in the US (Sayegh & Lasry, 1993).

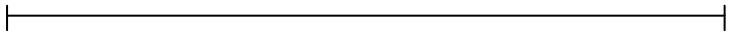
One of the first and widely accepted definitions of acculturation was proposed by Redfield, Linton, and Herskovits (1936, pp. 149-152): "Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups." The definition highlighted that change occurs in both groups with contact, and reflects an understanding of acculturation at the time, with the focus on its

cultural component (Berry & Lonner, 1986). While from an anthropological perspective acculturation was concerned with group level phenomena, Graves (1967) and later Berry (1990) highlighted the important distinction between individual (psychological) and group level acculturation. The current accepted definition of acculturation incorporates reflections in the field, as suggested by John Berry (2005), in that acculturation is the process of cultural and psychological change when contact between two or more cultures takes place.

Models of acculturation

Unidimensional models

Immigration is not a new phenomenon, and not surprisingly many theories of immigrants' adaptation in the new country have been developed over time. Even in ancient Greece there were attempts to understand acculturation (Rudmin, 2003b). Research on acculturation processes within psychology started with the development of so-called unidimensional models, known as unidirectional and linear, where acculturation is equated with assimilation (Nguyen & von Eye, 2002; Sayegh & Lasry, 1993). The unidimensional models suggest that the individual gradually moves away from his or her culture of origin towards that of the dominant culture (Gordon, 1964; Graves, 1967; Lambert, Mermigis, & Taylor, 1986) (see Figure 2.1). The assumptions made by unidimensional researchers were that it is difficult for individuals to retain both cultures; and the more elements of the new culture the person adopts, the fewer elements of the original culture he or she maintains (Berry, Poortinga, Breugelmans, Chasiotis, & Sam, 2011). This unidimensional approach assumes that end points of the continuum between cultures are negatively correlated and mutually exclusive.



Unacculturated Acculturated

('native' culture involvement) (host culture involvement)

Figure 2.1. **Unidimensional model of acculturation**

Source: Nguyen & von Eye (2002: 203)

One of the best known unidimensional models is that of Gordon (1964). Drawing on his research of ethnic, racial and religious groups in the US, he described seven types of assimilation to the dominant culture: cultural (e.g. host language acquisition or adoption of cultural patterns of host society), structural (entrance into host society groups, clubs, etc), marital, identification, attitudes (no prejudice), behaviour, and civic (no value or power conflict) assimilation. The individual usually acquires cultural assimilation (e.g. language acquisition) first, which allows him or her to enter the workforce or continue their education. However, Gordon (1964) pointed that structural assimilation is the most important step for other types of assimilation to follow.

Unidimensional models have been widely criticised for the assumption that the process of assimilation is linear, in the direction from one culture to another (Berry, et al., 2011; Sam, 2006). Today, the change process itself is understood to be a much more complex phenomenon, and is not viewed as a simple linear model (Nguyen & von Eye, 2002). Change can occur in both directions – to and from native and host cultures - and enhancing one culture does not necessarily mean the weakening of the other (Nguyen & von Eye, 2002). In addition, different cultural groups living in host societies still retain varied aspects of their original culture, without the host society becoming uniform (Berry, 2005). Recently it was recognised that immigrants typically describe themselves as having bicultural identities, both host and native identities, while unidimensional models allow a person to have only one

identity (Nguyen & von Eye, 2002). This is also reflected by the fact that legally a person can often have two or more passports – of the host country and prior country of citizenship. Unidimensional models have been characterised as describing US assimilation policies (Morawska, 1994). However, some researchers still use unidimensional models in their research with different immigrant groups, due to their simplicity and ease of use (Alba & Nee, 1997; Flannery, Reise, & Yu, 2001; Gonidakis et al., 2011).

Bidimensional models

More recent models of acculturation are based on a 'bidimensional approach', as reflected in the work of Berry (1980), Hutnik, (1986) and La Fromboise, Coleman, and Gerton (1993). Bidimensional models allow for an immigrant to maintain both his or her own culture and to adopt the host culture, thus allowing for bicultural identities to be formed. Berry's (1980) bidimensional framework is the most widely cited and used in research in this area (Arends-Toth & Fons, 2006; Jasinskaja-Lahti, 2000; Koneru, Weisman de Mamani, Flynn, & Betancourt, 2007; La Fromboise, et al., 1993). In Berry's model, two dimensions of acculturation (host and native culture orientation) are 'crossed,' resulting in four possible types of acculturation strategies (Figure 2.2). Acculturation strategies comprise of two components – attitudes and behaviours – which are employed in everyday interactions (Berry, 1980, 2006a). As can be seen from Figure 2.2 below, assimilation infers adopting dominant cultural values and losing the original culture; integration implies adopting the host culture while maintaining the original culture; marginalization refers to rejecting both the host and original cultures; and separation implies rejecting the host culture while maintaining the original culture. Research in this area has shown that the most successful acculturation strategy is integration (Berry, 1990); and integration is linked to better psychological outcomes, such as self-esteem, life satisfaction and better sociocultural adaptation (Berry, Phinney, Sam, & Vedder, 2006; Kosic, 2004; Phinney & Devich-Navarro, 1997). For example, in a study of Russian-speaking immigrants in New Zealand, those who sought to re-

qualify, improve their English, take part in the life of the New Zealand community, and maintain their own culture, so adopting integration strategy - were better adapted than others both psychologically and socioculturally (Maydell-Stevens, Masgoret, & Ward, 2007).

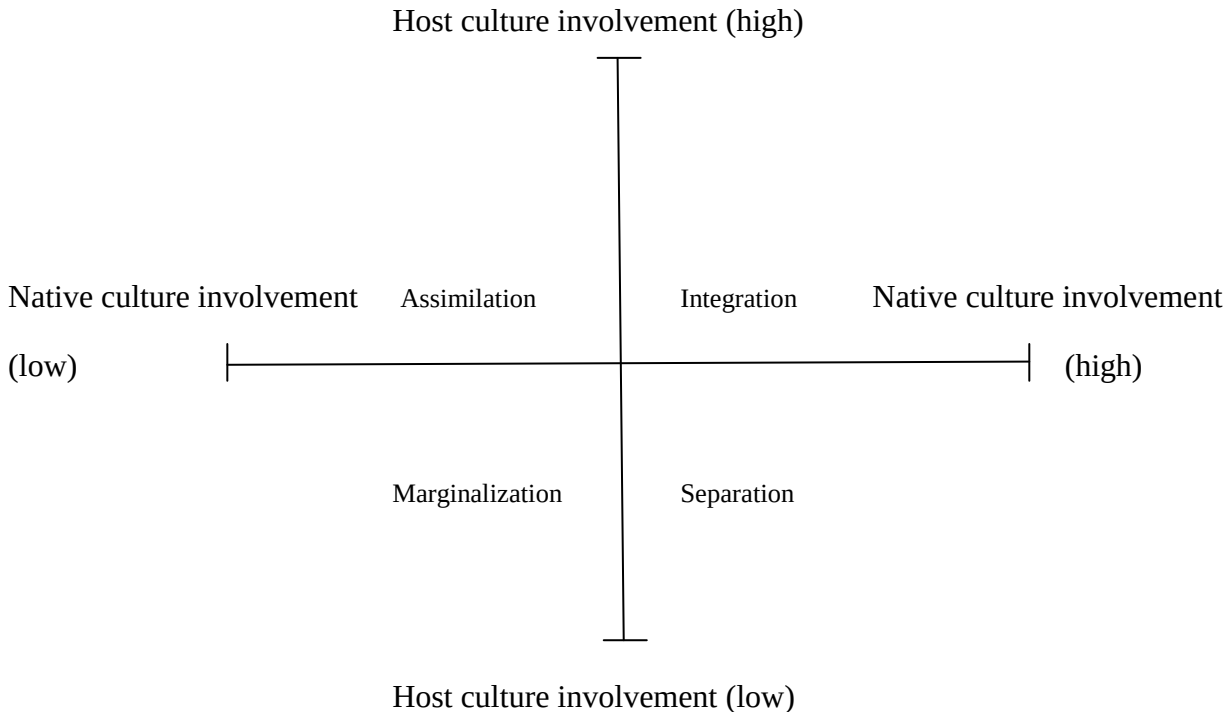


Figure 2.2 **Bidimensional model of acculturation**

Source: Nguyen & von Eye (2002: 203)

Although bidimensional models are considered to be better explanatory models than unidimensional models, several criticisms of these have also been made. Low to no correlations between host and native culture imply independence of dimensions assuming bidimensionality, while strong negative correlations would assume an existence of one dimension. However, dimensions in bidimensional models are not always independent. For example, significant correlations between host and native orientation were found in research with Vietnamese adolescents and Russian-speaking refugee adolescents and their parents (Birman & Trickett, 2001; Birman, Trickett, & Vinokurov, 2002; Nguyen & von Eye, 2002).

Following this, unidimensional models have been claimed to be a more simple measure of acculturation (Alba & Nee, 1997; Flannery, et al., 2001). However, other studies have found independence between two dimensions of acculturation (Ryder, Alden, & Paulhus, 2000). Lack of independence between host and native culture orientation can be partially explained by the construction of acculturation scales (Huynh, Howell, & Benet-Martínez, 2009; Kang 2006). For example, a study conducted with Asian immigrants in the US tested different formats of questions commonly found in acculturation scales. It was shown that lack of independence can be predicted by the scale format (Kang 2006). Another important point is that bidimensional models do not capture the fluid nature of acculturation, nor explain the formation of a third identity, a combination of both host and native identities (Flannery, et al., 2001).

Berry's fourfold acculturation paradigm has also been criticised on conceptual and psychometric grounds by Rudmin and colleagues (Rudmin, 2003a; Rudmin & Ahmadzadeh, 2001). These authors consider the confounds and complications arising from the fourfold paradigm. For example, Rudmin and Ahmadzadeh (2001) point out that marginalization is presented as a choice in various questionnaires following the fourfold paradigm, while it is defined as a rarely chosen option by Berry. Also, marginalization and separation cannot be part of acculturation strategies as, by definition, acculturation involves intercultural contact, not the rejection of the host culture (Rudmin & Ahmadzadeh, 2001). Another interesting point is that integration is not possible to achieve in cultural areas that are mutually exclusive, such as religion (Rudmin & Ahmadzadeh, 2001). Marginalization can also be explained by drawing on Maslow's theory of self-actualization, for example, where self-actualizing individuals can reject both cultures and choose pan-cultural identification (Rudmin & Ahmadzadeh, 2001). This earlier formulation would today fit with the idea of transnational identity. Some of the psychometric faults mentioned by Rudmin and Ahmadzadeh (2001) are

due to the ‘double-barrelled’ nature of the questions, long wording of the items, value-laden words, ipsative constructs, and lack of control for response biases.

Although bidimensional measures do not always show independence between host and native culture orientation, many researchers prefer to use them (Chae & Foley, 2010; Chung, Kim, & Abreu, 2004; Haritatos & Benet-Martínez, 2002). Even though unidimensional models may be parsimonious and easier to use, bidimensional models have better explanatory power (Ryder, et al., 2000). In a comparative study of unidimensional and bidimensional models, for example, bidimensionality better explained acculturation of Korean Americans (Lee, Sobal, & Frongillo, 2003). Some authors argue that even though the two dimensions in bidimensional models were not independent, correlations between the two dimensions are not perfectly negative, as a unidimensional model would imply (Nguyen, Messé, & Stollak, 1999). Importantly, the different dimensions of acculturation (host or own) have been found to be related to different outcome measures, such as school adjustment, psychological health, family relationships, and self-esteem, thus supporting the importance of distinguishing between the two (Birman, Trickett, & Buchanan, 2005; Birman, et al., 2002; Lee, et al., 2003; Nguyen, et al., 1999; Sanchez & Fernandez, 1993). If a unidimensional model was used in the above studies, then the link between outcome measures and acculturation might have been missed (Nguyen & von Eye, 2002). Bidimensional models have also been supported by factor-analysis (Laroche, Kim, Hui, & Joy, 1996; Nguyen & von Eye, 2002).

Some researchers have suggested improvement to the existing bidimensional models by introducing new components. For example, a tridirectional model has been suggested which includes merging new ethnicities. Flannery and colleagues (2001) argue that very often the integration of native and host ethnicities results in the developments of beliefs, behaviours, attitudes and identities that do not belong completely to one culture or to another, and instead, represent the emergence of a new ethnicity, termed ‘ethnogenesis’. Even though hyphenated

labels are commonly used, such as ‘Mexican-American’ or ‘Asian-American’, Flannery and colleagues argue that ethnogenesis is more that just hyphenated identity. Chicanos in America represent this concept, for example, where being a Chicano is more than being Mexican-American (Flannery, et al., 2001). Some other recent theories highlight the importance of ‘fit’ between acculturation strategies of the individual and their host society. For example, Bourhis and colleagues (1997), in presenting the Interactive Acculturation Model (IAM), stress that concordance occurs when immigrant acculturative orientation and host community orientation are the same, for example, integration strategies of immigrants are concordant with multicultural policies of the host society. Cultural discordance between expectations of majority and minority groups has been evaluated to expand this understanding. For example, among Russian-speaking youth in Finland, host and native identities were negatively related when discordance between expectations of the majority and minority cultures regarding native culture maintenance were experienced (Mähönen, Jasinskaja-Lahti, & Liebkind, 2011).

Furthermore, various models of acculturation focus on different domains or a combination of acculturation domains, for instance, in relation to beliefs, language acquisition and use, behaviour, values, or identity (Arends-Toth & Fons, 2006). Some researchers prefer to use only one domain as a proxy for acculturation, for example, language proficiency (Wallen, Feldman, & Anliker, 2002) or proportion of life in the host society (Shen & Takeuchi, 2001). However, this approach is now widely criticized, as it does not capture the complexity of the acculturation process (Arends-Toth & Fons, 2006; Koneru et al., 2007). The combined use of different domains of acculturation provides a broader picture of the acculturation process (Birman et al., 2002). For example, Birman and colleagues devised a scale to measure several domains of acculturation, including language, identity, and behaviour, to measure acculturation among Russian-speaking immigrants and Vietnamese immigrants in the US (Birman & Trickett, 2001; Ho & Birman, 2010). Their approach allows

the measurement of separate domains of acculturation, and the calculation of an overall acculturation score to both host and native culture using a bidimensional model (Birman & Trickett, 2001).

How can one determine if the process of acculturation was successful? Should outcomes of acculturation be measured by subjective feelings of well-being or acceptance or the objectively measured socio-economic position of an immigrant in the society? Can scores on anxiety and depression questionnaires serve as an indication of successful acculturation? In the next section, I expand on the above questions.

Adaptation as an Outcomes of Acculturation

Several conceptual frameworks have been developed to understand the outcomes of acculturation. Earlier scientists, from the beginning to the middle of the 20th century, were looking at acculturation outcomes from the position of psychopathology. This view was supported by epidemiological studies where immigrants represented a high percentage of hospitalised patients (Ward, Bochner, & Furnham, 2001). For example, historical statistics cited by Ward and colleagues (2001) indicated that in 1903, 70% of hospitalised mental patients in the US were immigrants. In 1960 anthropologist Oberg introduced the term 'culture shock' to explain the high incidence of psychopathology in immigrants. 'Culture shock' originates from anxiety in the unfamiliar environment, and Oberg (1960) uses the metaphor of 'a fish out of water' to explain this. 'Culture shock' theorists state that psychopathology results from the distress of immigration, when an immigrant encounters an unfamiliar culture. From this perspective, psychopathology seen in immigrants was regarded a weakness or personal flaw, without any reference or consideration to social adjustment or other pre- and post-immigration circumstances (Ward, et al., 2001).

Contemporary approaches have moved away from the model of 'culture shock' towards a more comprehensive view explaining acculturation and its outcomes. Recent models,

looking into individual acculturation, can be viewed from three major conceptual frameworks: stress and coping models (Berry, 1997, 2006b; Berry, et al., 2011), a culture-learning perspective (Ward, et al., 2001) and social identification theories (Phinney, 1990). These three frameworks correspond to Affective, Behavioural and Cognitive (ABC) components of acculturation in Ward and colleagues' conceptualization (Sam & Berry, 2010; Ward, et al., 2001). Compared to earlier approaches, these theories are more comprehensive, are process oriented, and take into account environmental factors (Ward, et al., 2001). In this thesis, I focus on the affective components of acculturation outcomes, utilising a stress and coping framework.

The stress and coping approach focuses on life changes and resources available to cope (Ward et al., 2001). This approach is drawn from Lazarus and Folkman's (1984) framework, which examines how people deal with stressors in their life through primary and secondary appraisal and a selection of coping strategies. Another theory incorporated into the stress and coping framework is Holmes and Rahe's (1967) study on life events, which showed that any changes in life, including positive and awaited ones, can be stressful (Holmes & Rahe, 1967). The stress and coping framework substantially broadened the narrow 'culture shock' perspective, and incorporated sociocultural aspects into the model, for example, societal attitudes and ideology, as well as highlighting successes in adapting to a new culture (Ward, et al., 2001).

Berry's acculturative stress model is most widely researched and discussed within the stress and coping framework in regards to acculturation. Acculturative stress has been described as a reaction experienced by a person in the process of intercultural contact and change, when these changes are experienced as difficulties (Berry, 2006b; Berry, et al., 2011). Acculturative stress reactions can include depressive and anxiety symptoms, especially when coping mechanisms or social support are not present (Berry, 2006b). Though depression can

arise for many reasons, Berry highlights that it may be a common response to acculturation due to cultural loss and uncertainty about life in the new country (Berry, 2006). Berry's model of acculturative stress includes many factors, based on empirical and theoretical advances in the field, which help to understand acculturative stress and subsequent psychological well-being (see Figure 2.3). In this model, both group (for example, policies in the host country) and individual (migration motivation) variables are taken into account. Moreover, pre-existing variables (for example, the political context in the country of origin) and factors appearing during intercultural contact (such as establishing new social support networks) are included (Berry, 2006, p. 45).

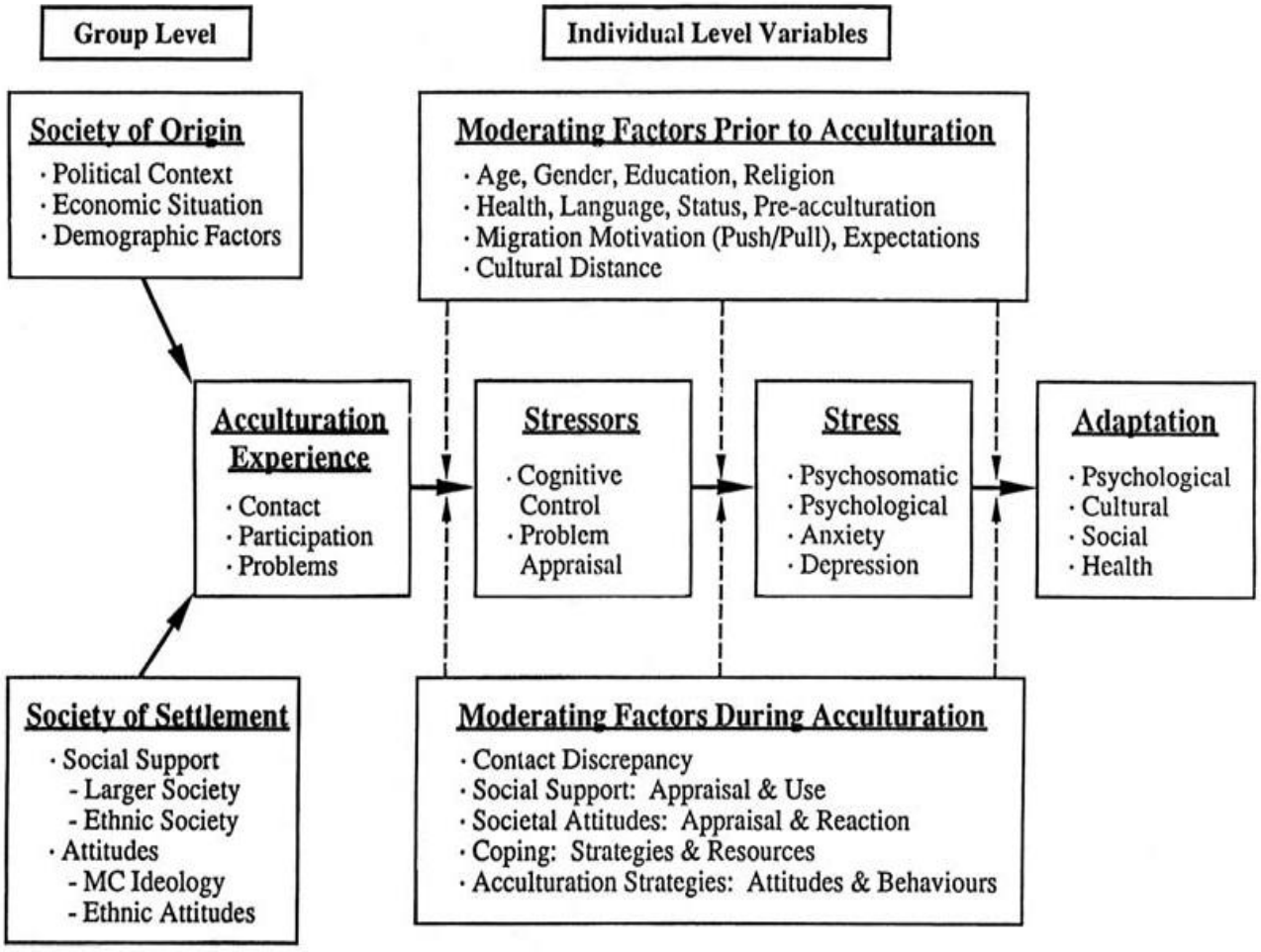


Figure 2.3. **Factors affecting acculturative stress and adaptation**

Source: Berry (2006b: 45)

Ward and colleague's model (2001) views successful acculturation from both psychological and sociocultural perspectives. This model draws on Lazarus' and Folkman's stress and coping framework, Berry's model of acculturative stress, and Furnham and Bochner's culture learning theory (Berry, 1970, 1997, 2006; Furnham & Bochner, 1986; Lazarus & Folkman, 1984). Culture learning theory highlights the importance of immigrants acquiring culture specific skills and behaviours for successful adaptation (Masgoret & Ward, 2006). Specific components of culture-learning include both verbal and non-verbal communication styles, language, and behavioural norms (Masgoret & Ward, 2006; Sam & Berry, 2010). The culture learning component here is similar to behavioural shifts described by Berry.Ward and colleagues' model (2001), similarly to Berry's model, takes into account pre- and post-migration variables, including individual and group level factors. The model is broader than Berry's framework and integrates the two approaches mentioned above: cultural learning and stress and coping.

Social identification theories look into how people categorise each other, how they perceive in-group and out-group members, and under what circumstances discrimination and prejudice appears. Collective group membership often defines how an individual thinks or acts, and develops social cognitions (Padilla & Perez, 2003). Looking into immigrant adaptation from a social identification theory perspective, researchers have been interested in understanding how a new, host identity is formed, how native (ethnic) identity is retained, and how this process is related to self-concept and psychological functioning (Jasinskaja-Lahti & Liebkind, 1998; Phinney, 1990; Phinney, Madden, & Santos, 1998).

Many different measures have been utilized to measure outcomes of acculturation, based on the conceptual framework of the researchers. For example, measures of depression and anxiety (Gonidakis, et al., 2011; Miller & Chandler, 2002), employment (Vinokurov, Birman, & Trickett, 2000b), well-being (Chae & Foley, 2010), and health outcomes (Lara,

Gamboa, Kahramanian, Morales, & Bautista, 2005; Maskarinec & Noh, 2004) are commonly used. Debate around which measures are the most appropriate to measure adaptation continue (Ward, et al., 2001). Adaptation can be divided into two broad categories: psychological (feelings of well-being and satisfaction) and sociocultural (cultural skills) adaptation (Berry, 2006b; Berry, et al., 2011; Ward & Kennedy, 1993). Psychological adaptation is often studied through psychological well-being or lack of depressive and anxiety symptoms, typically measured through self-report measures (Berry, et al., 2011), and sociocultural adaptation can be studied through measures of school achievement, social competence, and language skills (Berry, et al., 2011; Masgoret & Ward, 2006). Ward and colleagues (2001) argue for the importance of distinguishing between sociocultural (behavioural) and stress and coping (affective) outcomes of the acculturation process. Though these two categories are related, they were also shown to be empirically distinct and related to different factors and different dimensions of acculturation (Ward & Rana-Deuba, 1999). For example, psychological adaptation was shown to be related to social support and personality variables in all populations, and specifically with immigrants, while sociocultural adaptation is related to length of stay, cultural distance, and language ability (Ataca, 1998; Ward & Kennedy, 1992; Ward & Rana-Deuba, 1999). Also the specific sociocultural issues gradually resolve with time, especially depending on the age at immigration, while psychological problems may be more variable with time (Ward & Rana-Deuba, 1999).

In this thesis, I focus on the psychological outcomes of acculturation, that is psychological adaptation, within a stress and coping framework, with particular attention to anxiety and depressive symptoms. Psychological adaptation can be measured as an absence or presence of mental health issues, well-being, life satisfaction, or self esteem. In this thesis, I have elected to use depression and anxiety symptoms as indicators of psychological adaptation; however, the research studies reviewed in the next section often include other

affective outcomes. Mental health and psychological adaptation are used interchangeably in the sections to follow.

Mental health in immigrants internationally and in Australia

Immigrants have been systematically investigated for psychopathology in the US from the middle of the 20th century. Depression and anxiety are among the most commonly identified psychological problems in immigrants in Australia (Khavarpour & Rissel, 1997; Krupinski, 1981; McDonald, Vechi, Bowman, & Sanson-Fisher, 1996; Thompson, Hartel, Manderson, Woelz-Stirling, & Kelaher, 2002) and internationally (Ataca, 1998; Oh, Koeske, & Sales, 2002; Pernice & Brook, 1996). For example, early epidemiological studies in Australia found that immigrants were hospitalized more often for major depression than non-immigrants (Jayasuriya, Lang, & Fielding, 1992). Compared to Anglo-Australians, higher levels of depression and anxiety have been found in older aged Greek-born immigrants (Kiropoulos, Klimidis, & Minas, 2004), and Chinese immigrants living in Australia (Tang, Dennis, & Comino, 2009). The high incidence of mental health problems experienced by immigrants could be understood from the stress and coping perspective, described above.

In contrast, some studies have established that immigrants have better mental health than the host population. For example, recent mid-life immigrants to Canada showed better physical and mental health than their host counterparts (Gee, Kobayashi, & Prus, 2004). Immigrants in Canada were shown to have lower levels of depression and substance abuse (Ali, 2002). Despite lower socio-economic status in immigrant groups, Mexican-born immigrants were reported to have better mental health profiles than those born in the United States (Escobar et al., 1998; Vega et al., 1998). In Australia, Steel and colleagues (2009) showed that both Vietnamese immigrants to Australia and Vietnamese non-immigrants living in Vietnam had better mental health than an Australian sample. Similarly, several studies with younger populations in Australia found no difference or occasionally better mental health

among immigrant children and adolescents compared to Australian participants (Alati, Najman, Shuttelwood, Williams, & Bor, 2003; Davies & McKelvey, 1998; Klimidis, Stuart, & Minas, 1994). Some explanations for these results include the protective role of the traditional family networks and different perceptions of success (Escobar, Nervi, & Gara, 2000). Another explanation is the so-called 'healthy immigrant effect' which states that people who are generally healthier tend to immigrate or, as part of reselection process, are allowed entry to the host country (excluding refugees) (Flores & Brotanek, 2005; Gee, et al., 2004; Mirsky, Slonim-Nevo, & Rubinstein, 2007). Another potential issue can be a cultural response bias. For example, people in Asian cultures tend to use the midpoint of rating scales compared to North Americans, in particular on self-evaluative, positive response scales, which can also affect results (Chen, Lee, & Stevenson, 1995; Mellor, et al., 2012).

Few studies document the psychological adaptation of skilled immigrants. The samples used in the previous research were often not well-defined, and include a mixture of refugees and immigrants, or a mixture of immigrants regardless of migration status (Richardson, Miller-Lewis, Ngo, & Ilsley, 2002). A recent cross-sectional study, conducted in New Zealand with three skilled immigrant groups from India, China and South Africa, indicated no difference between their levels of psychological well-being and those in the local population (Alpass et al., 2007). Male gender, contact with home country, and better health were significant predictors of psychological well-being (Alpass, et al., 2007). These findings highlight the importance of defining the sample, as skilled and humanitarian immigrants who arrive from the same country can have very different trajectories of psychological adaptation.

A comprehensive search of the literature identified no studies in Australia examining the mental health problems in recently arrived skilled immigrants, although Richardson and colleagues (2002) examined psychological distress in two cohorts of recently arrived immigrants to Australia, of which one cohort included a high proportion with skilled

migration visas. As a consequence, there were more people in this cohort who had higher educational levels, who were fluent in English, and who were employed post-immigration. About 26% of the immigrants in both cohorts had symptoms of significant psychological distress as measured by General Health Questionnaire, compared to 8% of the Australian population (Richardson et al., 2002). Both cohorts, however, included immigrants holding visas of other categories, such as humanitarian, and family stream, which makes generalization of the results to a skilled immigrant group problematic. In addition, the authors did not control for English language fluency and socio-demographic factors, which makes interpretation of results more difficult (Richardson et al., 2002).

Russian-speaking immigrants and their mental health

To my knowledge, no research examining depressive and anxiety symptoms has been conducted among specific groups of skilled or any other Russian-speaking immigrant groups in Australia. The results of research examining depression and anxiety in FSU immigrants in other countries have been equivocal. For example, studies conducted in the US, Israel, and Germany have shown that levels of depression are higher in this population than their host counterparts (Aroian & Norris, 1999; Flaherty, Kohn, & Levav, 1988; Gutkovich et al., 1999; Kohn, Flaherty, & Levav, 1989; Miller & Chandler, 2002; Ritsner & Ponizovsky, 1999; Ullman & Tatar, 2001). Depression and distress related to acculturation in this group has been found to be long-standing (Aroian & Norris, 2002; Ponizovsky et al., 1998) and FSU immigrants tend to show their distress through somatic symptoms (Kohn, et al., 1989; Ritsner, Ponizovsky, Kurs, & Modai, 2000).

FSU immigrants have also been found to display more difficulties adjusting than immigrants from other countries; for example, an FSU group showed more anxiety and hostility than Ethiopian immigrants to Israel (Ponizovsky et al., 1998). One explanation lies in the fact that the FSU participants were highly-educated and may have had high expectations

for professional and economic opportunities, which were not supported with immigration, leading to disappointment and bitterness (Ponizovsky et al., 1998). However, in a study in Sweden, Russian immigrants did not display higher levels of psychiatric illness and psychosomatic complaints compared to the local population, and were shown to adapt better than immigrants from Poland and other countries of Eastern Europe (Blomstedt, Johansson, & Sundquist, 2007). Some explanations for the results include different migration trends in Sweden compared to the US or Israel, different host country factors, and variability of FSU nationalities in their sample (Blomstedt, et al., 2007). Other explanations include poorer social networks in Polish communities compared to Ukrainian ones, and that participants from former FSU countries fail to report symptoms of anxiety and depression due to the fear of stigmatization.

A number of related immigrant risk factors have been consistently identified to be most linked to the higher rates of psychopathology among immigrants and refugees. These include traumatic experiences, separation from family and friends, inability to speak the host country language, unemployment, and a drop in socio-economic status (Gonidakis, et al., 2011; Kiropoulos, et al., 2004; Thompson, et al., 2002). Other factors serve as protective, for example, social support or ability to speak the language (Ataca, 1998; Ward & Kennedy, 1992; Ward & Rana-Deuba, 1999). In the next section, I look further into the factors related to immigrant acculturation and psychological adaptation.

Factors related to immigrant acculturation and mental health

Previous research has identified a number of factors influencing acculturation and psychological adaptation. Current theoretical frameworks on acculturation and its outcome, adaptation, discussed above, incorporated a variety of these (see Figure 2.3 above). In this section, I present an overview of the factors deemed significant for acculturation and the mental health of Russian-speaking immigrants. I include factors based on Berry's

acculturative stress model, such as pre- and post-immigration factors, and report previous findings specifically conducted with Russian-speaking immigrants (Aroian & Norris, 1999; Flaherty, et al., 1988; Gutkovich, et al., 1999; Kohn, et al., 1989; Miller & Chandler, 2002; Ritsner & Ponizovsky, 1999; Ullman & Tatar, 2001).

Research on acculturation and its relationship to mental and physical well-being has produced mixed results. Some studies have found that lower levels of acculturation, using a unidimensional acculturation score, were related to better mental health in immigrants, for example, among Mexican immigrants in the US (Cuellar, Bastida, & Braccio, 2004; Vega, et al., 1998) and among Chinese Americans (Mak, Xiaohua Chen, Wong, & Zane, 2005). Acculturation can act directly or indirectly on adaptation. For example, the level of acculturation measured by proficiency in Finnish in FSU immigrants living in Finland was negatively related to psychological well-being directly, and also indirectly through an increase in perceived discrimination (Jasinskaja-Lahti & Liebkind, 2007). In another study, acculturation, measured by length of stay and reliance on either English or Spanish, and acculturative stress were positively related to alcohol use in Latino adolescents, indirectly by way of deterioration in family values (Gil, Wagner, & Vega, 2000).

In contrast, other researchers have found that a higher level of acculturation, was related to better adaptation, for example among Asian immigrants in the US (measured by a unidimensional scale) (Oh, et al., 2002; Shen & Takeuchi, 2001) and in Turkish adolescents in Norway and Sweden (measured by a bidimensional scale) (Virta, Sam, & Westin, 2004). A recent study examining the adaptation of Russian-speaking immigrants in New Zealand found that those wanting to integrate into the host society experienced less psychological distress with time after resettlement (Maydell-Stevens, et al., 2007). American acculturation has also been shown to be indirectly related to better mental health through a reduction of social alienation in Russian-speaking women in the US (Miller et al., 2006).

Other researchers have failed to find a relationship between acculturation and mental health, for example, in a study of Greenlanders in Denmark, where acculturation was assessed through how well immigrants speak both languages and how much participants value maintenance of Greenlander cultural identity by their children (Koch, Bjerregaard, & Curtis, 2003), in Mexican American couples, where acculturation was measured through language spoken during study interview and couple's interaction (Rodriguez Le Sage & Townsend, 2004), and in Korean international students in the US, measured by a bidimensional acculturation scale (Lee, Koeske, & Sales, 2004). The discrepancies found in the literature can probably be attributed to several different factors, including different conceptualizations of acculturation used by researchers (bidimensional or unidimensional framework), different histories and reasons for contact, the measurement of different domains of acculturation (language abilities, behaviour or beliefs), and the use of a variety of adaptation measures (Koneru, et al., 2007).

Group size

Researchers have suggested that it is important to look at the size of the immigrant community (Mirsky, et al., 2007). Murphy (1977) argued that the size of the immigrant group relative to the larger society affects mental health, with the smallest groups being affected more than the largest. Research has shown that FSU immigrants in Germany and Israel were adapting differently. Adolescents in Israel showed an improvement in their well-being with years of residency, while adolescents in Germany showed deterioration in their well-being (Mirsky, et al., 2007). Similarly, Russian-speaking immigrants in Israel were found to have better psychological adaptation than those in the US (Flaherty, et al., 1988). The Russian-speaking community comprises around one fifth of Israel's population, while in Germany and the US the proportion is much smaller. Russian-speaking immigrants have established a strong community in Israel, with their own TV, newspapers and restaurants. This may have facilitated the adaptation of the Russian-speaking group in Israel, while this social context

may have been less prominent in Germany (Mirsky, et al., 2007). The Russian-speaking immigrant community is relatively small in Australia, comprising only 0.2% of the population (Department of Immigration and Citizenship, 2008b). This may be a factor in the acculturation of this group. However, another factor contributing to differences in acculturation may be the homogeneity of the host society, with Germany being more homogeneous and more threatened by immigrants compared to Israel (Titzmann, Silbereisen, Mesch, & Schmitt-Rodermund, 2011). Another issue is historical: the history of war between Germany and the FSU potentially influences current relationships between two groups.

Gender

Women appear to be more susceptible to depressive and anxiety disorders than men (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2005). Immigrant women in particular may be more susceptible than men to mental health issues, given the additional stress resulting from acculturation, importance of close social relationships, and the disruption of these relationships with immigration (Laireiter & Baumann, 1992; Miller, et al., 2006). In a host country, immigrant women especially may be underemployed, possess poorer host language proficiency, and have more trouble establishing social contacts in their new surroundings, and therefore are more likely to be socially isolated (Ataca, 1998; Ward, et al., 2001). With changing family roles with immigration, increase in gender-based violence may also influence women's mental health. Also many immigrants arrive in the reproductive age and give birth in the host country. Lack of social support and familiar environment after childbirth can also be a factor in developing post-natal depression. Another factor that may impact on adaptation of female immigrants is that they may be the family members who have to deal with the wide variety of Anglo-Australians in formal context. This includes schools and health and medical care. They may also be required to manage the children's faster rate of acculturation.

Many previous studies have explored the relationship between gender and mental health among immigrants (Livingston, Neita, Riviere, & Livingston, 2007; Rodriguez & Nebot, 2011). For example, immigrant women in Israel report more mental health problems than men (Mirsky, 2009). FSU immigrant women in the US and Israel displayed greater psychological distress than men, and reported more somatic symptoms (Ritsner, Ponizovsky, & Ginath, 1999; Ritsner, Ponizovsky, et al., 2000; Ritsner, Ponizovsky, Nechamkin, & Modai, 2001). The question remains whether women admit to more difficulties or whether they experience more symptoms than man (Mirsky, 2009). Another possibility for higher levels of mental health problems in women can be attributed to the outcome measures. For example, externalizing behaviours, such as antisocial behaviour or alcohol abuse, may be reported more by men, while women may be more likely to internalize problems and so present with depression or anxiety (Sam, 1994).

In contrast to the above reports, in a 2 year longitudinal study gender was not reported to be significantly correlated with depression in FSU immigrants in the US (Aroian & Norris, 2002). One of the explanations suggested by these authors included less gender inequality in terms of education, work status and language skills, which may be characteristic of the FSU immigrant group in particular (Aroian & Norris, 2002).

Acculturation was shown to play an important role in different adaptation outcomes of women and men. Male and female immigrants show different trajectories of acculturation (Birman & Trickett, 2001; Liebkind, 1996), but when level of acculturation was taken into account, gender differences in the levels of depression disappeared (Furnham & Shiekh, 1993; González, Haan, & Hinton, 2001). These findings highlight the importance of exploring both acculturation and mental health with respect to gender, and gender needs to be taken into account when assessing predictors of acculturation or mental health.

Socio-economic status and education

Education is usually associated with better acculturation and adaptation. Having a better education can facilitate cultural learning, and can provide more opportunities for socialising and friendship, skills acquisition, and, in turn, better professional outcomes and higher socio-economic status (SES), and as a result, better psychological well-being (Ataca, 1998; Aycan & Berry, 1996). For example, education was shown to be important for the better sociocultural adaptation in a group of Polish, Russian, and Hungarian immigrants in the Netherlands (Polek, van Oudenhoven, & ten Berge, 2008). Level of education was also found to serve as a buffer against distress in women from FSU in the US, with education being more important for women than men as it provides them with greater independence in the host country (Aroian, Norris, & Chiang, 2003).

Skilled migrants possess relatively high levels of education. However, this does not guarantee that these migrants will have equivalent professional standing in the host culture. Very often work credentials are not accepted as valid in Australia (or elsewhere), regardless of migration category, leading to unemployment and downward status mobility. Unemployment has been shown to be negatively related to the psychological well-being among the general population (Kessler, Turner, & House, 1987), and has been shown to be significantly related to psychological distress in FSU immigrants in the US and Israel (Aroian & Norris, 2002; Ponizovsky, Radomislensky, & Grinshpoon, 2009). Downward status mobility refers to having lower occupational status with immigration, and it is a common outcome of immigration, at least at the early stages (Jayasuriya, et al., 1992). Limited status mobility commonly experienced by immigrants was shown to be related to psychological dysfunction (Beiser, Barwick, Berry, & Wood, 1988; Vinokurov, et al., 2000b). In contrast, satisfactory employment has been shown to be related to a sense of well-being among immigrants in Canada (Aycan & Berry, 1996), and among FSU immigrants in the US (Aroian, et al., 2003; Vinokurov, et al., 2000).

Age at immigration and length of residency

Age at immigration has been shown to be an important factor to consider in an immigrant's acculturation. Acculturation has shown to be easier for younger people, particularly those who have not started school (Beiser, et al., 1988). Younger age at immigration was shown to be positively related to sociocultural adaptation among the group of Polish, Russian, and Hungarian immigrants in the Netherlands (Polek, et al., 2008). However, if immigration occurs in adolescence, the process of acculturation is more difficult (Beiser, et al., 1988), and immigration in both adolescence and old age is considered to be a high risk for subsequent difficulties with adaptation (Beiser, et al., 1988; Sam & Berry, 1995). In older age, it might be more difficult to find employment or to learn new skills, including host language, necessary for successful acculturation in the new country. Ponizovsky and colleagues (1998), for example, showed that older FSU immigrants (> 31 years old) had more difficulties than the younger immigrants (18-30 years) adapting to the host country. Age at arrival might be a more important factor to consider in the acculturation of those who arrived during childhood than adulthood, with length of residency becoming more important for adult immigrants (Birman & Trickett, 2001).

Length of residency in the host country influences both sociocultural and psychological adaptation, and in many previous studies length of residency was used as a proxy of acculturation in exploring psychological adaptation in particular (Aroian & Norris, 2002; Mirsky, et al., 2007; Ponizovsky, et al., 1998). Several theories have been proposed which highlight the importance of relationships between the length of residency and mental health. The so-called 'U-shaped model,' proposed by Oberg (1960), suggests that the initial 'honeymoon' period changes to 'disenchantment,' 'resolution,' and finally, to an 'effective functioning' phase. This model implies the existence of few emotional problems at arrival, with an increase in problems later, then successful long-term adaptation. Similarly, Sluzski's (1986) model implies positive feelings and euphoria in the first six months of resettlement,

followed by a distress stage. Criticism of the research evaluating U-shape models points out that they are atheoretical (Ward, et al., 2001), and the design of studies to test them has been mainly cross-sectional, and often post-hoc rather than longitudinal (Polek, et al., 2008).

Most current research findings have not supported a U-curve hypothesis, and instead research results favour a linear model based on a stress and coping framework. The stress and coping framework suggests that immigrants suffer most distress at the early stages of immigration, when the number of changes in life is the highest (Ward, et al., 2001). Recent longitudinal studies conducted in New Zealand with Japanese students, for example, showed adjustment problems decreasing over time (Ward, Okura, Kennedy, & Kojima, 1998). Similar results have been found for Hmong immigrants in the US (Westermeyer, Neider, & Callies, 1989) and for Japanese exchange students (Furukawa, 1997).

Results from studies with FSU immigrants have provided mixed findings. Length of residency was not found to be associated with decreased depression scores in FSU immigrants to Israel (Ponizovsky, et al., 1998) or to Boston, US (Aroian & Norris, 2002). Contrary to the linear hypothesis, adolescent FSU immigrants in Israel and in Germany showed good psychological health during their first year of settlement (Mirsky, et al., 2007). Adolescents in Israel showed a U-curve pattern of psychological adjustment, with deterioration and subsequent improvement in the mental health scores, while the mental health of adolescents in Germany continued to deteriorate with time. The authors explain this in terms of fewer support structures and small proportion of Russian population in Germany (Mirsky, et al., 2007). Adults in both countries either stayed at the same level of adaptation, or showed a linear pattern of improvement (Mirsky et al., 2007). The study, however, only looked into the first four years post-immigration. Several other studies with FSU participants support the linear pattern of the relationship between length of residency and acculturation (Birman & Trickett, 2001; Hener, Weller, & Shor, 1997; Ritsner & Ponizovsky, 1999).

In summary, there is no consensus as to the relationship between the length of residency and adaptation in the FSU immigrants in different countries. The social context in the particular country, for example, how important is particular immigrant group, can explain differences in the adaptation trends, as patterns of adaptation were shown to be different for the FSU groups in Germany and Israel (Mirsky et al., 2007). Other explanations may lie in the fact that many studies group together participants with substantially different length of residence in the host country (Jasinskaja-Lahti & Liebkind, 2000), or include immigrants with different generational status in a single sample (Angel, Buckley, & Karl, 2001).

Expectations and motivation

Motivation to immigrate is an important factor associated with acculturation. Maydell-Stevens and colleagues (2007) showed that one of the most important factors in successful adaptation of Russian-speaking immigrants in New Zealand was their migration motivation. Typically, motivation is described in terms of *pull* and *push* factors. *Push* factors are those that force people to leave their native country, while *pull* factors relate to the attractions of the new country. *Push* factors often lead to involuntary immigration, including but not limited to refugees and humanitarian settlers, very different from *pull* factors, which lead to different expectations. Those with a higher 'push' motivation, for example, refugees, have higher levels of distress (Kim, 1988 as cited in Ward et al., 2001). Researchers have suggested that positive expectations or higher 'pull' motivation can buffer newly arrived immigrants from initial distress, and those who expect positive outcomes tend to be better psychologically adjusted (Mirsky et al., 2007). However, immigrants high on 'pull' motivation are also susceptible to psychological problems (Kim, 1988, cited in Ward et al., 2001). These findings can be explained by the extremely high expectations about positive immigration outcomes some highly proactive immigrants have (Berry, 2006).

General stress and immigration stress

Holmes and Rahe (1967) highlight that both positive and negative stressful events, such as death of a spouse or even changes in eating habits, can lead to increased vulnerability to psychopathology. They proposed that stress is cumulative and the life event scale devised by them reflects this idea. This scale has a number opposite each life event, and the overall stress is computed by summing up the numbers of the events to a single person. Advantages of these scales are that they are objective and relatively simple to use. However, life events were shown to explain usually less than 10 percent of variance in the psychological outcome measures (Ward, et al., 2001).

The stress and coping framework, suggested by Lazarus and Folkman (1984), highlights the importance of cognitive appraisal in the relationships between person and environment. Firstly, the person appraises whether the event in the environment is stressful. Secondly, he or she needs to decide if adequate coping resources are available, for example social support. In this framework, the so-called objective life stressors are viewed from an individual point of view, highlighting that different individuals can regard the same events from different perspectives and might have different coping resources and strategies available. This is one of the reasons why it is important to measure stress from a subjective point of view, as in perceived stress scales (Cohen & Hoberman, 1983). Perceived stress has been shown to be related to depression and poorer general health (Cohen et al., 1983) and to greater psychopathology in immigrants, with a large amount of shared variance between stress and psychopathology measures (Flores et al., 2008).

Stress arising specifically from immigration is important to consider when exploring mental health in immigrants, as this may increase the level of psychopathology. Traditional stress scales do not measure immigration stress. Aroian and colleagues conceptualised immigration stress as related to discrimination, novelty, feelings of loss and not being at

home, language difficulties and perceived discrimination (Aroian, Norris, Tran, & Schappler-Morris, 1998). Immigration specific demands were associated with higher levels of depression in FSU immigrants (Aroian & Norris, 2002; Roytburd & Friedlander, 2008; Vinokurov, Trickett, & Birman, 2002). Perceived discrimination was shown to be related to reduced well-being in FSU immigrants (Jasinskaja-Lahti & Liebkind, 2007). Improvement in depressive symptoms was found to be related to a decrease in immigration stress in FSU immigrants (Aroian & Norris, 2003), while ongoing immigration demands were related to long-lasting distress (Aroian & Norris, 2003). Immigration demands were also shown to be related to acculturation, i.e., perceived discrimination was related to maintaining Russian identity by adolescents (Birman & Trickett, 2001) and a decrease in immigration stress was associated with the length of stay in Chinese immigrants (Ma, Griffin, Capitulo, & Fitzpatrick, 2010).

Social support

Disruption of established social support networks and importance of re-establishing them in the host culture is common in immigration. Immigrants often need more social support than the host population, as they find themselves in an unfamiliar environment, lacking in resources and knowledge. Within the stress and coping framework, it has consistently been shown that social support is positively related to psychological and physical well-being and negatively to depression (Pernice & Brook, 1996; Seeman, 1996; Thoits, 1995; Sands & Berry, 1993; Vega, Kolody, Valle, & Hough, 1986; Vega, Kolody, Valle, & Weir, 1991). Social support plays an important role in the process of acculturation itself, for example, playing a role in acculturation among Asian immigrants to the US (Baek Choi & Thomas, 2009) and among Russian immigrants to the US (Birman, et al., 2002; Birman & Tyler, 1994; Miller & Chandler, 2002); however not all studies found this relationship (Orshan, 1996).

Social support can be received from a variety of sources, including family (Noh, Speechley, Kaspar, & Wu, 1992) and especially marriage partner (Ataca, 1998). Other researchers have investigated friendship networks (Vega et al., 1991). Social support can be

derived from both host and native support networks. For example, if a person is high on the integration strategy of acculturation, then he or she may receive support from members of both host and native groups, which increases life satisfaction (Kealey, 1989). Social support from native support networks was shown to be particularly important for the psychological well-being of immigrants (Adelman, 1988). Similarly, the large native support networks of the FSU immigrants in Israel was shown to be related to psychological well-being (Mirsky et al., 2007). Importantly, the significance of the quality of the social network, rather than mere contact per se, has also been highlighted (Berry, Kim, Minde, & Mok, 1987).

Expectations and norms regarding social support can influence how each individual utilizes it. Social support may be of particular importance in the Russian-speaking population as the reliance on close friends and family members were vital during Soviet times, and during the breakdown of the USSR. Researchers have pointed out that relationships between friends sometimes are seen as more intimate than between spouses (Halbertstadt, 1996). Social support was shown to be important for successful adaptation of Russian-speaking immigrants in the USA (Aroian & Norris, 2003; Ritsner, Ponizovsky, & Ginath, 1997; Vinokurov, Birman, & Trickett, 2000). Previous studies with Russian-speaking immigrants indicated that social support tended to be lower than in the general US population (Kohn, et al., 1989). It was suggested that social support served as a buffer against stress in low stress conditions, however, with increased stress, social support lost its protective power and becomes insufficient as a coping resource (Ritsner, Modai, & Ponizovsky, 2000).

Some researchers point out that there is a distinction between perceived and actual social support. Typically perceived social support is assessed by investigating how people perceive their social network, comprising of friends, family, or broader social group members, while actual social support can be measured by asking questions about the composition of their social networks. Also social support is not a uniform concept, which highlights the

importance to investigate different domains of social support among immigrants. There are several domains of social support, such as informational (helping to understand an event better), instrumental (provision of concrete assistance), and emotional support (provision of nurturance and reassurance). Different domains of social support can serve as buffers against particular stressors and help different areas of adaptation, for example, instrumental and informational social support can be most useful for economic adaptation in the host culture. Research on immigrants has particularly highlighted the importance of instrumental and educational social support, with both instrumental and emotional support important in facilitating adaptation among Russian-speaking immigrants in New Zealand (Maydell-Stevens et al., 2007).

Stigma and psychological help-seeking

Given the vast literature highlighting that immigrants often display poor mental health, it is important to look into the issue of immigrants' help-seeking behaviour. In this section, I look into this issue, as well as stigma around mental health in immigrants.

Worldwide, many immigrant communities constantly resist help-seeking behaviour for mental health issues (Chen, Kazanjian, & Wong, 2009; Chen, Kazanjian, Wong, & al., 2010; Ingleby, 2011; Li & Browne, 2000; Masuda, Suzumura, Beauchamp, Howells, & Clay, 2005). There are several reasons for this. Different cultures vary in their explanatory models of mental health illness, including its causation, duration, and outcome (Ingleby, 2011; Sheikh & Furnham, 2000). For example, elderly Russians were found to view those with mental illness as weak, lacking *dusha* (soul), self-control and moral character (Polyakova & Pacquiao, 2006). Sometimes mental health problems may be attributed to supernatural causes in non-western cultures (Sheikh & Furnham, 2000). Often mental illness is perceived in non-western cultures as referring to extreme disorders, which leads to immigrants entering services when their disorder is more severe, compared to the host population (Ingleby, 2011). Usually the

family of the person affected by mental illness or others in their community are supposed to take care of him or her instead of the formal health sector (Wynaden et al., 2005; Wynaden et al., 2005). Also often immigrants are unfamiliar with the services available in the host country, especially when there is no equivalent of these services in their country of origin (Team, 2006; Polyakova & Pacquiao, 2006).

Explanation of help-seeking behaviours for mental health problems is an important task if service utilization is to be raised in general, and in immigrants communities in particular. Recently, researchers have started to pay more attention to attitudinal and belief components explaining use of services for mental health issues. Psychological help-seeking attitudes were found to be an important factor in actual help-seeking behaviour and service utilization in the past research (Brown et al., 2010; Mackenzie, Knox, Gekoski, & Macaulay, 2004). A recent large scale study conducted in Europe showed that attitudes towards psychological help-seeking were significantly related to actual service use (ten Have et al., 2010) Several studies, conducted specifically in Australia, found that attitudes towards treatment were predictive of seeking help from GPs for psychological issues in rural Australia (Komiti, Judd, & Jackson, 2006). Attitudes towards seeking help were significant predictors of intentions to seek help in another Australian study (Bayer & Peay, 1997). However, some studies found discrepancies between attitudes and actual help-seeking: for example, the majority of young people aged 12-25 in Australia believed counselling was helpful, however, less than half used it to address their own problems (Reavley, Yap, Wright, & Jorm, 2011). Similarly, in rural Australia, help-seeking attitudes were not shown to influence life-time help-seeking (Judd et al., 2006).

Stigma related to mental illness is another factor influencing psychological help-seeking behaviours (Brown, et al., 2010). Stigma around mental health has been continually highlighted as a crucial topic when researching mental health, with reports of human rights violation still occurring around the world (Drew et al., 2011; World Health Organization

[WHO], 2005). The unemployment rate is often reported to be much higher in people with mental health problems than the general population, and people with mental health problems often hide this from their employers (Drew, et al., 2011). In many low to middle income countries, children and adolescents with mental health disabilities experience considerable barriers in accessing education (Drew, et al., 2011). Other rights of people with mental illness are also violated, for example, the ability to marry and have children (Drew, et al., 2011).

A person is referred to as being stigmatized when he or she is feared, avoided or discriminated against. Stigma has been differentiated into personal stigma, for example, reflecting self-attitudes towards mental illness, and perceived stigma, reflecting how a person thinks others perceive mental illness (Griffiths, Christensen, & Jorm, 2008; Griffiths et al., 2006). Stigmatized people are devalued or discredited by the broader society, and mental illness is often stigmatized (Goffman, 1963).

Stigma related to mental and physical problems is present in most societies in the world, and has been shown to prevent people from disclosing their condition (Fabrega, 1991). Often, immigrants maintain stigmatizing attitudes towards psychological help-seeking from their country of origin. Westbrook, Legge, & Pennay (1993) argue that stigma around people with disabilities appears to be stronger in collectivistic groups, such as Greek and Chinese immigrants, than in individualistic groups, such as among Germans or the Anglo-Australians, which the authors explained by fear of stigma spreading to other in-group members in collectivistic groups. Higher stigmatizing attitudes have been found to be related to people with mental illness compared to people affected with diabetes, a heart condition or physical disability, which might be connected to the belief that people with mental illness have control over the cause and condition of their illness (Corrigan, 2000; Westbrook, et al., 1993). Also people might have difficulties interacting with those with mental illness due to perceived unpredictability of their behaviour.

Stigma related to mental health appears to play a significant role in accessing appropriate services in Australia (Wrigley, Jackson, Judd, & Komiti, 2005; Wynaden, et al., 2005) and overseas (Papadopoulus, Leavey, & Vincent, 2002). Those who have stigma towards mental illness often do not go to see a specialist and do not receive adequate psychological help, which can lead to detrimental outcomes for the person themselves, for their families, and results in a burden to the community due to the late presentation. Stigma also leads to increased psychological distress and lower self-esteem (Griffiths & Christensen, 2004). Many studies have found that stigma related to mental illness is higher in immigrant groups. In the US, Japanese students were found to have higher stigma towards people with mental health problems than American students (Masuda et al., 2009). In Australia, stigma towards depression appears to be higher in people who were born overseas (Griffiths, Christensen, & Jorm, 2008; Kiropoulos, Griffiths, & Blashki, 2011), for example, it is higher in former Yugoslavian immigrants compared to Anglo-Australians (Copelj & Kiropoulos, 2011). Less tolerance towards emotional or psychological issues has also been found in Vietnamese immigrants than in Anglo-Australians (Duong-Ohtsuka & Ohtsuka, 2001) and stigma, shame, and not seeking professional health have been shown to be prominent among Asian immigrants to Australia (Wynaden, et al., 2005).

Factors associated with psychological help-seeking attitudes and tolerance towards people with mental illness were shown to be multifold, and can include causation attribution, for example, personal or biological deficiency, education and familiarity with mental illness, age, past experience with accessing mental services, and current distress (Dietrich et al., 2004; Griffiths, et al., 2008; Leaf, Bruce, Tischler, & Holzer, 1987; Masuda, et al., 2005; Shulman & Adams, 2002). Previous research shows contradictory results regarding gender, stigma and help-seeking attitudes, with some researchers reporting that men show higher stigma towards people with mental illness (Griffiths, et al., 2008), while others report that women exhibit higher stigma (Lauber, Nordt, Falcato, & Rossler, 2004; Leaf, et al., 1987). Other researchers

have found no relationships between gender and help-seeking attitudes (Zhang & Dixon, 2003).

Living in the host community, where attitudes towards mental health may be different from the native culture, influence immigrants' attitudes and behaviour. Several studies have looked specifically into changes in stigma towards mental problems and psychological help-seeking with acculturation. For example, age at immigration and length of stay were found to play a role in altering the attitudes towards mental illness and help-seeking in several US studies of Asian Indians (Kumar & Nevid, 2010; Panganamala & Plummer, 1998), Asian college students (Atkinson & Gim, 1989), and Vietnamese participants (Nguyen & Anderson, 2005). Retaining native identity was shown to be related to more personal stigma levels in Yugoslav immigrants living in Australia (Copelj & Kiropoulos, 2011) and retaining native culture values were negatively related to seeking psychological help in Asian participants in the US (Kim & Omizo, 2003). Chinese first and second generation immigrants showed less stigma towards mental illness, related to their adoption of Australian cultural practices. Similarly, Zhang and Dixon (2003) showed that higher acculturation towards American culture is related to higher stigma tolerance and attitudes towards seeking professional help in Asian international students in the US.

Help-seeking behaviour and stigma towards mental health among Russian-speaking immigrants

No studies appear to have been conducted in Australia specifically investigating psychological help-seeking behaviours and stigma towards mental health among Russian-speaking immigrants. Many studies from other countries reported that this group has low help-seeking behaviour and high stigmatizing attitudes towards mental illness. For example, previous research in Russian-speaking immigrants in the US found that depression is a common problem for these immigrants and they were shown not to seek professional help for

its treatment (Aroian & Norris, 2002). Russians were shown to be less tolerant to mental health problems than a British sample (Shulman & Adams, 2002). Older aged Russian immigrants were found to minimize mental illness, often labelling it as 'stress' (Polyakova & Pacquiao, 2006) and older aged Russian immigrants have been found to think of depression as a common outcome of immigration and aging, or a consequence of living through war (Polyakova & Pacquiao, 2006; Team, 2006). Ritsner and colleagues (2000) suggested that high levels of somatization symptoms in a FSU group in Israel were related to stigma around mental health problems. Somatization and stoicism were also shown to be strong among Russian-speaking elderly in the US (Polyakova & Pacquiao, 2006). Typically, the majority of FSU immigrants indicated that they would prefer to get help from their family members or friends, or they should be able to sort their problems themselves (Mirsky, Baron-Draiman, & Kedem, 2002; Polyakova & Pacquiao, 2006; Team, 2006). However, family members can be of little psychological help when they are themselves overwhelmed by the demands of immigration (Aroian, Spitzer, & Bell, 1996). Stigma, disgrace and shame to the family tend to be long-standing in the Russian community, even when the person has recovered (Polyakova & Pacquiao, 2006). This may be reinforced as a result of common practices in the Soviet Union: when someone is hospitalized for mental illness, even after recovery, they would be automatically registered and discriminated against in their rights to access jobs and education (Shulman & Adams, 2002). Managing mental health illness by seeking solace in religion is another way for Russian-speaking people to address their mental health issues (Team, 2006).

There is contradictory evidence, too, that Russian culture has traditionally shown tolerance towards people who are mentally ill. Shulman & Adams (2002) describe certain types of mentally ill people who in the past were regarded as holy fools, and respected in the community; they claim too that mentally ill people were traditionally cared for within their community by their families, often with lots of patience. In support of this, several studies have not found that Russians have more stigmatizing attitudes than Westerners. For example,

when people currently living in Russia, Germany and Mongolia were compared, Russians were actually more tolerant on many items towards psychiatric patients (Dietrich, et al., 2004). In another study, similar attitudes towards mentally ill were found in Germany, Russia and Slovakia, with Russians showing more tolerance than Slovakians or Germans on certain stigma scale items (Schomerus, Matschinger, Kenzin, Breier, & Angermeyer, 2006).

Often, Russian-speaking people from FSU show distrust to psychologists and psychiatrists (Polyakova & Pacquiao, 2006), largely originating from political reasons. Historically, this relates to Soviet abuse of psychiatric diagnoses in the middle 20th century, when people who were a threat to the ruling government at the time, such as political activists, nationalists and other non-mainstream intellectuals, were often sent to psychiatric hospitals for the treatment of 'schizophrenia' (Bonnie, 2002; Voren, 2010). In his speech in 1957, Nikita Khrushchev, the leader of USSR at that time, mentioned that "those who might start calling for opposition to Communism ... clearly their mental state is not normal" (Knapp, McDaid, Mossialos, & Thornicroft, 2007, p. 402). This mistrust of psychiatrists may be generalized to psychologists and other mental health professionals (Slonim-Nevo, Sharaga, & Mirsky, 1999).

In addition, immigrants from the FSU might not be aware of the various options of professional mental health care and which professionals can provide this mental health care (Polyakova & Pacquiao, 2006). Russian-speaking immigrants can be particularly mistrustful of host culture mental health workers, as these workers may not show an understanding of Russian culture and traditions (Polyakova & Pacquiao, 2006). Typically, psychiatrists have been seen as the only provider of mental health care, as psychology is regarded as more of an academic discipline in the FSU (Kozulin & Venger, 1999).

The literature review provided in the current section, outlined important issues for consideration and gaps in the existing research. The next section describes methodology of the study, as well as research aims and rationale.

Part II

STUDY DESIGN

Chapter 3

Thesis Rationale

Although ‘skilled immigration’ is the fastest growing migration stream in Australia, administrative and epidemiological data and systematic research on the mental health of this population is lacking. Most recent Russian-speaking immigrants arrive on the skilled immigrant program, and there is a lack of research on this particular cultural group. The current thesis focuses on this population. Skilled immigrants are expected to adapt better than many other groups for several reasons, including better English proficiency, younger age, better physical and mental health due to strict visa requirements, and better professional prospects. However, smaller immigrant groups relative to the larger host society have been shown to have more mental health issues. Previous studies have shown that Russian-speaking immigrants have difficulties with adaptation in host countries, and typically have high levels of mental health problems compared to the host and other immigrant groups (Aroian & Norris, 1999; Flaherty, et al., 1988; Gutkovich, et al., 1999; Kohn, et al., 1989; Miller & Chandler, 2002; Ritsner & Ponizovsky, 1999; Ullman & Tatar, 2001).

The current study uses on Berry’s bidimensional theory and the multi-domain format of acculturation (Berry, et al., 2011; Birman, et al., 2002). Though acknowledging shortcomings of the theory, I believe that Berry’s model provides the best explanation of acculturation processes and outcomes and it is the most widely used in research to date. I have focused on both Australian and Russian acculturation, using language, behaviour and identity domains. It is not possible to assess the full model in the format of a doctoral thesis, and therefore, I focus on the components of the model most relevant to Russian-speaking immigrants.

There is a lack of information about the help seeking behaviour of FSU immigrants living in Australia. It may be expected that FSU immigrants, like other immigrant groups, are reluctant to present for professional psychological help for mental health problems such as

depression (Kiropoulos, Blashki & Klimidis, 2006; Ziguras, Klimidis, Lewis & Stuart, 2003). Stigma around mental health issues might be particularly strong among Russian immigrants due to cultural factors outlined above, thus impeding help-seeking behaviours of this particular group to a greater extent than among other immigrant groups. However, traditionally tolerant attitudes towards those with mental illness can influence Russian-speaking immigrants in Australia to hold less stigmatizing attitudes.

Research aims

In this thesis, I present the first empirical analysis of anxiety and depressive symptoms, of acculturation patterns, psychological help-seeking, and stigma towards mental health in this population. The current research can be described as exploratory. The research aims are as follows:

(1): to examine the levels of depression and anxiety symptoms in Russian-speaking skilled immigrants in Australia compared to non-immigrants living in FSU, and an Anglo-Australian group, while controlling for socio-demographic and other factors.

(2): to explore relationships between measures of Russian and Australian acculturation and immigration stress in immigrants from the FSU living in Australia and whether immigration stress uniquely contributes to measures of Australian and Russian acculturation, and to examine whether Russian immigrants living in Australia endorse a bidimensional acculturation model.

(3): to examine levels of depression-related stigma and psychological help seeking attitudes in adult immigrants from the FSU living in Australia, and to compare these with Russian non-immigrants and Anglo-Australians, while controlling for socio-demographic factors and level of depression; and to examine the relationship between acculturation

factors, depression stigma and psychological help-seeking attitudes in a Russian-speaking immigrant sample, while controlling for socio-demographic factors and level of depression.

The current research project aims to provide much needed information on the mental health status, stigma around mental health and psychological help-seeking attitudes of skilled immigrants from FSU living in Australia. I also seek to advance our understanding of acculturation and factors contributing or impeding acculturation of skilled immigrants from FSU living in Australia.

Chapter 4

Method

Procedure

The research project was conducted from 2008 – 2012, with data collection taking place from 2009 till 2010. Monash University Human Research Ethics Committee (CF09/1131 - 2009000552) granted approval for the current study (Appendix A). English language versions of questionnaires were translated into Russian by the researcher, who is fluent in both Russian and English and who, at the time of translation, was a Provisional Psychologist. After translation, both English and Russian versions were verified with another bilingual immigrant, who has both linguistic and psychological backgrounds. The final translations were verified by a bilingual External Testing Coordinator from the Defence Force, School of Languages. All suggested corrections were discussed. This method allowed me to make the most of the knowledge of bilingual mental health professionals, and was preferred over a sequential translation/back translation method. Content validity was checked by examining the psychometric properties of the scales after data were collected and preceding any further analysis.

It is typical for cross-cultural research to obtain a non-random sample rather than random samples (Ataca, 1998). It was not possible to obtain a complete list of Russian-speaking immigrants who had arrived on a skilled immigrant visa, and this lead to my decision to recruit a convenience sample. The selection of participants was guided by the desire to select as widespread and representative sample as possible. Russian-speaking immigrants were recruited through flyers advertising the project at ethnic-specific social clubs and organisations in metropolitan areas of Melbourne; advertisements in Russian-community web-forums; and advertisements in Russian newspapers in Australia (Appendix B). Anglo-

Australians were recruited through Facebook, Melbourne web-forums, such as Melbourne Maniac (http://melbournemaniac.livejournal.com/), and the Monash University web board (Appendix C). Recruitment targeted Anglo-Australians with varied socio-economic standing to target and recruit a sample comparable to the Russian-speaking immigrant group. Russian-speaking non-immigrant groups were approached through advertisements in Russian-community web-forums (www.kharkovforum.com/), Facebook and Russian networking web communities (V Kontakte (vkontakte.ru/) and Odnoklassniki (http://odnoklassniki.ru/) (Appendix D). Recruitment again targeted Russian-speaking participants from varied socio-economic backgrounds.

All participants received an explanatory statement (Appendix E) about the project and signed an electronic consent form (Appendix F) before proceeding. All questionnaires were completed on line. An in built web mechanism was employed to make sure participants were chosen from the required sample. For example, Russian-speaking immigrants were asked about their visa type, and if they specified a visa other than skilled-immigration visa, they were unable to proceed. All demographic information, and answers to depression and anxiety questionnaires were collected through a secure Monash University website, while other questionnaires were placed on the external website QuestionPro. At the end of data collection, I received two Excel files from both websites with the raw data, which then were collated into one SPSS file. Web alerts were developed to identify participants with high depression and anxiety scores. If a participant scored high, I received the location and e-mail details and prepared a semi-automatic email with information about depression and anxiety, and referral details to send to these participants (Appendix G). Almost all participants who received e-mails with referral details were from the cities where services were easily accessible. Those participants who might have had some difficulties accessing psychological help, would still have access to their GPs and telephone/online counselling.

Statistical analyses were undertaken using SPSS V 18. Statistical methods are described in the Results section of the articles, with specific analytic approaches relating to each paper.

Participants

As noted, data for the current project were collected from three samples: Russian-speaking immigrant living in Australia (the Russian immigrant sample), Anglo-Australians living in Australia (the Anglo-Australian sample), and Russian-speaking non-immigrants living in the FSU (the Russian non-immigrant sample).

Russian immigrant sample

Sixty five Russian immigrants (37 females and 28 males) living in Australia participated in the study. The average age of this sample was 35.2 (*SD* = 6.1). All participants arrived on a skilled immigration visa and were first generation immigrants. The majority came from Russia (46%) and Ukraine (17%), with some indicating USSR as their birthplace (26%). Only those between ages 20 and 60 were recruited. Selection criteria for skilled immigration have changed regularly over time. However, due to the visa age requirements and point system, it is difficult to arrive on a skilled immigrant program if over 40 years old. The skilled migration visa program only became accessible for immigrants from the FSU after the collapse of the Soviet Union in 1989, thus making age 60 the upper limit. Only main applicants and their spouses were included into the sample. Dependent children or parents were not considered to belong to the targeted sample. Thus, the lower age limit was established based on immigration selection criteria for main applicants and possibility to gain enough points for qualifications and work experience.

Anglo-Australian sample

Sixty three Anglo-Australian participants (54 females and 9 males) living in Australia completed questionnaires. Their mean age was 29 years (*SD* = 6.3). The age group of

participants were limited to 20-60 range to match Russian-speaking immigrants. Only those who were born in Australia and whose parents and grandparents were of an Anglo-Celtic background (i.e. born in Australia, England, Scotland, Wales or Ireland and consider themselves to be of an Anglo-Celtic background) were included in the sample.

Russian non-immigrant group

Sixty five participants (56 females and 9 males) from Russia (69.2%), Ukraine (23.1%), and Belarus (7.7%) participated in the study. The mean age of participants was 30 years (*SD* = 8.8). The age group of participants was limited to 20-60 range to match Russian-speaking immigrants. Three from 15 FSU countries were chosen for several reasons. Participants were required to speak and understand Russian well. The majority of the population in these three countries is fluent in Russian. Another reason was the importance of ensuring that the researcher was able to find and access appropriate services for participants with high levels of depression and anxiety. It would be more difficult to find these services in all FSU countries, so the decision was made to limit recruitment to these three countries.

Materials

A web-based questionnaire was employed for data collection. Anglo-Australian and Russian non-immigrant groups completed almost identical sequence of socio-demographic questions. Participants from the Russian-speaking immigrant group completed a slightly different version, where questions directly related to their immigration experience were included (see Appendix H for the English and Russian versions, with explanation which questions were included for each group). All three groups then proceeded to complete scales assessing levels of depression and anxiety, social support, attitudes to mental health, help-seeking behaviour, and perceived stress (Appendix I). Additional questions for Russian-speaking immigrants were added to the socio-demographic scale and two additional scales - acculturation and

immigration – were also added (Appendix J). Questionaries are presented below in the order they appeared on-line.

Demographic information

The demographic questionnaire for all three groups enquired about sex, date of birth, household income and how many people are supported by this income, occupation, educational level, self-assessed health level, relationship status, and employment status. Participants were asked to state their highest level of education completed on a 5-point scale and including 'school', 'college/ TAFE', 'Bachelor', 'Master's', and 'PhD'. Relationship status categories included 'married/ de facto', 'widow/widower', 'divorced/separated', and 'never married'. Physical health was measured using an item asking how they would define their health, rated on a 5-point scale ('very good', 'good', 'satisfactory', 'poor', and 'very poor'). Current employment status was also measured using the following categories: 'full time', 'part time', 'looking for work', 'housewife', 'unable to work due to illness or injury', 'retired', 'other '.

Each questionnaire for all three groups included questions to ensure participants met the criteria for inclusion into the study: Russian-speaking immigrants were asked about their visa types and if they or their spouses were the main applicants; Russian-speaking non-immigrants were asked which FSU country they were from; both Russian-speaking groups were asked how fluent they were in Russian to ensure they could read and understand the questionnaires well; and Anglo-Australians were asked if their parents and grandparents were of an Anglo-Celtic background, which country they were from, and their native language. If answers to the above questions did not fit the defined criteria, the participants were not able to proceed.

Additional questions for the participants in the FSU immigrant group included information about their immigration motivation, applicant type ('main', 'spouse'), age at

arrival, language spoken at home and native language; how well they felt they adapted to life in Australia (‘as expected’, ‘quicker’, ‘slower’), outcomes of immigration (‘gains’, ‘losses’), occupation prior to immigration, and change in professional status with immigration (‘same’, ‘higher’, ‘lower’).

Depression

Symptoms of depression in participants were measured with the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977), developed to measure depressive symptoms in general populations. CES-D consists of 20 questions and reflects such depressive symptoms as depressed mood, feelings of worthlessness and hopelessness, loss of appetite, poor concentration, and sleep disturbance. A 4 point Likert scale was used asking “how often have you felt this way during the past week”: 0 = rarely or none of the time (less than 1 day), 1 = some or a little of the time (1–2 days), 2 = occasionally or a moderate amount of time (3–4 days), and 3 = most or all of the time (5–7 days). Four questions were reverse scored, and the total was calculated by summing all the items. CES-D scores range from 0 to 60 with higher scores indicating more severe depressive symptoms. Scores of 21 or more indicate possibility of severe depression. This number was used as a cut-off score for generating a semi-automatic email to participants with the details of services. Critics of the scale argue that it generates many false positives and is not very efficient in identifying true positives (Naughton & Wiklund, 1993), and that it measures symptoms pertinent both to generalized anxiety and depression (Breslau, 1985, Roberts & Vernon, 1983). However, its reliability and validity have been tested widely in a variety of different cultural groups and populations (Naughton & Wiklund, 1993). CES-D has good internal consistency as measured by Cronbach’s alpha (0.83 - 0.91), acceptable test-retest reliability (0.51–0.67), and good construct validity (Naughton & Wiklund, 1993; Radloff, 1977).

Anxiety

Anxiety was measured with the 20-item state version of the State-Trait Anxiety Inventory (STAI), developed by Spielberger, Gorsuch, and Lushene (1970). It is the most widely used anxiety scale and has been used extensively in cross-cultural research (Abbassi & Stacks, 2007; Iwata & Higuchi, 2000). State anxiety may fluctuate and is a transitory emotional state, while trait anxiety is more stable and reflects anxiety disposition. The state anxiety version, used in the current study, can better reflect immigration experience (Ataca, 1998). Responses lie on a four-point scale ('not at all', 'somewhat', 'moderately' and 'very much so'). The scores ranged from 20 to 80, with higher scores indicating more severe anxiety symptoms. Questions include both negative "I am tense" and positive items "I feel calm", with positive items being reversed scored. Spielberger, Gorsuch, and Lushene (1970) reported test-retest reliability of the state scale to be .54. Barnes and colleagues (2002), after reviewing more than 800 articles utilizing STAI, concluded that both internal consistency and test-retest coefficients were on average acceptable.

Social Support

Social Support was measured with the Interpersonal Support Evaluation List for the General Population (ISEL), developed by Cohen and colleagues (1985). Four separate functions of social support are measured by 10 statements. The 'tangible' social support measures the perceived amount of tangible help, and includes items such as 'If I needed help fixing an appliance or repairing my car, there is someone who would help me.' The 'appraisal' social support subscale measures the perceived availability of emotional support, for example, 'There is no one that I feel comfortable to talking about intimate personal problems'. The 'belonging' subscale measures the perceived feeling of belonging and includes items such as 'I feel like I'm not always included by my circle of friends'. A modified version of this scale was used which did not include the 'self-esteem' subscale. The modified version consisted of

30 questions. A four-point scale (‘definitely true’, ‘probably true’, ‘probably false’ and ‘definitely false’) was used. The scores ranged from 0 to 120, with higher scores indicating better social support. Scores can be calculated as a total, and for each subscale separately. On the official web-page of the test (http://www.psy.cmu.edu:16080/~scohen/), reliability (alpha) is reported to vary from .77 - .86 to .88 - .90, depending on population.

Stress

Perceived Stress was measured with the Perceived Stress Scale (PSS) (Cohen, Kamarck, & Mermelstein, 1983). Participants rated how much their life appeared to be unpredictable and uncontrollable on a 5-point scale (‘Never’ ‘Almost Never’, ‘Sometimes’, ‘Fairly often’ and ‘Very often’). The scores ranged from 0 to 40, with lower scores indicating lower stress. Four items were reversed scored. Examples of the questions include ‘In the last month, how often have you found that you could not cope with all the things that you had to do?’ and ‘In the last month, how often have you felt that you were on top of things?’. The scale showed adequate reliability and validity (Cohen, Kamarck, & Mermelstein, 1983).

Immigration stress

Immigration stress was measured by Demands of Immigration Scale (DI) (Aroian, Norris, Tran, & Schappler-Morris, 1998). The DI has been specifically validated with FSU immigrants in several studies (Aroian & Norris, 2003; Aroian, et al., 1998). The scale consists of 23 items and measures demands related to immigration, such as loss (‘I miss the people I left behind in my original country’), novelty (‘I have to depend on other people to show or teach me how things are done here’), occupational adjustment (‘I have less career opportunities than Australians’), language difficulties (‘Australians have a hard time understanding my accent’), discrimination (‘People with foreign accents are treated with less respect’), and not feeling at home in the host country (‘I do not feel that this is my true home’). Participants rated their distress along a six-point scale, ranging from not at all (0) to

very much (5) distressed, with higher scores indicating greater distress. Previous studies showed good internal consistency and test-retest reliability (Aroian & Norris, 2003).

Acculturation

Level of acculturation was measured by the 54 item Language, Behaviour and Identity scale (LIB) (Birman & Trickett, 2001). The scale was developed with particular consideration for Russian immigrants in the US. This scale was adapted to the current study by changing references to American culture and language to Australian culture and language. LIB is a bi-dimensional scale in that it does not provide the overall score for acculturation, rather two separate acculturation scores for Australian (AAI) and Russian (RAI) acculturation indices (27 items per Index). RAI and AAI can be further divided into three subscales each: language, identity and behaviour, assessed on a 4-point Likert-type scale (1 = not at all to 4 = very much) and consisting of parallel items, for example 'I am proud of being Russian/Australian', How much do you read Australian/Russian books, newspapers, or magazines?'. Scores range from 27 to 108, with higher score indicated greater acculturation to a Russian/Australian culture. Previous studies reported high Cronbach's alpha reliability scores (Birman, Trickett, & Buchanan, 2005; Birman, Trickett, & Vinokurov, 2002).

Depression Stigma

Stigmatizing attitudes towards depression were measured using Depression Stigma Scale (DSS), consisting of 9 items assessing own attitudes towards depression (Personal stigma) and 9 items assessing perceived views of others towards depression (Perceived Stigma) (Griffiths et al., 2006). Participants were presented with a vignette about John, a 30 year old with depressive symptoms satisfying DSM criteria for major depressive disorder. A 5-point Likert scale (from 1 = strongly agree to 5 = strongly disagree) was used to measure the responses. Both subscales contained the same items with slightly different wordings, for example 'A problem like John's is a sign of personal weakness' for Personal stigma, and

'Most people believe that a problem like John's is a sign of personal weakness' for Perceived stigma. Previous studies showed good reliability of the scale (Copelj & Kiropoulos, 2011).

Help-seeking attitudes

Help-seeking attitudes were measured by the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) (Mackenzie, Knox, Gekoski, & Macaulay, 2004), adapted from Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Turner, 1970). IASMHS scale consisted of 24 items measuring three factor subscales: Psychological Openness (openness to acknowledge psychological problems), Help-seeking Propensity (willingness to seek help for mental help issues), and Indifference to Stigma (concerns that the person might have with other people's reaction to their mental problems). Ratings for each item were made on a 5-point sliding scale from disagree to agree, with higher scores indicating more positive overall attitude to psychological help-seeking. Several items were reversed scored. Example of the questions are 'There are certain problems which should not be discussed outside of one's immediate family', 'If good friends asked my advice about a psychological problem, I might recommend that they see a professional'. The inventory showed moderate to high alpha coefficients and test-retest reliability (Mackenzie, Gekoski, & Knox, 2006).

The next part is divided into three chapters; each corresponding to the research aims described above. Data analysis for each research question is described in detail in the relevant chapter.

PART III

EMPIRICAL ANALYSES

Chapter 5

Depressive and anxiety symptoms in Russian-speaking skilled immigrants from FSU: a comparison with Anglo-Australians and a Russian-speaking non-immigrant group

Preamble to Paper 1

This chapter presents the first empirical study of the thesis. The paper provides an overview of studies of immigrants' mental health in Australia and overseas, with specific focus on skilled immigrants and Russian-speaking immigrants. Socio-demographic and depressive and anxiety symptoms were measured in these three groups. The first research question of this thesis was answered by comparing the three groups on their depressive and anxiety symptoms, while controlling for the differences in socio-demographic variables. Given the number of mental health problems reported in the immigrants in Australia and overseas, and a large number of skilled immigrants arriving recently to Australia, it is important to obtain information on skilled immigrants. Further analysis in understanding of a pattern and factors contributing/ protecting immigrants, specifically skilled immigrants, from mental health problems is required in the future studies. The results of this paper were important for the decision made regarding second aim of the thesis (see chapter 6).

The article has been submitted for publication to the journal *Transcultural Psychiatry*, a peer-reviewed journal publishing articles on cultural psychiatry and mental health, discussing issues on the cultural influences on psychopathology to cultural determinants of psychotherapy. The impact factor of the journal is 0.984, 80/100 (Psychiatry), 27/76 (Anthropology).

Declaration for Thesis Chapter Five

Monash University

Declaration by candidate

In Chapter five (Paper 1), the nature and extent of my contribution to the work was as follows:

Nature of contribution	**Extent of contribution (%)**
Participation in design, formulation of ideas, data analyses and securing ethics approval; review of appropriate literature; review of materials; recruitment of participants; data collection; and draft and revision of this paper.	70%

The following co-authors contributed to the work. Co-authors who are students at Monash University must also indicate the extent of their contribution in percentage terms:

Name	**Nature of contribution**	**Extent of contribution (%) for student co-authors only**
Litza A. Kiropoulos	Conceptualisation of study design, assisted in preparation of statistical section and ethics; assisted in the preparation of the manuscript	30%

Candidate's Signature		**Date**

Declaration by co-authors

The undersigned hereby certify that:

(1) the above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

(2) they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

(3) they take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

(4) there are no other authors of the publication according to these criteria;

(5) potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and

(6) the original data are stored at the following location(s) and will be held for at least five years from the date indicated below:

Location(s)	Locked filing cabinet, Social Sciences and Health Research Unit, Monash University

[Please note that the location(s) must be institutional in nature, and should be indicated here as a department, centre or institute, with specific campus identification where relevant.]

Signature 1		**Date**
Signature 2		
Signature 3		

Paper 1: Depressive and anxiety symptoms in Russian-speaking skilled immigrants from the Former Soviet Union (FSU) living in Australia: a comparison with Anglo-Australians and Russian-speaking non-immigrant group

Authors: Alla Demutska, School of Psychology and Psychiatry, Monash University

Litza A. Kiropoulos Psychological Sciences, The University of Melbourne, School of Psychology and Psychiatry, Monash University

Address:

Alla Demutska

Faculty of Medicine, Nursing and Health Sciences

Monash University,

Victoria 3800

Australia

Tel: [redacted] Fax: [redacted]

E-mail: [redacted]

Running Title: Depression and anxiety in immigrants from the FSU

Keywords: depression, anxiety, Russian-speaking immigrants, Former Soviet Union, Australia

Word count: abstract – 135; Text – 4 980

ABSTRACT

In this article, we compare levels of depressive and anxiety symptoms in immigrants from the former Soviet Union (FSU) living in Australia, who arrived on the skilled migration program, with a Russian-speaking sample living in the FSU and an Anglo-Australian sample. Sixty five Russian speaking immigrants, 65 Russian speaking non-immigrants and 63 Anglo-Australians were recruited through social clubs, community web forums and web groups, churches, schools, and universities. Participants completed online questionnaires which included the Centre for Epidemiologic Studies Depression Scale, the State-Trait Anxiety Inventory, Interpersonal Support Evaluation List, Perceived Stress Scale and socio-demographic questions. Results indicated that the immigrant group scored significantly lower on the depression and anxiety measures than the two comparative groups. Although demographic differences between three groups were observed, they did not account for the differences in depressive and anxiety symptoms.

Immigrants constitute 24 percent of the Australian population (Australian Bureau of Statistics [ABS], 2011), with the annual number of skilled immigrants having increased from 24 000 in 1996-7 to 92 000 in 2005–06, making this category the largest amongst other permanent visa categories in Australia (Linacre, 2007). As part of the skilled migration visa category, applicants have to meet stringent criteria including being under 45 years of age and of good health, be proficient in English, and possess qualifications which are in demand in Australia (Department of Immigration and Citizenship [DIAC], 2008). After the collapse of the Soviet Union in 1990s, many Russian-speaking immigrants from the countries now constituting the former Soviet Union (FSU) started to arrive on the skilled migration program, with total Russian-speaking population exceeding 36 000 people (ABS, 2008). The majority of recent skilled immigrants are highly educated, with good English skills, and are typically employed as professionals (DIAC, 2010). The 2006 Census showed that within Australia, the

majority of Russian-speaking immigrants lived in New South Wales and Victoria, with these immigrants identifying as being of Jewish, Russian, or Ukrainian ancestry (DIAC, n.d.)

Depression and anxiety are among the most commonly identified psychological problems in immigrants in Australia (Kiropoulos, Klimidis, & Minas, 2004; Tang, Dennis, & Comino, 2009; Thompson, 2002) and internationally (Ataca, 1998; Oh, Koeske, & Sales, 2002; Pernice & Brook, 1996; Gonidakis, et al., 2011). Several explanations have been proposed for high levels of anxiety and depression found in immigrants. These have included 'culture shock' model, suggestions that people who are predisposed to psychopathology are more likely than others to migrate, and stress and coping approach (Berry, 2006b; Oberg, 1960; Ward et al., 2001). In addition, immigrants and refugees are more likely to experience pre- and post-migration risk factors such as traumatic experiences, separation from family and friends, inability to speak the host country language, unemployment, and a drop in socio-economic status (Gonidakis, et al., 2011; Kiropoulos, Klimidis, & Minas, 2004; Thompson, Hartel, Manderson, Woelz-Stirling, & Kelaher, 2002).

In contrast, some studies have reported less anxiety, depressive and other mental health symptoms in immigrants than the host population, for example, some immigrants in Australia (Alati, Najman, Shuttlewood, Williams, & Bor, 2003; Davies & McKelvey, 1998; Klimidis, Stuart, & Minas, 1994; Steel et al., 2009), Canada (Ali, 2002; Gee, Kobayashi, & Prus, 2004) and in the US (Escobar et al., 1998; Vega et al., 1998). Some explanations for these results include the protective role of the traditional family, different perceptions of success, and lower substance abuse (Escobar, Nervi, & Gara, 2000). Another explanation is the so-called 'healthy immigrant effect', which states that people who are generally healthier apply to immigrate and are more likely to be accepted as immigrants (Flores & Brotanek, 2005; Gee et al., 2004; Mirsky, Slonim-Nevo, & Rubinstein, 2007).

Another explanation to account for differences in the mental health of immigrants is the

size of the immigrant group relative to the host society (Murphy, 1977). It has been suggested that the smaller immigrant groups are more likely to be affected by mental health problems than larger groups. For example, FSU immigrants in Germany and Israel were shown to adapt differently: adolescents in Israel showed improved well-being with increasing years of residency, while adolescents in Germany showed deterioration in well-being (Mirsky et al., 2007). The Russian-speaking community in Israel comprises around one fifth of its population, while in Germany the proportion is much smaller. Russian-speaking immigrants have established a strong community in Israel, with their own TV, newspapers and restaurants. This can facilitate adaptation of the Russian-speaking group in Israel, while a supportive social context is less prominent in Germany (Mirsky et al., 2007).

Most studies examining immigrant groups have employed a two group design, comparing immigrants with a local, non-immigrant group. However, this design does not measure whether characteristics of those who stay in the country of origin differ from those who have immigrated (Berry, 2006). Ataca (1998) examined the mental health of three groups: Turkish immigrant couples in Canada, non-immigrant Canadian couples, and Turkish couples in Turkey. Both Turkish groups were shown to have more psychological difficulties than Canadian couples, with no difference in scores between two Turkish groups (Ataca, 1998). Another study, employing a three group design, was conducted in Australia by Steel and colleagues (2009). They showed more mental health issues, such as substance use, and mood and anxiety symptoms, in Australians compared to Vietnamese immigrants living in Australia and Vietnamese non-immigrants living in Vietnam. But in addition, Vietnamese non-immigrants reported better mental health than Vietnamese immigrants to Australia when a diagnostic measure including culturally relevant items was administered (Steel et al., 2009).

Few studies document the mental health of skilled immigrants specifically. A recent cross-sectional study, conducted in New Zealand with three skilled immigrant groups from

India, China and South Africa, did not reflect lower levels of psychological well-being in these groups compared to the local population (Alpass et al., 2007). These findings highlight the importance of defining the sample, as skilled and humanitarian immigrants who arrive from the same country, can have very different trajectories of psychological adaptation.

In Australia, Richardson and colleagues (2002) examined psychological distress employing the general Health Questionnaire in two cohorts of recently arrived immigrants. The two cohorts also included immigrants on humanitarian and family stream visas. One cohort included a high percentage of immigrants who held skilled migration visas, with these immigrants possessing higher educational levels, better English language skills, and more likely to be employed post-immigration. Even so, 26% of immigrants in both cohorts had symptoms of significant psychological distress compared to 8% of the Australian population (Richardson et al., 2002).

To our knowledge, no research examining depressive and anxiety symptoms has been conducted among specific groups of skilled immigrants, in particular Russian-speaking immigrants living in Australia. Results of research examining depression and anxiety in FSU immigrants in other countries have been equivocal. For example, research conducted in the US, Israel, and Germany has shown that levels of depression are higher in this population than their host counterparts (Aroian & Norris, 1999; Flaherty, Kohn, & Levav, 1988; Gutkovich et al., 1999; Kohn, Flaherty, & Levav, 1989; Miller & Chandler, 2002; Ritsner & Ponizovsky, 1999; Ullman & Tatar, 2001). Results have also shown that depression and distress related to acculturation in this group has been found to be long-standing (Aroian & Norris, 2002; Ponizovsky et al., 1998) and that FSU immigrants have also been found to display more difficulties adjusting than immigrants from other countries (Ponizovsky et al., 1998) and tend to show their distress through somatic symptoms (Kohn et al., 1989; Ritsner, Ponizovsky, Kurs, & Modai, 2000). However, in a study conducted in Sweden, Russian immigrants did

not display higher levels of psychiatric illness and psychosomatic complaints compared to the local population, and were shown to adapt better than immigrants from Poland and other countries of Eastern Europe (Blomstedt, Johansson, & Sundquist, 2007).

Despite the fact that 'skilled immigration' is the fastest growing migration stream in Australia, data and systematic research on the mental health of this population is lacking. On the one hand, it can be argued that Russian-speaking skilled immigrants are expected to adapt better than many other immigrant groups due to several protective factors, including better English proficiency, younger age, better physical health, and better professional prospects. On the other hand, smaller immigrant groups relative to the larger host society have been shown to have more mental health issues. Previous studies cited above have shown that Russian-speaking immigrants have difficulties with adaptation in host countries, typically have high levels of mental health problems compared to the host and other immigrant groups, often do not seek professional help, utilizing their immediate social networks instead, and their mental health difficulties are long-standing (Aroian & Norris, 1999; Aroian & Norris, 2002; Flaherty, Kohn, & Levav, 1988; Gutkovich et al., 1999; Kohn, Flaherty, & Levav, 1989; Miller & Chandler, 2002; Ponizovsky et al., 1998; Ritsner & Ponizovsky, 1999; Ullman & Tatar, 2001). The research we discuss here provided much needed information on the mental health status of skilled immigrants from FSU living in Australia. Specifically, we examined the levels of depression and anxiety symptoms in Russian-speaking immigrants in Australia compared to non-immigrants living in FSU, and an Anglo-Australian group.

METHOD

Participants

Overall, 193 adults participated in the current study. Three groups were targeted, which included Russian-speaking immigrants living in Australia, Anglo-Australians living in Australia, and Russian-speaking non-immigrant group living in the FSU.

Russian immigrant sample

Sixty five Russian immigrants (37 females and 28 males), who were living in Australia with an average age 35.2 (*SD* = 6.1), participated in the study. All participants arrived on a skilled immigration visa program. Only main applicants and their spouses were included in the sample.

Russian-speaking immigrants are a heterogeneous group both in terms of their immigration pathways and ethnicity. Skilled immigrants are the latest wave of Russian-speaking immigrants, starting to arrive after the collapse of the Soviet Union in 1991. Unlike earlier immigrants who were often persecuted or selectively discriminated in Soviet Union (Christa, 2001), most skilled immigrants were not directly threatened by the political regime and made it their choice to migrate. The FSU comprises of a variety of ethnicities and nationalities, with Ukrainians, Belarusians, Moldavians, and Russians the most widespread and numerous cultural groups. In the current study, the majority of participants identified as being either Russian or Ukrainian; all were fluent in the Russian language.

Anglo-Australian sample

Sixty three Anglo-Australian participants (54 females and 9 males), with a mean age of 29 years (*SD* = 6.3), living in Australia, completed questionnaires. Only those who were born in Australia and whose parents and grandparents were of an Anglo-Celtic background (that is, born in Australia, England, Scotland, Wales or Ireland) were included in the sample.

Russian non-immigrant group

Sixty five participants (56 females and 9 males) with a mean age of 30 years (*SD* = 8.8) currently living in Russia (69.2%), Ukraine (23.1%), and Belarus (7.7%) participated in the study. Three from 15 FSU countries were chosen for several reasons, including that participants were required to be fluent in the Russian language and the majority of the

population in these three countries speak and understand Russian; and appropriate services for psychological support for participants with high levels of depressive and anxiety symptoms were available in these countries while these services are not readily available across all FSU countries.

Procedure

The Monash University Human Research Ethics Committee granted approval for this study. English language versions of the questionnaires were translated into Russian by the first author, who is fluent in both Russian and English, who has a linguistics degree, and at the time was a Provisional Psychologist. After translation, both English and Russian versions were verified with another bilingual immigrant, who also had both linguistics and psychology background. The final translations were verified by a professional bilingual translator. All suggested corrections were discussed among those involved in the translation process. This method allowed us to make the most of the knowledge of the bilingual mental health professionals, and thus it was preferred over the sequential translation/back translation method. Reliability was checked by examining the psychometric properties of the scales after data were collected and preceding any further analysis.

Russian-speaking immigrants were recruited through flyers advertising the project at ethnic-specific social clubs and organizations in metropolitan areas of Melbourne; advertisements in Russian-community web-forums; and advertisements in Russian newspapers in Australia. Russian-speaking non-immigrant and Anglo-Australian groups were recruited through advertisements in Russian-community web-forums (for the Russians) and Melbourne web-forums (for the Anglo-Australians), including the university web board; and advertisements on Facebook and Russian networking web communities (similar to Facebook).

All questionnaires were completed on line. Participants received an explanatory statement about the project and signed an electronic consent before proceeding to the

questionnaire. All demographic information, depression and anxiety scores were collected through a secure Monash University website. Web alerts were in place to identify participants with high depressive and anxiety scores, and e-mails were sent to participants with high scores regarding information about depression and anxiety, in addition to appropriate psychological support services in the local area.

Statistical analyses were undertaken using SPSS V 18.

Materials

All three groups completed an on-line questionnaire assessing socio-demographic background, levels of depressive and anxiety symptoms, social support, attitudes towards mental health, help-seeking behaviour, and perceived stress. Additionally, the Russian-speaking immigrant group completed scales related specifically to their immigration experience, including immigration stress and acculturation scales. Only scales relevant to the current article will be described.

Demographic information

All participants were asked to complete questions related to gender, date of birth, occupation, educational level, self-assessed health level, relationship status, and employment status.

Depression

Symptoms of depression in participants were measured with the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977). The CES-D consists of 20-items and reflects such depressive symptoms as depressed mood, feelings of worthlessness and hopelessness, loss of appetite, poor concentration, and sleep disturbance. Responses lie on a four-point scale. Scores of 21 or more indicated possibility of depression. This number was used as a cut-off score for generating a semi-automatic email to participants with referral

information. In the current study CES-D had good internal consistency as measured by Cronbach's alpha (0.86 - 0.88 for the two Russian-speaking samples, and .92 for Anglo-Australian sample).

Anxiety

Anxiety was measured with the 20-item state version of the State-Trait Anxiety Inventory (STAI), developed by Spielberger, Gorsuch, and Lushene (1970). It is the most widely used anxiety scale and the scale has been used extensively in cross-cultural research (Abbassi & Stacks, 2007; Iwata & Higuchi, 2000; Kiropoulos, Klimidis, & Minas, 2004; Kiropoulos, Griffiths, & Blashki, 2011). Responses lie on a four-point scale (from 'not at all' to 'very much so'). The scores ranged from 20 to 80, with higher scores indicating more severe anxiety symptoms. In the current study, the state version of STAI displayed good internal consistency with Cronbach's alphas being 0.92 for the Russian-speaking immigrant group, 0.95 for the Russian-speaking non-immigrant group, and .93 for the Anglo-Australian sample.

Social Support

Social Support was measured with the Interpersonal Support Evaluation List for the General Population (ISEL), developed by Cohen and colleagues (1985). The ISEL measures four separate functions of social support, with each consisting of a list of 10 statements. The 'tangible' social support measures perceived amount of tangible help. The 'appraisal' social support subscale measures the perceived availability of emotional support. The 'belonging' subscale measures the perceived feeling of belonging. A modified version of this scale was used which did not include the 'Self-esteem' subscale. The modified version consisted of 30 questions, measured on a four-point scale (from 'definitely true', to 'definitely false'). The scores ranged from 0 to 120, with higher scores indicating better social support. Scores can be calculated as a total, and for each subscale separately. The scale reliability, as measured by

Cronbach's alpha, was 0.95 for the Russian-speaking immigrant group, 0.92 for the Russian-speaking non-immigrants, and .94 for the Anglo-Australian sample.

Perceived Stress

Perceived Stress was measured with the Perceived Stress Scale (PSS) (Cohen, Kamarck, & Mermelstein, 1983). Participants rated how much their life appeared to be unpredictable and uncontrollable on a 5-point scale (from 'Never' to 'Very often'). The scores ranged from 0 to 40, with lower scores indicating lower stress. In the current study the scale had good internal consistency as measured by Cronbach's alpha (0.88 and 0.9 for the two Russian-speaking samples, and .91 for the Anglo-Australians).

Results

Table 5.1 summarizes the descriptive characteristics for the Russian-speaking immigrant, Russian-speaking non-immigrant, and Anglo-Australian groups. Chi-square tests of independence showed that the three groups differed significantly on the following variables: gender, χ^2 (2, N = 193) = 20, p < .01, relationship status, χ^2 (2, N = 193) = 48, p <.01, education, χ^2 (8, N = 193) = 133.7, p <.01, employment status χ^2 (6, N = 192) = 17.9, p <.001, and health status χ^2 (8, N = 192) = 25.9, p <.01). Russian-speaking immigrants were more likely to be married, had higher levels of education, more likely to be employed full-time and less likely to be unable to work than the two non-immigrant groups. One-way analyses of variance (ANOVA) indicated that age [F (2, 187) = 12.96, p < .01] and level of perceived stress [F (2, 176) = 15.9, p < .01] were significantly different between the three groups. In terms of effect size, calculated using eta squared, the actual difference was of medium size (.12) and large size (.15) respectively. Post-hoc comparisons using Tukey's HSD showed that the Anglo-Australian group scored significantly higher on the perceived stress measure (M=20.69, SD=8.3) compared to the immigrant group (M=13.2, SD=5.9) and the Russian-speaking non-immigrant group (M=16, SD=7.6), while mean stress levels were not

significantly different between two Russian-speaking groups. Post-hoc comparisons using Tukey's HSD test indicated that the mean age of the Russian-speaking immigrant group (M = 35.2, SD = 6.1) was significantly higher than the mean ages of both the Russian-speaking non-immigrant group (M = 30.4, SD = 8.8) and the Anglo-Australian group (M = 29.1, SD = 6.3). Mean ages of the Anglo-Australian and Russian-speaking non-immigrant groups were not significantly different. Social support scores did not differ significantly between groups [F (2, 174) = .38, p = .963].

Table 5.1

Demographic Characteristics of Russian-speaking Immigrants, Russian-speaking Non-immigrants, and Anglo-Australians

Variables		Russian-speaking immigrants *N (%)*	Russian-speaking non-immigrants *N (%)*	Anglo-Australians *N (%)*
Relationship status	Married/De facto	46 (70.8)	37 (56.9)	21 (33.3)
	Widow/Widower	0	0	0
	Divorced/Separated	15 (23.1)	4 (6.2)	3 (4.8)
	Never married	4 (6.2)	24 (36.9)	38 (61.3)
Highest Educational Level	School	0	3 (4.6)	15 (23.8)
	College or TAFE	3 (4.6)	3 (4.6)	9 (14.3)
	Bachelor	0	1 (1.5)	32 (50.8)
	Master's	54 (83.1)	46 (70.8)	5 (7.9)

	PhD	8 (12.3)	12 (18.5)	2 (3.2)
Employment Status *	Full time	49 (64.9)	30 (46.2)	26 (41.9)
	Part time	9 (13.8)	19 (29.2)	23 (37.1)
	Not working/ Looking for work	14 (21.5)	10 (15.4)	11 (17.7)
	Unable to work due to illness or injury	0	6 (9.2)	2 (3.2)
Health **	Very good/Good	60 (92)	39 (60)	39 (63)
	Satisfactory	5 (8)	26 (40)	20 (32)
	Very poor/ Poor	0	0	3 (5)

* collapsed into 4-point scale due to statistical requirements

** collapsed into 3-point scale due to statistical requirements

The demographic and stress variables may moderate differences in anxiety and depression if the variables correlate significantly with the dependent variables. Table 5.2 summarizes the correlations between the demographic variables, stress, social support and the dependent variables. As can be seen, all variables were significantly correlated with anxiety and depression scores, apart from employment status.

A one-way analysis of variance (ANOVA) was used to explore differences in depression and anxiety scores between the three groups. There was a statistically significant difference in depression scores [$F(2, 190) = 26.2$, $p < .001$, $\eta^2 = .22$] and anxiety scores [$F(2, 190) = 23.62$, $p < .001$, $\eta^2 = .2$] between three groups. Post-hoc comparisons using Tukey's HSD test indicated that the Anglo-Australian group reported significantly higher depression scores ($M = 21.35$, $SD = 11.64$) than both Russian-speaking groups. The Russian-speaking

non-immigrant group (M = 14.8, SD = 9.56) was significantly higher on depression scores than the immigrant group (M = 8.83, SD = 7.85). The Anglo-Australian group reported significantly higher anxiety scores (M = 45, SD = 11.51) than both Russian-speaking groups. The Russian-speaking non-immigrant group (M = 37.29, SD = 13) was significantly higher on anxiety scores than the immigrant group (M = 31.37, SD = 8.83).

Table 5.2

Pearson Product-Moment Correlations between Demographic variables, and Anxiety and Depression Scores

	1	2	3	4	5	6	7	8
(1) Age								
(2) Gender	-.38**							.
(3) Relationship status	.42**	-.09						
(4) Highest Educational Level	.19**	-.02	.26**					
(5) Employment Status	-.09	.17*	-.029	-.17*				
(6) Health Status	-.12	.07	-.14*	-.24**	.27**			
(7) CES-D	-.25**	.27**	-.41**	-.30**	.14	.42**		
(8) STAI	-.21**	.29**	-.37**	-.20**	.16*	.33**	.80**	
(9) Perceived Stress	-.22**	.29**	-.33**	-.20**	.13	.41**	.80**	.78**

*p>. 05

**p<.01

A series of independent analyses of covariance (ANCOVAs) were also carried out to remove the independent effects of those variables that correlated significantly with anxiety and depression scores. Table 5.3 summarizes the results for anxiety. Group differences for anxiety scores remained after controlling individually for age, gender, relationship status, highest educational level, employment and health status, and stress. Post-hoc analyses were not undertaken, and differences among the groups have yet to be explored.

Table 5.3

Summary of Independent ANCOVA for Anxiety

Covariate	df_1, df_2	F	p	η^2
Age	2, 186	18.5	< .001	.17
Gender	2, 189	18.3	<.000	.16
Relationship status	2, 188	14.7	<.000	.14
Highest Educational Level	2, 189	19.3	<.000	.17
Employment Status	2, 188	22.3	<.000	.192
Health	2, 188	17.9	<.000	.16
Perceived Stress	2, 175	7.8	.001	.08

Table 5.4 summarizes the results for depression. Group differences for depression remained after controlling individually for age, gender, relationship status, highest educational level, employment and health status, and stress. Only stress reduced the effect of group on depression to a great extent. Post-hoc analyses were not undertaken, and differences among the groups have yet to be explored.

Table 5.4

Summary of Independent ANCOVA for Depression

Covariate	df_1, df_2	*F*	*p*	η^2
Age	2, 186	19.6	<.001	.17
Gender	2, 189	20.68	<.000	.18
Relationship status	1, 188	16.03	<.000	.15
Highest Educational Level	2, 189	15.4	<.000	.14
Health	2, 188	19.3	<.000	.17
Perceived Stress	2, 175	6.2	.002	.07

Discussion

In this study, Russian-speaking skilled immigrants living in Australia reported lower levels of depressive and anxiety symptoms than Russian-speaking non-immigrants and Anglo-Australians. In addition, Russian-speaking non-immigrants reported higher depression and anxiety scores than the immigrant group living in Australia. Significant differences in reported levels of depression and anxiety symptoms between the three groups were still present after controlling for demographic variables in which the three groups differed such as age, gender, relationship status, highest educational level, employment and health status, and stress.

The current findings that the Russian-speaking skilled immigrants reported lower levels of anxiety and depressive symptoms compared to the Russian-speaking non-immigrants and Anglo-Australians are in line with previous research which has found that immigrants and their children had better mental health when compared to their host counterparts in Australia (Steel et al., 2009; Alati, Najman, Shuttlewood, Williams, & Bor, 2003; Davies & McKelvey,

1998; Klimidis, Stuart, & Minas, 1994). Current findings are also in line with previous research undertaken internationally which has found that immigrants living in Canada were shown to have better mental health, compared to non-immigrants (Gee, Kobayashi, & Prus, 2004; Ali, 2002); in the US Mexican-born immigrants were found to better mental health (Escobar et al., 1998; Vega et al., 1998); in New Zealand skilled immigrants from India, China and South Africa in New Zealand were found to have comparable mental health to the local population (Alpass et al., 2007); and in Sweden and in the US Russian-speaking immigrants also showed comparable or lower levels of psychopathology compared to the local population (Blomstedt, Johansson, & Sundquist, 2007; Hoffmann et al., 2006).

However, contrary to our results, many studies have identified higher levels of depressive and anxiety symptom reporting in immigrants living in Australia (Kiropoulos, Klimidis, & Minas, 2004; Khavarpour & Rissel, 1997; Krupinski, 1981; McDonald, Vechi, Bowman, & Sanson-Fisher, 1996; Thompson, 2002; Tang, Dennis, & Comino, 2009) and in other countries, such as Canada, USA, and New Zealand (Ataca, 1998; Oh, Koeske, & Sales, 2002; Pernice & Brook, 1996). The majority of studies examining the mental health of Russian-speaking immigrants indicated higher levels of distress in this group compared to their host counterparts (Aroian & Norris, 1999; Flaherty, Kohn, & Levav, 1988; Kohn, Flaherty, & Levav, 1989; Ritsner & Ponizovsky, 1999; Ponizovsky et al., 1998; Miller & Chandler, 2002; Ullman & Tatar, 2001; Gutkovich et al., 1999).

The differences between characteristics of our Russian-speaking immigrant sample and Russian-speaking immigrant samples employed in previous research can provide an explanation for the results obtained. Participants in the current study migrated voluntarily and were not persecuted in the FSU, while some previous research with Russian-immigrants employed refugees who had some pre-migratory traumatic experiences (for example, Aroian & Norris, 1999). Participants in the skilled immigrant group recruited for this study were

relatively young (with a mean age of 35 years), compared to previous studies which primarily recruited and examined mid to older aged Russian-speaking immigrants (Aroian & Norris, 1999; Kohn, Flaherty, & Levav, 1989; Miller & Chandler, 2002; Gutkovich et al., 1999; Ponizovsky et al., 1998). Hoffman and colleagues investigated levels of depression and anxiety in recently arrived, relatively young Russian-speaking immigrants, who came to the US mostly seeking economic and occupational opportunities (Hoffmann, et al., 2006). This study, like our study, found that Russian-speaking immigrants had lower prevalence rates of both anxiety and depression compared to Americans (Hoffmann, et al., 2006). The Russian-speaking immigrants in our study also reported good health, with 92 percent rating their health as very good or good. Skilled migrants often have high levels of education, which was certainly true for the current sample. Having a better education can facilitate cultural learning, skills acquisition, and, in turn, better professional outcomes and higher socio-economic status (SES). For example, education was shown to be important for better sociocultural adjustment in a group of Polish, Russian, Hungarian immigrants in the Netherlands (Polek, van Oudenhoven, & ten Berge, 2007). In addition, level of education was found to serve as a buffer against distress in women from FSU in the USA (Aroian, Norris, & Chiang, 2003). While many of the previous studies with Russian-speaking participants employed highly educated samples (Aroian & Norris, 1999; Gutkovich et al., 1999; Kohn, Flaherty, & Levav, 1989; Ponizovsky et al., 1998), the majority of participants in our sample also worked full time. Unemployment has been found to be negatively related to the psychological well-being among the general population (Kessler, Turner, & House, 1987), and, in addition, has been found to be a significant predictor for depression in FSU immigrants in the US (Aroian & Norris, 2002). In contrast to our sample, Russian-speaking immigrants in previous research reported high unemployment rates which may have contributed to the higher rates of psychological distress reported in this group (Aroian & Norris, 1999; Gutkovich et al., 1999; Kohn, Flaherty, & Levav, 1989).

Another factor that may contribute to the lower levels of depressive and anxiety symptoms reported by the current sample is the level of social support. Our study found comparable levels of social support between three groups. Social support in immigrant groups has been shown to be negatively related to level of depression (Pernice & Brook, 1996; Seeman, 1996; Thoits, 1995) and positively related to psychological well-being (Sands & Berry, 1993; Vega, Kolody, Valle, & Hough, 1986; Vega, Kolody, Valle, & Weir, 1991). Previous studies with Russian-speaking immigrants indicated that social support tended to be lower in this group compared to the general USA population (Kohn, Flaherty, & Levav, 1989). Lack of social support was shown to be a significant predictor of demoralization for Russian-speaking immigrants to the USA and Israel (Ritsner, Ponizovsky, & Ginath, 1997).

Lower levels of depressive and anxiety symptoms in Russian-speaking immigrants may also be due to the scales used, which were developed and validated on English-speaking (and primarily US) populations. The concepts used in these scales, even with valid translation, can be unfamiliar or seem strange to those of a Russian background. Indeed, when culturally derived diagnostic measures were used with Vietnamese non-immigrants and Vietnamese immigrants to Australia, the prevalence rates for mental disorders for both groups increased (Steel et al., 2009). Scales, allowing for culturally relevant expressions of psychological distress, may have rendered different results to those obtained in the current study for the Russian immigrants.

In line with this, many immigrants were shown to manifest their anxiety and depression symptoms through somatic presentation (Kleinman, 2004). Reporting of somatic symptoms can be viewed as more culturally acceptable in many ethnic groups rather than communicating their psychological difficulties, especially in primary health care settings (Aragona et al., 2010, Kleinman, 2004). For example, Russian-speaking immigrants tended to somatise their anxiety and depressive symptoms (Aroian & Norris, 1999; Kohn et al., 1989;

Ritsner, Ponizovsky, Kurs, & Modai, 2000). Several explanations were suggested, including existence of mental illness stigma and abuse of psychiatric diagnosis in FSU (Ritsner et al., 2001). However, in the current study, we did not use any specific somatisation scales to examine whether the current group of immigrants were somatising` symptoms of depression and anxiety.

The Anglo-Australian sample employed in the current study had high levels of depressive and anxiety symptoms as reported by CES-D and STAI. The mean CES-D score in the Anglo-Australian group was very high, compared to the US sample (Radloff, 1977), or to a similar aged Australian sample (Simpson, Schumaker, Dorahy, & Shrestha, 1996). The mean CES-D score of the Russian immigrant group in the current study was lower compared to the US sample (Radloff, 1977), and much lower than the mean score in midlife immigrant women from FSU living in the US (Miller & Chandler, 2002).

Previous research with American (Poltavski & Ferraro, 2003) and Anglo-Australian participants (Kiropoulos, Klimidis, & Minas, 2004; Khan, Marlow, & Head, 2008) showed lower STAI means compared to the mean of the Anglo-Australian sample in our study. It is not clear as to why Anglo-Australian participants in our research had such high scores on the anxiety and depression measures. As previous research has shown, women typically have higher scores on depression and anxiety measures (Nolen-Hoeksema, 1990). In the current study the majority of participants in two non-immigrant samples were women, with the immigrant group being more equally distributed on gender. However, the differences between three groups in anxiety and depression levels could not be attributed to gender as after controlling for gender, the differences between groups remained.

The current research used an on-line questionnaire which was advertised through various web forums, and consequently, we had no influence over the sampling. We have not explored if those responding were diagnosed with depression or anxiety disorders in the past

or present. It is possible that in Australia it is more common for those with high levels of anxiety and depression symptoms or a diagnosed mental health problem to search and access information via the Internet, while it might be less likely for Russian-speaking people to use the Internet for this purpose. Thus, those who may have a mental health problem or who had high levels of anxiety and depressive symptoms in Australia may have been more inclined to fill in a web-based survey on this topic.

We are not aware of a three group design employing a Russian-speaking immigrant population. It is not surprising that Russian-speaking participants currently living in FSU showed poorer mental health compared to the Russian-speaking immigrants, given lower standards of living in Russia, Ukraine, or Belarus. According to the 2010 Human Development Index, Australia occupied the second place in the three basic dimensions of human development, such as education, life expectancy, and income, while Russia and Ukraine were on the 65th and 69th place respectively (Human Development Report, 2010). However, because the study was cross-sectional, it is impossible to make any inferences as to whether immigration improved skilled immigrants' mental health, or whether skilled immigrants originally had better mental health status. It is surprising that Anglo-Australians displayed higher depression and anxiety symptoms compared to the Russian-speaking non-immigrant group, considering the Human Developmental Index. Similar to our study, Tennison and colleagues (2010) also found that American students in the US had more depressive symptoms compared to Russian students living in Russia, even though Russian students reported more traumatic life experiences.

Limitations

The current research included the use of self-rating scales in an online format, with non-random sampling. It is possible that those with anxiety and depressive symptoms in Australia use Internet to access relevant information, and thus fill in surveys on this topic. While the

methods employed to select our sample were similar for all three groups, three samples were different on a majority of socio-demographic measures. For example, the Russian-speaking immigrant group was older, more likely to be married, had higher levels of education, more likely to be employed full-time and less likely to be unable to work than the two other non-immigrant groups.

Future research should employ larger sample sizes so the results can be generalized to a wider Russian-speaking population in Australia. In addition, examination of other psychological variables, such as personality, may also be useful in explaining group differences on the mental health measures. Future research should also include culturally sensitive measures which take into account somatic presentation of psychological distress, validated in both English and Russian languages.

ACKNOWLEDGEMENTS

Special thanks to Professor Lenore Manderson for the comments on the draft of the article, Dr Kathryn Gilson, Monash University for initial input into the design of this study, and Professor Kim Ng, Monash University for his statistical advice.

REFERENCES

Abbassi, A., & Stacks, J. (2007). Culture and anxiety: a cross-cultural study among college students. *Journal of Professional Counseling, Practice, Theory, & Research, 35*, 26-37.

Alati, R., Najman, J. M., Shuttlewood, G. J., Williams, G. M., & Bor, W. (2003). Changes in mental health status amongst children of migrants to Australia: a longitudinal study. *Sociology of Health & Illness, 25*(7), 866-888.

Ali, J. (2002). *Mental health of Canada's Immigrants. Supplement to Health Reports*, (Cat. No.. 82-003). Ottawa: Statistics Canada. Retrieved January 11, 2011, from http://www.statcan.gc.ca/pub/82-003-s/2002001/pdf/82-003-s2002006-eng.pdf

Alpass, F., Flett, R., Trlin, A., Henderson, A., North, N., Skinner, M., et al. (2007). Psychological wellbeing in three groups of skilled immigrants to New Zealand. *Australian Journal of Rehabilitation Counselling, 13* (1), 1-13.

Aragona, M., Catino, E., Pucci, D., Carrer, S., Colosimo, F., Lafuente, M., et al. (2010). The relationship between somatization and posttraumatic symptoms among immigrants receiving primary care services. *Journal of Traumatic Stress, 23*(5), 615-622.

Aroian, K. J., & Norris, A. (2002). Assessing risk for depression among immigrants at two-year follow-up. *Archives of Psychiatric Nursing, 16*(6), 245-253.

Aroian, K. J., & Norris, A. E. (1999). Somatization and depression among former Soviet immigrants. *Journal of Cultural Diversity, 6*(3), 93-101.

Aroian, K. J., Norris, A. E., & Chiang, L. (2003). Gender differences in psychological distress among immigrants from the former Soviet Union. *Sex Roles, 48*(1-2), 39-51.

Ataca, B. (1998). *Psychological, sociocultural, and marital adaptation of Turkish immigrants in Canada.* Unpublished doctoral dissertation, Queen's University, Kingston, Ontario.

Australian Bureau of Statistics (2011). *Australian Demographic Statistics, Mar 2011.* Retrieved May 5, 2012 from http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0

Berry, J. W. (2006a). Design of acculturation studies. In D. L. Sam & Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology*. Cambridge: Cambridge University Press.

Berry, J. W. (2006b). Stress perspectives on acculturation. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 43-57). Cambridge Cambridge Univeristy Press.

Blomstedt, Y., Johansson, S. E., & Sundquist, J. (2007). Mental health of immigrants from the former Soviet Bloc: a future problem for primary health care in the enlarged European Union? A cross-sectional study. *Bmc Public Health, 7(27).*

Christa, B. (2001) Russians. In J. Jupp (Ed.), *The Australian People - An Encyclopaedia of the Nation, Its People and Their Origins* (pp.636-642). Cambridge: Cambridge University Press

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 385-396.

Cohen, S., Memelstein, R., Kamarck, T., & Hoberman, H. (1985). Measuring the functional components of social support. In I.G. Sarason & B. Sarason (Eds.), *Social support: Theory, research and application* (pp.73-94). The Hague: Martinus Nijhoff.

Davies, L. C., & McKelvey, R. S. (1998). Emotional and behavioral problems and competencies among immigrant and non-immigrant adolescents. *Australian and New Zealand Journal of Psychiatry, 32*(5), 658-665.

Department of Immigration and Citizenship (2008). *Visas, Immigration and Refugees.* Retrieved January 21, 2011, from http://www.immi.gov.au/skilled/general-skilled-migration/

Department of Immigration and Citizenship. (n.d.). *Community information summary Russian Federation-born.* Retrieved January 25, 2011, from http://www.immi.gov.au/media/publications/statistics/comm-summ/_pdf/russian-federation.pdf

Escobar, J. I., Gara, M., Silver, R. C., Waitzkin, H., Holman, A., & Compton, W. (1998). Somatisation disorder in primary care. *British Journal of Psychiatry, 173*, 262-266.

Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry, 8*(2), 64-72.

Flaherty, J. A., Kohn, R., & Levav, I. (1988). Demoralization in Soviet-Jewish immigrants to the United States and Israel. *Comprehensive Psychiatry, 29*, 588-597.

Flores, G., & Brotanek, J. (2005). The healthy immigrant effect. *Archives of Pediatrics and Adolescent Medicine,* 159(3), 261-265.

Gee, E. M., Kobayashi, K. M., & Prus, S. G. (2004). Examining the healthy immigrant effect in mid- to later life: findings from the Canadian Community Health Survey. *Canadian Journal of Aging Supplement*, S55-S63.

Gonidakis, F., Korakakis, P., Ploumpidis, D., Karapavlou, D.-A., Rogakou, E., & Madianos, M. G. (2011). The relationship between acculturation factors and symptoms of depression: A cross-sectional study with immigrants living in Athens. *Transcultural Psychiatry,* 48(4), 437-454.

Gutkovich, Z., R. N. Rosenthal, et al. (1999). Depression and demoralization among Russian-Jewish immigrants in primary care. *Psychosomatics, 40,* 117-125.

Hoffmann, C., McFarland, B. H., Kinzie, J. D., Bresler, L., Rakhlin, D., Wolf, S., et al. (2006). Psychological distress among recent Russian immigrants in the United States. *International Journal of Social Psychiatry, 52*(1), 29-40.

Human Development Report (2010). *Human Development Index and its components.* New York: United Nations Developmental Program. Retrieved April 15, 2011, from http://hdr.undp.org/en/media/HDR_2010_EN_Table1.pdf

Iwata, N., & Higuchi, H. R. (2000). Responses of Japanese and American university students to the STAI items that assess the presence or absence of anxiety. *Journal of Personality Assessment, 74*, 48-62.

Jayasuriya, L., Lang, D., & Fielding, A. (1994). *Ethnicity, Immigration and Mental Illness: A critical review of Australian research*. Canberra: Bureau of Immigration Research.

Kessler, R. C., Turner, J. B., & House, J. S. (1987). Intervening processes in the relationship between unemployment and health. *Psychological Medicine, 17*, 949-961.

Khan, R. S., Marlow, C., & Head, A. (2008). Physiological and psychological responses to a 12-week BodyBalance training programme. *Journal of Science and Medicine in Sport, 11*(3), 299-307.

Khavarpour, F., & Rissel, C. (1997). Mental health status of Iranian migrants in Sydney. *Australian and New Zealand Journal of Psychiatry*(31), 828-834.

Kiropoulos, L. A., Klimidis, S., & Minas, H. (2004). Depression and anxiety: a comparison of older-aged Greek-born immigrants and Anglo-Australians. *Australian & New Zealand Journal of Psychiatry, 38*(9), 714-724.

Kleinman, A. (2004). Culture and depression. *The New England Journal of Medicine, 351*(10), 951-953.

Klimidis, S., Stuart, G., & Minas, I. H. (1994). Immigrant status and gender effects on psychopathology and self-concept in adolescents: a test of the migration-morbidity hypothesis. *Comprehensive Psychiatry, 35*(39), 404.

Kohn, R., Flaherty, J. A., & Levav, I. (1989). Somatic symptoms among older Soviet immigrants: an exploratory study. *International Journal of Social Psychiatry, 35*, 350-360.

Krupinski, J. (1981). Epidemiology and social psychiatric research. In R. Banchevska, A. MacKenzie & J. Krupinski (Eds.), *Psychiatric Research in Victoria: 25 years from 1956-1981. Special Publication No. 9.* Melbourne: Mental Health Research Institute, Health Commission of Victoria.

Linacre, S (2007). *Migration: permanent additions to Australia's population* (Cat. No.. 4102.0). Canberra: Australian Bureau of Statistics. Retrieved January 23, 2011, from http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/C91452EF314864A8CA25732F001C92F8/$File/41020_Migration%20-%20permanent%20additions%20to%20Australia's%20population%20_2007.pdf

Loue, S. (1998). Defining the immigrant. In S. Loue (Ed.), *Handbook of Immigrant Health* (pp. 19-36). New York: Plenum Press.

McDonald, R., Vechi, C., Bowman, J., & Sanson-Fisher, R. (1996). Mental health status of a Latin American community in New South Wales. *Australian and New Zealand Journal of Psychiatry, 30*, 457-462.

Miller, A. M., & Chandler, P. J. (2002). Acculturation, resilience, and depression in midlife women from the former Soviet Union. *Nursing Research, 51*(1), 26-32.

Mirsky, J., Slonim-Nevo, V., & Rubinstein, L. (2007). Psychological wellness and distress among recent immigrants: a four-year longitudinal study in Israel and Germany. *International Migration Review, 45*(1), 151-175.

Murphy, H. B. M. (1977). Migration, culture and mental health. *Psychological Medicine, 7*, 677-684.

Museum Victroia. (n.d.) *History of immigration from Russian Federation*. Retrieved January 25, 2011, from http://museumvictoria.com.au/origins/history.aspx?pid=50

Naughton, M. J., & Wiklund, I. (1993). A critical review of dimension-specific measures of health-related quality of life in cross-cultural research. *Quality of Life Research, 2*, 397–432.

Nolen-Hoeksema, S. (1990). *Sex differences in depression*. Stanford, CA: Stanford University Press.

Oberg, K. (1960). Cultural shock: adjustment to new cultural environments. *Practical Anthropology, 7*, 177-182

Oh, Y., Koeske, G. F., & Sales, E. (2002). Acculturation, stress and depressive symptoms among Korean immigrants in the United States. *The Journal of Social Psychology, 142*, 511-526.

Pernice, R., & Brook, J. (1996). The mental health pattern of migrants: is there a euphoric period followed by a mental health crisis? *International Journal of Social Psychiatry, 42*(1), 18-27.

Polek, E., van Oudenhoven, J. P., & ten Berge, J. M. F. (2007). Attachment styles and demographic factors as predictors of sociocultural and psychological adjustment of Eastern European immigrants in the Netherlands. *International Journal of Psychology, 43*(5), 919 - 928.

Poltavski, D., & Ferraro, F. R. (2003). Stress and illness in American and Russian college students. *Personality and Individual Differences, 34*(6), 971-982.

Ponizovsky, A., Ginath, Y., Durst, R., Wondimeneh, B., Safro, S., & Minuchin-Itzigson, S. e. a. (1998). Psychological distress among Ethiopian and Russian Jewish immigrants to Israel: A cross-cultural study. *International Journal of Social Psychiatry, 44*, 35-45.

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.

Richardson, S., L. Miller-Lewis, P. Ngo and D. Ilsley. (2002). *The Settlement Experiences of New Migrants. A comparison of Wave One of LSIA 1 and LSIA 2.* Canberra: Commonwealth of Australia. Retrieved February 25, 2011, from http://www.immi.gov.au/media/publications/pdf/settle_exp.pdf

Ritsner, M., & Ponizovsky, A. (1998). Psychological symptoms among an immigrant population: A prevalence study. *Comprehensive Psychiatry*, *39*(1), 21-27.

Ritsner, M., & Ponizovsky, A. (1999). Psychological distress through immigration: The two-phase temporal pattern? *International Journal of Social Psychiatry*, *45*(2), 125-139.

Ritsner, M., Ponizovsky, A., & Ginath, Y. (1997). Changing patterns of distress during the adjustment of recent immigrants: A 1-year follow-up study. *Acta Psychiatrica Scandinavica*, *95*, 494-499.

Ritsner, M., Ponizovsky, A., Kurs, R., & Modai, I. (2000). Somatization in an immigrant population in Israel: A community survey of prevalence, risk factors, and help-seeking behavior *American Journal of Psychiatry, 157*(385-392).

Sands, E. A., & Berry, J. W. (1993). Acculturation and mental health among Greek-Canadians in Toronto. *Canadian Journal of Community Mental Health, 12*, 117-127.

Seeman, T. E. (1996). Social ties and health: The benefits of social integration. *Annals of Epidemiology, 6*, 442-451.

Simpson, P. L., Schumaker, J. F., Dorahy, M. J., & Shrestha, S. N. (1996). Depression and life satisfaction in Nepal and Australia. *Journal of Social Psychology, 136*(6), 783-790.

Spielberger, C. D., Gorsuch, R.L., and Lushene. R.E. (1970). *Manual for the State-Trait Anxiety Inventory.* Palo Alto, CA: Consulting Psychologists Press

Steel, Z., Silove, D., Giao, N. M., Phan, T. T. B., Chey, T., Whelan, A., et al. (2009). International and indigenous diagnoses of mental disorder among Vietnamese living in Vietnam and Australia. *British Journal of Psychiatry, 194*(4), 326-333.

Tang, G. W. G., Dennis, S., & Comino, E. (2009). Anxiety and depression in Chinese patients attending an Australian GP clinic. *Australian Family Physician, 38*(7), 552-555.

Tennison, L. R., Rodgers, L. S., Beker, D., Vorobjeva, K. I., Creed, E. T., & Simonenko, A. (2010). Cortisol and symptoms of psychopathology in russian and american college students. *International Journal of Psychology, 45*(3), 165-173.

Thoits, P. A. (1995). Stress, coping and social support processes: Where are we? What next? *Journal of Health and Social Behavior, 35*, 53-79.

Thompson, S., Hartel, G., Manderson, L., Woelz-Stirling, N., & Kelaher, M. (2002). The mental health status of Filipinas in Queensland. *Australian and New Zealand Journal of Psychiatry, 36*, 674-680.

Ullman, C., & Tatar, M. (2001). Psychological adjustment among Israeli adolescent immigrants: A report on life satisfaction, self-concept, and self-esteem. *Journal of Youth and Adolescence, 30*(4).

Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry, 55*, 771-778.

Vega, W. A., Kolody, B., Valle, R., & Hough, R. (1986). Depressive symptoms and their correlates among immigrant Mexican women in the United States. *Social Science and Medicine, 22*, 645-652.

Vega, W. A., Kolody, B., Valle, R., & Weir, J. (1991). Social networks, social support, and their relationship to depression among immigrant Mexican women. Human Organization, *50*, 154-162.

Ward, C., Bochner, S., & Furnham, A. A. (2001). *The psychology of culture shock.* London: Routledge.

Chapter 6

Predictors of acculturation in skilled immigrants from the Former Soviet Union (FSU) living in Australia

Preamble to Paper 2

While there is a plethora of literature on acculturation among immigrant groups worldwide, including the acculturation of Russian-speaking immigrants in the US, Finland and Israel, no similar studies exist in Australia. The second empirical study of the current thesis aimed to fill the gap in the literature regarding the acculturation of Russian-speaking immigrants in Australia, specifically this study aimed to examine the relationship between acculturation and immigration stress in this group. The original aim of the current study was to explore relationships between acculturation and mental health in the Russian-speaking immigrants in Australia and to investigate factors contributing to their levels of depression and anxiety. However, due to the results obtained in the first paper, specifically low levels of anxiety and depression in Russian-speaking skilled immigrants, compared to Anglo-Australian group, and low variability in depression and anxiety scores, the decision was made instead to investigate acculturation, and to examine factors contributing to acculturation in Russian-speaking immigrants.

The article has been submitted for publication to the Journal of Immigrant and Minority Health, a peer-reviewed journal focusing on publishing articles pertaining to immigrant health. The impact factor of the journal is 1.492 (2010).

Declaration for Thesis Chapter Six

Monash University

Declaration by candidate

In Chapter six (Paper 2) the nature and extent of my contribution to the work was as follows:

Nature of contribution	**Extent of contribution (%)**
Participation in design, formulation of ideas, data analyses and securing ethics approval; review of appropriate literature; review of materials; recruitment of participants; data collection; and draft and revision of this paper.	70%

The following co-authors contributed to the work. Co-authors who are students at Monash University must also indicate the extent of their contribution in percentage terms:

Name	**Nature of contribution**	**Extent of contribution (%] for student co-authors only**
Litza A. Kiropoulos	Conceptualisation of study design, assisted in preparation of statistical section and ethics; assisted in the preparation of the manuscript	30%

Candidate's Signature		**Date**

Declaration by co-authors

The undersigned hereby certify that:

(7) the above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

(8) they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

(9) they take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

(10) there are no other authors of the publication according to these criteria;

(11) potential conflicts of interest have been disclosed to (a) granting bodies, (b)the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and

(12) the original data are stored at the following location(s) and will be held for a t least five years from the date indicated below:

Location(s]	Locked filing cabinet, Social Sciences and Health Research Unit, Monash University

(Please note that the location(s) must be institutional in nature, and should be indicated here as a department, centre or institute, with specific campus identification where relevant.)

Signature 1		**Date**
Signature 2		
Signature 3		

Running head: Acculturation in immigrants from the Former Soviet Union living in Australia

Paper 2: Predictors of acculturation in skilled immigrants from the Former Soviet Union (FSU) living in Australia

Authors: Alla Demutska, School of Psychology and Psychiatry, Monash University

Litza A. Kiropoulos Psychological Sciences, The University of Melbourne, School of Psychology and Psychiatry, Monash University

Corresponding author:

Alla Demutska

Faculty of Medicine, Nursing and Health Sciences

Monash University,

Victoria 3800

Australia

Tel: [redacted] Fax: [redacted]

E-mail: [redacted]

Keywords: acculturation, Russian-speaking immigrants, Former Soviet Union, Australia

Word count: abstract - 147

Text – 2 857

ABSTRACT

In this article, we explore relationships between measures of Russian and Australian acculturation and immigration stress in immigrants from the former Soviet Union (FSU) living in Australia and whether Russian immigrants endorse a bidimensional acculturation model. Sixty five Russian speaking immigrants were recruited through social clubs, community web forums and web groups, and churches. Participants completed online questionnaires which included the Language, Identity and Behaviour (LIB) scale to measure acculturation, the Demands of Immigration scale to measure immigration stress, the Interpersonal Support Evaluation List (ISEL) to measure social support, and socio-demographic questions. Results indicated that immigration stress was related to higher levels of Russian acculturation and lower levels of Australian acculturation, after controlling for socio-demographic factors. No association between Russian and Australian dimensions of acculturation was found which supports that acculturation can occur independently along both host and native dimensions of acculturation**.** Limitations and future directions are discussed.

INTRODUCTION

Skilled immigration has become the largest category among permanent visa categories in Australia [1]. To be eligible, applicants have to be under 45 years of age and in good health, be proficient in English, and possess qualifications which are in demand in Australia [2]. Several waves of immigration from Russia and FSU to Australia have been recorded [3], with skilled immigrants being the latest wave, primarily arriving after the collapse of the Soviet Union in 1991 [3]. Most skilled immigrants, unlike many previous Russian immigrants, chose to immigrate and were not forced out by the political regime. The majority of skilled immigrants are highly educated, with good English skills, and are typically employed as professionals [2]. It might be expected that these skilled immigrants would adapt

well to their new context, and have different trajectories of acculturation compared to refugees and other immigrant groups. However, apart from a few studies [4], there is a lack of information regarding this group.

Acculturation is defined as the process of cultural and psychological change when the contact between two or more cultures takes place [5]. The field of acculturation research within psychology started with the so-called unidimensional models, in which acculturation equates with assimilation [6, 7]. The unidimensional models suggest that an individual gradually moves from their original ethnic identity towards the host culture identity [8-10]. The assumptions made by researchers using the unidimensional model were that it is difficult to retain both cultures; and that the more elements of the new culture the person gains, the less elements of the original culture he or she maintains [11].

More recent models of acculturation are based on a 'bidimensional approach' [12-14], implying that it is possible for an immigrant to maintain both their own culture and adopt the host culture, thus allowing for bicultural identities to be formed. Most research in this area has shown that the most successful acculturation strategy, linked to self-esteem, life satisfaction and better sociocultural adaptation, is related to retaining both the original culture and integrating into the host culture [15, 16]. In a study of Russian-speaking immigrants in New Zealand, for example, the strategy of integrating both host and native cultures was shown to be related to better psychological and sociocultural adaptation [17].

Acculturation can be measured with its proxies such as language or length of stay, or with scales of acculturation, such as the Language, Identity and Behaviour (LIB) scale [18], which allows measuring acculturation to both the host and native culture. Acculturation was shown to be related to several socio-demographic factors, such as age, gender, level of education, occupation, and social support in Russian-speaking immigrants in the US and Europe. Several studies have found that Russian-speaking women and men show different

trajectories of acculturation [18, 19]. Younger age at immigration was shown to be positively related to sociocultural adjustment in the group of Polish, Russian, and Hungarian immigrants in the Netherlands [20], and age was positively related to retaining Russian culture in Soviet Jewish refugees in the US [19]. However, some studies found that age at arrival is mostly important for adolescents, and less for adults, with length of residency being the more important factor for acculturation to American culture [18]. Education was shown to play a role in acculturation to both Russian and American culture, with less educated people retaining more elements of culture of origin [18]. Better employment was shown to be related to an increase in American acculturation [21]. Social support was shown to play a role in acculturation among Russian immigrants to the US [19, 22, 23]; however not all studies found a relationships between acculturation and social support [24].

Stress arising from immigration is important to consider when exploring acculturation in immigrants. Immigration specific stress has been found to be associated with acculturation. For example, perceived discrimination, a form of immigration stress, was shown to be related to the maintenance of Russian identity by adolescents in the US [18], to the disidentification from the host culture among Russian-speaking immigrants in Finland [25, 26], to the retention of Russian identity and to lower American identity in adult participants living in the US [27], and was negatively related to acculturation to American culture in Russian-speaking participants living in the US [27, 28]. Similarly, discrimination experienced during adolescence was found to be related to retaining Russian culture later in life [29]. In another study, immigration stress was shown to be negatively related to acculturation, measured by the length of stay in the host country in Chinese immigrant nurses [30]. Interestingly, in a study of Russian immigrants to Finland, the higher the level of linguistic acculturation, the more they perceived that they were subject to discrimination [31].

The aim of this article is to explore relationships between measures of Russian and

Australian acculturation and immigration stress. We are also interested in examining whether immigration stress uniquely contributes to measures of Australian and Russian acculturation, and whether data collected from Russian immigrants living in Australia are consistent with bidimensional acculturation model.

METHOD

Participants

Sixty five Russian immigrants (37 female and 28 male), living in Australia participated in the study (mean age 35.2, *SD* = 6.1). All participants had arrived on a skilled immigration visa program. In the current study, all participants were fluent in Russian and 46.2% reported Russia as their birthplace.

Data Collection

The Monash University Human Research Ethics Committee granted approval for this study. Translations of the scales were made by the first author, who is fluent in both Russian and English, who has a linguistics degree, and at the time was a Provisional Psychologist. Then both English and Russian versions were verified with another bilingual immigrant with both linguistics and psychology background, and by a professional bilingual translator. Reliability was checked by examining the psychometric properties of the scales after data were collected and preceding any further analysis.

Russian-speaking immigrants were recruited through various ethnospecific social organizations, newspapers and web-forums. An explanatory statement about the project, an electronic consent form and all questionnaires were placed online. Eligibility criteria included being between 20-60 years of age and having migrated to Australia on the skilled visa category.

Measures

Demographic information

Participants were asked to complete questions on gender, date of birth, occupation, educational level, relationship status, employment status, year of arrival in Australia, age at arrival, and change in professional status with immigration.

Social Support

Social Support was measured with the Interpersonal Support Evaluation List for the General Population (ISEL) [32, 33]. The ISEL measures four separate functions of social support - tangible, appraisal, belonging and self-esteem - with each subscale comprising 10 statements. A modified version of this scale which did not include the self-esteem subscale was used. The modified version consisted of 30 questions, measured on a four-point scale (‘definitely true’, ‘probably true’, ‘probably false’ and ‘definitely false’). The scores ranged from 0 to 120, with higher scores indicating better social support.

Immigration stress

Immigration stress was measured by the Demands of Immigration Scale (DI) [34]. The DI has been specifically validated with FSU immigrants in several studies [34, 35]. The scale consists of 23 items and measures demands related to immigration, such as loss (‘I miss the people I left behind in my original country’), novelty (‘I have to depend on other people to show or teach me how things are done here’), occupational adjustment (‘I have less career opportunities than Australians’), language difficulties (‘Australians have a hard time understanding my accent’), discrimination (‘People with foreign accents are treated with less respect’), and not feeling at home in the host country (‘I do not feel that this is my true home’). Participants rated their distress along a six-point scale ranging from not at all (0) to very much distressed (5).

Acculturation

Level of acculturation was measured by the 54 item Language, Identity and Behaviour (LIB) scale [18]. The scale was developed with particular consideration for Russian immigrants in America. This scale was adapted to the current study by changing references to American culture and language to Australian culture and language. LIB is a bidimensional scale in that it does not provide the overall score for acculturation; rather, it provides two separate acculturation scores for the Australian (AAI) and Russian (RAI) acculturation indices (27 items per Index). Australian and Russian acculturation indices measure how much a participant endorses Australian or Russian culture, assessing the degree of involvement into these two cultures. RAI and AAI can be further divided into three subscales each: language, identity and behaviour, assessed on a 4-point Likert-type scale (1 = not at all to 4 = very much). Higher scores indicated greater acculturation to the Russian/Australian culture.

Statistical Analyses

We aimed to examine the contribution of immigration stress to the variance in Australian and Russian acculturation scores for Russian immigrants living in Australia. Cronbach's α was calculated to examine internal consistency of the scales used to measure acculturation and are presented in Table 6.1. There was no violation of the assumption of multicollinearity. Given that relationships between marital status, gender, occupational level, social support and acculturation have been previously reported for a similar aged Russian immigrant group [18-24] we undertook hierarchical multiple regression analyses while adjusting for the effects of these variables when examining the contribution of immigration stress on the variance in the Australian and Russian acculturation variables.

RESULTS

The majority of participants were highly educated (95% of them had at least Master

level degrees), mostly working full-time (65%) and were married or living with a partner (71%). Median income per person equalled around 42 000 (M = 44,322, SD = 30,974). The proportion of life in Australia was calculated by taking into account the age of the participant and their arrival date. On average, 17% of the life they lived in Australia. The majority (80%) had the same or higher professional status after immigration as opposed to having a lower status. Most participants came from Russia (46%) and Ukraine (17%), with some indicating USSR as their birthplace (26%). Most participants (80%) indicated they wanted to immigrate as opposed to being forced by circumstances to migrate to Australia. All participants indicated that they adapted either quicker than or at the same level as they were expecting, as opposed to adapting slower than expected.

Descriptive statistics for the scales used in the analysis are presented in Table 6.1. As can be seen, all scales and their subscales had high reliability. Means of measures of Russian acculturation were generally higher than for Australian acculturation.

Table 6.1 Means, standard deviations, range and Cronbach's alphas for social support, acculturation and demands of immigration measures

Scale and subscale name	*M*	*SD*	Cronbach's Alpha
DI Total	56.2	19.6	.90
RAI	81.1	10.1	.88
AAI	78.2	9.7	.87
Social Support	62.5	17.7	.95

DI – Demands of Immigration; RAI - Russian Acculturation Index; AAI – Australian Acculturation Index

Correlations between Russian and Australian indices were computed to see if the

dimensions of two cultures were independent. The correlation between RAI and AAI was r = -.2, p > .5, which shows no evidence of linear relationships between these constructs, and is consistent with a bidimensional model.

The five socio-demographic variables accounted for 26% of the variance in the Australian acculturation index in Step 1, (Adjusted R^2 = .26, F (5, 46) = 4.41, p = .002). As can be seen from Table 2, proportion of life in Australia was the only significant predictor of Australian acculturation. In Step 2, addition of the immigration stress variable accounted for 18% increase in the variance explained, (Adjusted R^2 = .18, F (1, 45) = 16.87, p < .001), with the overall model explaining 44% of the variance, (Adjusted R^2 = .44, F (6, 45) = 7.75, p < .001). Significant independent predictors included proportion of life in Australia, not being married and immigration stress.

Table 6.2 Hierarchical Regression Analysis for Australian Acculturation

Variable	*B*	*SE B*	*β*	*t*	*p*
		Step 1			
Social Support	.06	.08	.11	.79	.432
PLA	38.55	11.25	.45	3.43	.002
Male Gender	-.72	2.98	-.03	-.24	.810
Not married	3.665	2.43	.19	1.51	.139
Lower professional status	-5.29	3.15	-.22	-1.68	.100
		Step 2			
Social Support	-0.06	0.07	-0.10	-0.83	.411
PLA	27.05	9.01	0.34	3.00	.004
Male gender	-2.32	2.60	-0.10	-0.89	.376
Not married	4.44	2.11	0.23	2.11	.041
Lower professional status	-2.20	2.82	-0.09	-0.78	.438
Immigration Stress	-0.27	0.07	-0.54	-4.11	.000

PLA – proportion of life in Australia

The five socio-demographic variables accounted for 17% of the variance in the Russian acculturation index in Step 1, (Adjusted R^2 = .17, F (5, 46) = 3.15, p = .016). Lower professional status was a significant independent predictor. In Step 2, addition of the immigration stress factor accounted for 9.5% increase in the variance explained, (Adjusted R^2 = .095, F (1, 45) = 6.58, p < 0.14), with the overall model explaining 26% of the variance in Russian acculturation, (Adjusted R^2 = .26, F (6, 45) = 4.04, p = .003). Significant independent predictors included social support and immigration stress.

Table 6.3 Hierarchical Regression Analysis for Russian Acculturation

Variable	*B*	*SE B*	*β*	*t*	*p*
		Step 1			
Social Support	.17	.09	.28	2.1	.052
PLA	14.98	11.1	.18	1.35	.184
Male gender	-4.97	3.22	-.21	-1.54	.130
Not married	-1.37	2.64	-.07	-.52	.605
Lower Professional Status	8.28	3.41	.33	2.43	.019
		Step 2			
Social Support	.26	.09	.43	2.98	.005
PLA	20.34	10.69	.25	1.90	.063
Male Gender	-3.78	3.08	-.16	-1.23	.226
Not married	-1.95	2.51	-.11	-.78	.440
Lower professional status	6.1	3.34	.24	1.79	.080
Immigration Stress	.20	.08	.38	2.57	.014

PLA – proportion of life in Australia

DISCUSSION

The present study examined Australian and Russian acculturation in Russian-speaking immigrants living in Australia, and whether immigration stress was a significant unique predictor of these variables. We also examined the relationship between the Russian and Australian acculturation dimensions. Results indicated that longer proportion of life in Australia, not being married, and lower immigration stress were associated with higher Australian acculturation scores, whereas higher social support and higher immigration stress was associated with higher Russian acculturation scores.

The results indicated that immigration stress, containing subscales measuring discrimination, novelty, feelings of loss and not being at home, language difficulties, and perceived discrimination, was related to higher levels of Russian acculturation and lower levels of Australian acculturation, after controlling for socio-demographic factors. Demands of immigration scores were shown to be negatively related to English Language proficiency as an indicator of acculturation in a previous study with Russian-speaking immigrant women in the US [23]. The majority of previous studies with different immigrant groups looked into the discrimination domain of immigration stress specifically. For example, discrimination was a predictor in retaining native culture and/or rejecting host culture in Russian-speaking immigrants in the US [18, 27-29]. Other immigrant groups showed similar patterns, for example, acculturative stress was negatively related to acculturation in Chinese adolescent immigrants in Canada [36]; and discrimination, acculturation and stress were related in the study of Dominican immigrant women [37].

Overall, no association between Russian and Australian dimensions of acculturation was found in this study. This contradicts several past studies using the same scale, where a pattern of negative correlations between Russian and American dimensions of acculturation was found [18, 22, 27]. Our finding gives support to the bidimensional framework developed

by Berry and reflected in several past studies [12-14, 38], suggesting that acculturation can occur independently along both host and native dimensions of acculturation.

Other variables examined in this study, and found to be important in the acculturation process of Russian-speaking immigrants in Australia, were also found to be important in other studies. Longer proportion of life in Australia was implicated in increases in Australian acculturation, which is consistent with previous studies with Russian-speaking immigrants in the US, where acculturation to host culture has increased over time [18, 27, 39, 40]. Our results indicated that having no partner was related to higher Australian acculturation. We were unable to locate a study with Russian-speaking immigrants where relationship status was included as a predictor of acculturation. Very often Russian-speaking immigrants migrate with their partners and families, or marry within the Russian community. It is plausible to suggest that not having a partner facilitates friendship and social life outside the Russian community, thus increasing the opportunity of acculturation into the Australia/host nation way of life. Future studies are needed to examine this. The results also indicated that Russian acculturation remains stable over time, and is not affected by proportion of life in Australia, which is similar to the findings with Russian-speaking participants in the US [27, 39]. Russian acculturation increased with higher social support, which suggests that participants in the current study mainly seek support sought through their Russian-speaking networks. This finding is similar to the results found with Russian-speaking adolescents in the US [27].

Limitations

Several limitations impact on generalization of the findings, these include the small sample size, the use of self-rating scales in an online format, and the non-random sampling procedure, which may not be representative of the wider Russian-speaking community in Australia.

Future Research

Future research is required with Russian-speaking immigrants, as well as other skilled-immigrant groups in Australia, to examine acculturation and immigration stress. It is important to investigate the different facets of acculturation, which can allow a more thorough understanding of acculturation process. Longitudinal studies should also be employed to provide better understanding of the acculturation process among immigrant groups. Future research should employ larger sample sizes so the results can be generalized to a wider Russian-speaking population in Australia. In addition, examination of other psychological variables, such as neuroticism, hardiness, or marital satisfaction, may be useful in understanding the process of acculturation.

New Contribution to the Literature

The current study was the first of its kind to explore the process of acculturation and factors related to Russian-speaking immigrants to Australia. Immigration stress was shown to be related to retention of Russian and rejection of Australian culture. The current study provided support to the bidimensional model of acculturation.

ACKNOWLEDGEMENTS

Special thanks to Professor Lenore Manderson, Monash University for her comments, Dr Kathryn Gilson, Monash University for initial input into the design, and Dr John Taffe , Monash University for his statistical advice regarding this article.

References

1. Linacre S. Migration: permanent additions to Australia's population (Cat. No. 4102.0). In. Canberra: Australian Bureau of Statistics; 2007.

2. Department of Immigration and Citizenship. Visas, Immigration and Refugees. Retrieved January 21, 2011 from http://www.immi.gov.au/skilled/general-skilled-migration/; 2008

3. Christa B. Russians. In: Jupp J, editor. The Australian People - An Encyclopedia of the Nation, Its People and Their Origins. Cambridge: Cambridge University Press; 2001: 636-642.

4. Richardson S, Miller-Lewis L, Ngo P, Ilsley D. The settlement experiences of new migrants: a comparison of wave one of LSIA 1 and LSIA 2. Adelaide, Australia: National Institute of Labour Studies, Flinders University; 2002.

5. Berry JW. Acculturation: Living successfully in two cultures. International Journal of Intercultural Relations 2005;29:697-712.

6. Sayegh L, Lasry J-C. Immigrants' adaptation in Canada: assimilation, acculturation, and orthogonal cultural identification. Canadian Psychology 1993;34(1):98-109.

7. Nguyen HH, von Eye A. The acculturation scale for Vietnamese adolescents (ASVA): A bidimensional perspective. International Journal of Behavioral Development, 2002;26:202-213.

8. Gordon MM. Assimilation in American life. New York: Oxford University Press; 1964.

9. Graves TD. Psychological acculturation in a tri-ethnic community. Southwestern journal of anthropology 1967;23(4):337 -350

10. Lambert WE, Mermigis L, Taylor DM. Greek Canadians' attitudes toward own group and other Canadian ethnic groups: A test of the multiculturalism hypothesis. Canadian Journal of Behavioral Science 1986;18:35-51.

11. Berry JW, Poortinga YH, Breugelmans SM, Chasiotis A, Sam DL. Cross-cultural psychology: Research and applications (3rd ed.). Cambridge: Cambridge University Press; 2011.

12. Hutnik N. Patterns of ethnic minority identification and modes of social adaptation. Ethnic and racial studies 1986;9:150-167.

13. Berry JW. Acculturation as varieties of adaptation. In: Padilla A, editor. Acculturation: Theory, models, and findings. Boulder, CO: Westview; 1980;9–25.

14. La Fromboise T, Coleman HLK, Gerton J. Psychological impact of biculturalism: Evidence and theory. Psychol Bull 1993;114:395-412.

15. Berry JW, Phinney JS, Sam DL, Vedder P. Immigrant youth: Acculturation, identity and adaptation. Applied Psychology: An International Review 2006;55:303-332.

16. Phinney JS, Devich-Navarro M. Variations in bicultural identification among African American and Mexican American adolescents. Journal of Research on Adolescence 1997;7:3-32.

17. Maydell-Stevens E, Masgoret A-M, Ward T. Problems of psychological and sociocultural adaptation among Russian-speaking immigrants in New Zealand. Social Policy Journal of New Zealand 2007;30:178-198.

18. Birman D, Trickett EJ. Cultural Transitions in First-Generation Immigrants: Acculturation of Soviet Jewish Refugee Adolescents and Parents. Journal of Cross-Cultural Psychology 2001;32:456-477.

19. Birman D, Tyler FB. Acculturation and alienation of Soviet Jewish refugees in the United States. Genet Genetic, Social and General Psychology Monographs 1994;120(1):101-15.

20. Polek E, van Oudenhoven JP, ten Berge JMF. Attachment styles and demographic factors as predictors of sociocultural and psychological adjustment of Eastern European immigrants in the Netherlands. International Journal of Psychology 2008;43(5):919-928.

21. Vinokurov A, Birman D, Trickett E. Psychological and acculturation correlates of work status among Soviet Jewish refugees in the United States. International Migration Review 2000;34(2):538-559.

22. Birman D, Trickett EJ, Vinokurov A. Acculturation and adaptation of Soviet Jewish refugee adolescents: predictors of adjustment across life domains. Am J Community Psychol, 2002;30:585-607.

23. Miller AM, Chandler PJ. Acculturation, resilience, and depression in midlife women from the former Soviet Union. Nurs Res 2002;51(1):26-32.

24. Orshan SA. Acculturation, Perceived Social Support, and Self-Esteem in Primigravida Puerto Rican Teenagers. West J Nurs Res 1996;18(4):460-473.

25. Jasinskaja-Lahti I, Liebkind K, Solheim E. To identify or not to identify? National disidentification as an alternative reaction to perceived ethnic discrimination. Applied Psychology: An International Review 2009;58(1):105-128.

26. Mähönen TA, Jasinskaja-Lahti I, Liebkind K. Cultural discordance and the polarization of identities. Group Processes & Intergroup Relations 2011;14(4):505-515.

27. Birman D, Trickett EJ, Buchanan R. A tale of two cities: replication of a study on the acculturation and adaptation of immigrant adolescents from the Former Soviet Union in a different community context. Am J Community Psychol, 2005;35(1-2):83-101.

28. Vinokurov A, Trickett EJ, Birman D. Acculturative hassles an immigrant adolescents: A life-domain assessment for Soviet Jewish refugees. J Soc Psychol 2002;142(4):425-445.

29. Roytburd L, Friedlander ML. Predictors of Soviet Jewish refugees' acculturation: Differentiation of self and acculturative stress. Cultural Diversity & Ethnic Minority Psychology 2008;14(1):67-74.

30. Ma AX, Griffin MTQ, Capitulo KL, Fitzpatrick JJ. Demands of immigration among Chinese immigrant nurses. International Journal of Nursing Practice 2010;16(5):443-453.

31. Jasinskaja-Lahti I, Liebkind, K. A structural model of acculturation and well-being among immigrants from the former USSR in Finland. European Psychologist, 2007; 12(2): 80-9231.

32. Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. Journal of Health and Social Behavior 1983;24:385-396.

33. Cohen S, Hoberman H. Positive events and social supports as buffers of life change stress. Journal of Applied Social Psychology 1983;13:99-125.

34. Aroian KJ, Norris A, Tran TV, Schappler-Morris N. Development and psychometric evaluation of the Demands of Immigration Scale J Nurs Meas1998;6(2).

35. Aroian KJ, Norris A. Depression trajectories in relatively recent immigrants. Compr Psychiatry 2003;44,(5):420-427.

36. Kuo BCH, Roysircar G. Predictors of acculturation for Chinese adolescents in Canada: Age of arrival, length of stay, social class, and English reading ability. Journal of Multicultural Development and Counselling 2004;32:143-154.

37. Araújo Dawson B. Discrimination, stress, and acculturation among Dominican immigrant women. Hispanic Journal of Behavioral Sciences 2009;31(1):96-111.

38. Berry JW. Contexts of acculturation. In: Sam DL, Berry JW, editors. The Cambridge Handbook of Acculturation Psychology. Cambridge: Cambridge University Press; 2006: 27–42

39. Vinokurov A, Birman D, Trickett E. Psychological and Acculturation correlates of work status among Soviet Jewish refugees in the U.S. International Migration Review 2000;34:538-559.

40. Miller AM, Wang E, Szalacha LA, Sorokin O. Longitudinal Changes in Acculturation for Immigrant Women From the Former Soviet Union. Journal of Cross-Cultural Psychology 2009;40(3):400-415.

Chapter 7

Depression stigma and psychological help seeking attitudes in immigrants from the FSU

Preamble to Paper 3

This paper addresses the last aim of the current thesis, i.e. how levels of depression-related stigma and psychological help seeking attitudes differ in three groups: Russian-speaking immigrants, Russian-speaking non-immigrants and Anglo-Australians; and how acculturation, depression stigma and psychological help-seeking attitudes are related in a Russian-speaking immigrant sample. This paper differs from the other two papers, as it does not directly explore the acculturation process or its outcomes. This paper explores what Russian-speaking immigrants think about mental illness which is a common outcome when difficulties in acculturation are experienced, and whether they will be prepared to seek professional help. This paper explores an important issue of service utilisation, which is typically low in immigrant groups.

The article has been submitted for publication to the Journal of Community Psychology, a peer-reviewed journal focusing on human behaviour in community settings, including descriptions and evaluations of service programs, studies of youth, and the interaction of groups in the larger community. The impact factor of the journal is 0.792, 17/36 (Social work), 75/120 (Psychology Multidisciplinary) and 87/114 (Public Environmental and Occupational Health).

Declaration for Thesis Chapter Seven

Monash University

Declaration by candidate

In Chapter seven (Paper 3) the nature and extent of my contribution to the work was as follows:

Nature of contribution	**Extent of contribution (%)**
Participation in design, formulation of ideas, data analyses and securing ethics approval; review of appropriate literature; review of materials; recruitment of participants; data collection; and draft and revision of this paper.	70%

The following co-authors contributed to the work. Co-authors who are students at Monash University must also indicate the extent of their contribution in percentage terms:

Name	**Nature of contribution**	**Extent of contribution (%) for student co-authors only**
Litza A. Kiropoulos	Conceptualisation of study design, preparation of statistical section; assisted with ethics and in the preparation of the manuscript	30%

Candidate's Signature		**Date**

Declaration by co-authors

The undersigned hereby certify that:

(13) the above declaration correctly reflects the nature and extent of the candidate's contribution to this work, and the nature of the contribution of each of the co-authors.

(14) they meet the criteria for authorship in that they have participated in the conception, execution, or interpretation, of at least that part of the publication in their field of expertise;

(15) they take public responsibility for their part of the publication, except for the responsible author who accepts overall responsibility for the publication;

(16) there are no other authors of the publication according to these criteria;

(17) potential conflicts of interest have been disclosed to (a) granting bodies, (b) the editor or publisher of journals or other publications, and (c) the head of the responsible academic unit; and

(18) the original data are stored at the following location(s) and will be held for at least five years from the date indicated below:

Location(s)	Locked filing cabinet, Social Sciences and Health Research Unit, Monash University

[Please note that the location(s) must be institutional in nature, and should be indicated here as a department, centre or institute, with specific campus identification where relevant.

Signature 1		**Date**
Signature 2		
Signature 3		

Paper 3: Depression stigma and psychological help-seeking in Russian-speaking skilled immigrants from the Former Soviet Union (FSU) living in Australia

Alla Demutska[1] Litza A. Kiropoulos[1,2]

[1] School of Psychology and Psychiatry, Monash University

[2] Psychological Sciences, The University of Melbourne

Corresponding author:

Alla Demutska

Faculty of Medicine, Nursing and Health Sciences
Monash University,
Victoria 3800
Australia

Tel: [redacted] Fax: +[redacted]

E-mail: [redacted]

Keywords: stigma, psychological help-seeking, Russian-speaking immigrants, Former Soviet Union, Australia

Abstract word count: 150 words

ABSTRACT

In this article, depression stigma and psychological help-seeking attitudes are compared in immigrants from the former Soviet Union (FSU) living in Australia, a Russian-speaking sample living in the FSU, and Anglo-Australians. Sixty five Russian speaking immigrants, 65 Russian speaking non-immigrants and 63 Anglo-Australians were recruited through social clubs and organization, community web forums and web groups. Participants completed online questionnaires which included Centre for Epidemiologic Studies Depression Scale, Language, Behaviour and Identity scale, Depression Stigma Scale, Attitudes toward Seeking Mental Health Services Scale, and socio-demographic questions. Russian-speaking immigrants were found to have more perceived stigma, and less personal stigma than in Anglo-Australians. Anglo-Australians were found to be higher on Psychological Openness and Help-seeking Propensity subscales, than Russian immigrants, while Russian non-immigrants and Russian immigrants did not differ from each other on these measures. No relationship between acculturation factors, depression stigma and psychological help-seeking was found in the present study.

One of the problems reported for many immigrant communities is their low help-seeking behaviour for mental health issues (Chen, Kazanjian, & Wong, 2009 ; Chen, Kazanjian, Wong, & al., 2010; Ingleby, 2011; Li & Browne, 2000). There are many reasons for this. Different cultures vary in their explanatory models of mental illness, including its causation, duration, and outcome (Ingleby, 2011; Kiropoulos & Bauer, 2011; Sheikh & Furnham, 2000). For example, elderly Russians were found to view those with mental illness as weak, lacking *dusha* (soul), self-control and moral character (Polyakova & Pacquiao, 2006). Sometimes mental health problems can be attributed to supernatural causes in non-western cultures (Nguyen & Anderson, 2005; Sheikh & Furnham, 2000). Mental illness may

be perceived as referring to extreme disorders, which may lead to immigrants accessing services only when their disorder is severe (Ingleby, 2011). Usually in immigrant communities there is an expectation that the family of the person affected by mental illness or others in their community will become carers instead of formal health sector (Wynaden et al., 2005).

Recently, researchers have started to pay more attention to attitudinal and belief components in the use of mental health services. The importance of investigating psychological help-seeking attitudes cannot be underestimated, given they are significant predictors for intentions to seek psychological help (Morgan & Robinson, 2003) and in actual help-seeking behaviour and service utilization (Brown et al., 2010; Mackenzie, Knox, Gekoski, & Macaulay, 2004). A recent large scale study conducted in Europe showed that attitudes towards psychological help-seeking were found to be significantly related to actual service use (ten Have et al., 2010). Several studies conducted in Australia found that attitudes towards treatment influenced actual psychological help-seeking (Komiti, Judd, & Jackson, 2006) and intentions to seek help (Bayer & Peay, 1997). However, discrepancies between attitudes and actual help-seeking were found, for example, the majority of young people aged 12-25 in Australia believed counselling was helpful, however, less than half used it for their problems (Reavley, Yap, Wright, & Jorm, 2011). Similarly, in rural Australia help-seeking attitudes were not shown to influence life-time help-seeking (Judd et al., 2006).

Stigma towards mental illness is another factor shown to affect psychological help-seeking behaviours, and in accessing appropriate mental health services in Australia (Wrigley, Jackson, Judd, & Komiti, 2005; Wynaden et al., 2005) and internationally (Brown, et al., 2010; Papadopoulus, Leavey, & Vincent, 2002). Those who experience mental health related stigma often do not go to see a specialist, thus do not receive adequate psychological help, which can lead to detrimental outcomes for the person themselves and for their families, and

can bring a great burden to the community due to late presentation. Stigma can also lead to increased psychological distress and lower self-esteem (Griffiths & Christensen, 2004).

Stigma has been divided into personal stigma, reflecting self-attitudes towards mental illness, and perceived stigma, reflecting how a person thinks others are perceiving mental illness (Griffiths, Nakane, Christensen, Yoshioka, Jorm, & Nakane, 2006; Griffiths, Christensen, & Jorm, 2008). Different pathways for not seeking help due to perceived or personal stigma have been described, for example, through personal stigma, people might choose not to seek treatment as it will help them to avoid negative feelings of shame and guilt about themselves (Brown, et al., 2010).

Stigma towards mental illness appears to be higher in immigrant groups, and immigrants have lower help-seeking attitudes. In the US, Japanese students were found to have higher stigma towards people with mental health problems than American students (Masuda et al., 2009). In Australia, personal stigma towards depression appears to be higher in people who were born overseas (Griffiths, Christensen, & Jorm, 2008), and personal and perceived stigma was higher in Greek born and Italian born immigrants (Kiropoulos, Griffiths, & Blashki, 2011), and in former Yugoslavian immigrants compared to Anglo-Australians (Copelj & Kiropoulos, 2011). Less tolerance towards emotional or psychological issues has been found in Vietnamese immigrants than in Anglo-Australians (Duong-Ohtsuka & Ohtsuka, 2001). Stigma, shame, and not seeking professional health were found to be prominent in Asian immigrants living in Australia (Wynaden, et al., 2005).

Factors associated with psychological help-seeking attitudes and stigma towards people with mental illness were shown to be multifold, and can include causation attribution of illness, for example, personal deficiency or biological causes, education and familiarity with mental health, age, gender, current distress, and past experiences in seeking psychological help (Dietrich et al., 2004; Griffiths, et al., 2008; Leaf, Bruce, Tischler, & Holzer, 1987;

Masuda, Suzumura, Beauchamp, Howells, & Clay, 2005; Shulman & Adams, 2002). Relationship between stigma itself and help-seeking attitudes were reported as well (Barney, Griffiths, Jorm, & Christensen, 2006; Brown, et al., 2010; Ting & Hwang, 2009).

Another interesting question is how living in the host community, where attitudes towards mental illness might be different from the culture of origin, influence immigrants' attitudes to people with mental illness and help-seeking and the relevance of acculturation to this. Acculturation is a process of cultural and psychological change when the contact between two or more cultures takes place (Berry, 2005). Several studies have looked at the changes in stigma towards mental problems and in psychological help-seeking attitudes with acculturation. For example, age at immigration and length of stay were shown to play a role in altering the attitudes towards mental illness and help-seeking in several US studies of Asian Indians (Kumar & Nevid, 2010; Panganamala & Plummer, 1998), of Asian college students (Atkinson & Gim, 1989), and of Vietnamese participants (Nguyen & Anderson, 2005). Retaining native identity was shown to be related to more personal depression stigma levels in Yugoslavian immigrants living in Australia (Copelj & Kiropoulos, 2011) and retaining native culture values were negatively related to seeking psychological help in Asian participants in the US (Kim & Omizo, 2003; Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010). Zang and Dixon (2003) showed that higher acculturation towards American culture is related to higher stigma tolerance and attitudes towards seeking professional help in Asian international students in the US.

No studies appear to have been conducted in Australia investigating psychological help-seeking behaviours and stigma towards mental health among Russian-speaking immigrants. Many studies from other countries have reported that this group has low help-seeking behaviour and high stigmatizing attitudes towards mental illness. For example, in the US depression is a common problem for Russian-speaking immigrants and they were shown not

to seek professional help for its treatment (Aroian & Norris, 2002). Russians were shown to be less tolerant to mental health problems than a British sample (Shulman & Adams, 2002). Older aged Russian immigrants were found to minimize mental illness, often labelling it as 'stress' (Polyakova & Pacquiao, 2006). Additionally, older aged Russian immigrants have been found to think of depression as a common outcome of immigration and aging, or a consequence of living through war (Polyakova & Pacquiao, 2006; Team, 2006). Ritsner and colleagues (2000) suggested that high levels of somatisation symptoms in a FSU group in Israel was related to stigma around mental health problems, and somatisation and stoicism was also particularly strong among Russian-speaking elderly in the US (Polyakova & Pacquiao, 2006). One of the pathways for Russian-speaking immigrants to seek help for mental help issues is turning to religion (Team, 2006). The majority of FSU immigrants also indicated that they would prefer to get help from their family members or friends, or they should be able to sort their problems themselves (Mirsky, Baron-Draiman, & Kedem, 2002; Polyakova & Pacquiao, 2006; Team, 2006). However, family members can be of little psychological help when they are themselves overwhelmed by the demands of immigration (Aroian, Spitzer, & Bell, 1996). Stigma, disgrace and shame to the family tend to be long-standing in the Russian community, even when the person diagnosed with mental illness has recovered (Polyakova & Pacquiao, 2006). This may be due to the common practices in Soviet Union, when someone hospitalized for mental illness, even after recovery, would be automatically registered in the system and discriminated against in their rights to accessing jobs and education (Shulman & Adams, 2002).

However, there is contradictory evidence that Russian culture has traditionally shown tolerance towards people who are mentally ill. In the past, some mentally ill were regarded as holy fools, and respected in the Russian community (Shulman & Adams, 2002). Mentally ill people were traditionally cared for within their community by their families, often with lots of patience (Shulman & Adams, 2002). Several studies have found that Russians hold less

stigmatizing attitudes than Westerners. For example, when people currently living in Russia, Germany and Mongolia were compared, Russians were shown to be more tolerant on many scale items towards psychiatric patients (Dietrich, et al., 2004). Similar attitudes towards mentally ill were found in Germany, Russia and Slovakia, with Russians showing more tolerance than Slovakians or Germans on certain stigma scale items (Schomerus, Matschinger, Kenzin, Breier, & Angermeyer, 2006).

Often, Russian-speaking people from FSU show distrust to psychologists and psychiatrists (Polyakova & Pacquiao, 2006), largely originating for political reasons. Historically, this relates to Soviet system abusing mental health diagnosis in the middle 20th century, when people who were a threat to the ruling government at the time, such as political activists, nationalists and other intellectuals, were often sent to psychiatric hospitals for treatment of 'schizophrenia' (Bonnie, 2002; Voren, 2010). In his speech in 1957, Nikita Khrushchev, the leader of USSR at that time, mentioned that "those who might start calling for opposition to Communism ... clearly their mental state is not normal." (Knapp, McDaid, Mossialos, & Thornicroft, 2007, p. 402). This mistrust of psychiatrists may be generalized to psychologists and other mental health professionals (Slonim-Nevo, Sharaga, & Mirsky, 1999). Immigrants from the FSU might not be aware of the various options of professional mental health care and which professionals can provide this mental health care (Polyakova & Pacquiao, 2006). Russian-speaking immigrants can be particularly mistrustful of host culture mental health workers, as these workers may not show an understanding of Russian culture and traditions (Polyakova & Pacquiao, 2006). Typically, psychiatrists have been seen as the only provider of mental health care in the FSU, as psychology was regarded as more of an academic discipline in the FSU (Kozulin & Venger, 1999).

FSU immigrants, like other immigrant groups living in Australia, might be reluctant to present for professional psychological help for mental health problems such as depression

(Kiropoulos, Blashki & Klimidis, 2006; Ziguras, Klimidis, Lewis & Stuart, 2003). Stigma around mental health issues might be particularly strong among Russian immigrants due to the factors outlined above, thus impeding help-seeking behaviours of this particular group to a greater extent than in other immigrant groups. However, traditional tolerant attitudes towards those with mental illness may also influence Russian-speaking immigrants in Australia to have less stigma.

Hence, the aims of this study are to: 1) examine levels of depression-related stigma and psychological help seeking attitudes in adult immigrants from the FSU living in Australia and compare these with Russian non-immigrants and Anglo-Australians, while controlling for socio-demographic factors and level of depression; and 2) examine the relationship between acculturation factors, depression stigma and psychological help-seeking attitudes in a Russian-speaking immigrant sample, while controlling for socio-demographic factors and level of depression.

METHOD

Participants

Russian immigrant sample

Sixty five Russian immigrants (37 female and 28 male), who were living in Australia and arrived on a skilled immigration visa, participated in the study. The average age of participants was 35.2 (*SD* = 6.1). Skilled visa applicants have to be under 45 years of age and of good health, be proficient in English, and possess qualifications which are in demand in Australia (Department of Immigration and Citizenship, 2008). Skilled immigrants started to arrive after the collapse of the Soviet Union in 1991. Unlike earlier immigrants, often persecuted or discriminated in Soviet Union (Christa, 2001), most skilled immigrants were not directly threatened by the political regime and choose to migrate for socio-economic

reasons. In the current study, the majority of participants came from Russian, Ukraine, or Belarus and were fluent in the Russian language.

Anglo-Australian sample

Sixty three Anglo-Australian participants (54 female and 9 male), living in Australia, participated in the study with a mean age of 29 years (*SD* = 6.3). Only those born in Australia and whose parents and grandparents were born in Australia, England, Scotland, Wales or Ireland were included in the sample.

Russian non-immigrant sample

Sixty five participants (56 female and 9 male) from Russia (69.2%), Ukraine (23.1%), and Belarus (7.7%) participated in the study. Mean age of participants was 30 years (*SD* = 8.8), and they were fluent in Russian.

Procedure

The Monash University Human Research Ethics Committee granted approval for this study. Russian-speaking non-immigrants were recruited through advertisements in Russian-community web-forums and Russian networking web communities (similar to Facebook). Anglo-Australian group was recruited through Melbourne web-forums, including university web board and Facebook. Russian-speaking immigrants were recruited through advertisements in Russian-community web-forums, Facebook and similar communities, Russian newspapers in Australia, and flyers at ethnic-specific social clubs and organizations in metropolitan areas of Melbourne.

Participants received an explanatory statement, and were required to complete a consent form before proceeding to the online questionnaire. All demographic information, depression and anxiety scores were collected through a secure Monash University website. The web

mechanism was employed to ensure participants received emails when they had high score on depressive or anxiety symptoms, with the relevant support services information.

English language versions of the questionnaires were translated into Russian by the first author, who is fluent in both Russian and English, who has a linguistics degree, and at the time was a Provisional Psychologist. After translation, both English and Russian versions were verified with another bilingual immigrant, who also had both linguistics and psychology background. The final translations were verified by a professional bilingual translator. All suggested corrections were discussed among those involved in the translation process. This method allowed us to make the most of the knowledge of the bilingual mental health professionals, and was preferred to the sequential translation/back translation method. Reliability was checked by examining the psychometric properties of the scales after data were collected, preceding any further analysis.

Materials

All three groups completed an on-line questionnaire assessing socio-demographic background and specific scales described below. Russian-speaking immigrant group completed additional scales related specifically to their immigration experience, such as acculturation scale.

Demographic information

All participants were asked to complete questions related to gender, date of birth, occupation, educational level, relationship status, and employment status.

Depression

Symptoms of depression in participants were measured with the Center for Epidemiologic Studies Depression Scale (CES-D), developed to measure depressive

symptoms in general population (Radloff, 1977). The CES-D consists of 20-items measuring depressed mood, feelings of worthlessness and hopelessness, loss of appetite, poor concentration, and sleep disturbance on a 4 point Likert scale asking 'how often have you felt this way during the past week': 0 = rarely or none of the time (less than 1 day), 1 = some or a little of the time (1–2 days), 2 = occasionally or a moderate amount of time (3–4 days), and 4 = most or all of the time (5–7 days). Scores of 21 or more were indicative of possible depression. This number was used as a cut-off score for generating a semi-automatic email to participants with referral information.

Acculturation

Level of acculturation was measured by the 54 item Language, Behaviour and Identity scale (LIB) (Birman & Trickett, 2001). The scale was developed with particular consideration for Russian immigrants in America. This scale was adapted to the current study by changing references to American culture and language to Australian culture and language. LIB is a bidimensional scale, which does not provide the overall score for acculturation, but rather two separate acculturation scores for Australian (AAI) and Russian (RAI) acculturation indices (27 items per Index). RAI and AAI can be further divided into three subscales each: language, identity and behaviour, assessed on a 4-point Likert-type scale (1 = not at all to 4 = very much). Higher score indicated greater acculturation to a Russian/Australian culture.

Depression Stigma

Stigmatising attitudes towards depression were measured using Depression Stigma Scale (DSS), consisting of 9 items assessing own attitudes towards depression (Personal stigma) and 9 items assessing perceived views of others towards depression (Perceived Stigma) (Griffiths et al., 2006a). Participants were presented with a vignette about John, 30 year old with symptoms of depression satisfying DSM criteria for major depressive disorder. A 5-point Likert scale (from 1 = strongly to 5 = strongly disagree) was used to measure the

responses. Sample items for the personal stigma subscale included, for example ‘A problem like John’s is a sign of personal weakness’, and for perceived stigma subscale included ‘Most people believe that a problem like John’s is a sign of personal weakness’.

Help-seeking attitudes

Help-seeking attitudes were measured by the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) (Mackenzie, et al., 2004), adapted from Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Turner, 1970). IASMHA scale consisted of 24 items measuring three factor subscales: Psychological Openness (openness to acknowledge psychological problems), Help-seeking Propensity (willingness to seek help for mental help issues), and Indifference to Stigma (concerns that the person might have with other people’s reaction to their mental problems). Ratings for each item were made on a 5-point Likert scale from 1 = disagree to 5 = agree.

Data analysis

Differences between socio-demographic variables were examined using chi square analyses. To examine differences between groups on personal and perceived stigma, psychological help seeking and level of depression, individual analyses of variance (ANOVAs) were performed. To examine predictors of stigma and psychological help seeking, multiple hierarchical regression analyses were performed. Age, gender, level of education, level of depression and group membership were entered as predictors. All categorical predictors were dichotomized prior to use in the regression analyses. To examine Russian and Australian acculturation and their relationship with stigma and psychological help seeking in the Russian immigrant sample only, we undertook multiple hierarchical regression analyses, controlling for age, gender and level of depression. All statistical analyses were conducted using SPSS V20.

Results

Table 7.1 summarizes descriptive characteristics for the Russian-speaking immigrant, Russian-speaking non-immigrant, and Anglo-Australian groups. Chi-square tests of independence showed that three groups differed significantly on the following variables: gender, χ^2 (2, N = 193) = 20, p < .01, relationship status, χ^2 (2, N = 193) = 48, p <.01, education, χ^2 (8, N = 193) = 133.7, p <.01, and employment status, χ^2 (6, N = 192) = 17.9, p <.001. Russian-speaking immigrants were more likely to be married, had higher levels of education, more likely to be employed full-time, and less likely to be unable to work than the two non-immigrant groups. A one-way analysis of variance (ANOVA) indicated that age *[F* (2, 187) = 12.96, p < .01] was significantly different between the three groups. Post-hoc comparisons using Tukey's HSD test indicated that the mean age of the Russian-speaking immigrant group (M = 35.2, SD = 6.1) was significantly higher than the mean ages of both the Russian-speaking non-immigrant group (M = 30.4, SD = 8.8) and the Anglo-Australian group (M = 29.1, SD = 6.3). Mean ages of the Anglo-Australian and Russian-speaking non-immigrant groups were not significantly different.

Table 7.1

Demographic Characteristics of Russian-speaking immigrants, Russian-speaking non-immigrants, and Anglo-Australians

	Russian-immigrants	Russian non-immigrants	Anglo-Australians
	N (%)	*N (%)*	*N (%)*
Relationship status			
Married/De facto	46 (70.8)	37 (56.9)	21 (33.3)
Divorced/Separated	15 (23.1)	4 (6.2)	3 (4.8)
Never married	4 (6.2)	24 (36.9)	38 (61.3)
Highest Level of Education			
Secondary school	0	3 (4.6)	15 (23.8)
College or TAFE	3 (4.6)	3 (4.6)	9 (14.3)
Bachelor	0	1 (1.5)	32 (50.8)
Master's	54 (83.1)	46 (70.8)	5 (7.9)
PhD	8 (12.3)	12 (18.5)	2 (3.2)
Employment status			
Full time	49 (64.9)	30 (46.2)	26 (41.9)
Part time	9 (13.8)	19 (29.2)	23 (37.1)
Not working/ Looking for work	14 (21.5)	10 (15.4)	11 (17.7)
Unable to work due to illness or injury	0	6 (9.2)	2 (3.2)

Table 7.2 presents the means, standard deviations and F values for depression related stigma and psychological help seeking between the three groups. For personal and perceived stigma, post hoc analyses showed that Russian-speaking immigrant group scored significantly lower on these measures compared to Anglo-Australian group, but there was no difference between the two Russian-speaking groups. For psychological openness and help-seeking propensity, the Russian-speaking immigrant group scored significantly lower than Russian-speaking non-immigrant and Anglo-Australian groups. No difference between groups was found on indifference to stigma variable. As can be seen from the table, for the significant differences in reported variables among three groups, effect size was mostly large, with medium size for the Help-Seeking propensity.

Table 7.2

Means, standard deviations and F values for depression related stigma, psychological help seeking and depression levels between the three groups

	Russian immigrants (N = 65) *M (SD)*	Russian non-immigrants (N = 65) *M (SD)*	Anglo-Australians (N = 63) *M (SD)*	*F*	η^2
Depression Stigma					
Personal	30.29(6.28)	31.25 (*4.97*)	37.36 (*4.78*)	30.99**	.26
Perceived	26.21(*5.58*)	24.47 (*5.07*)	22.16 (*5.71*)	8.23***	.09
Psychological Help seeking					
Openness	17.29 (7.21)	19.86(6.16)	22.61 (5.05)	11.14***	.11
Propensity	20.59 (5.83)	23.15 (6.71)	24.11 (6.45)	4.89**	.05
Stigma	20.68 (5.71)	20.7 5(6.72)	21.37 (7.47)	0.19	.00
Level of depression	8.83 (7.85)	14.8 (9.56)	21.35 (11.64)	26.19***	.22

Note. *$p < .05$. **$p < .01$. *** $p < .001$.

Personal – Personal Stigma; Perceived – Perceived stigma; IASMHS - Inventory of Attitudes toward Seeking Mental Health Services; Openness - Psychological Openness; Propensity - Help-Seeking propensity; Stigma - Indifference to Stigma.

Table 7.3 presents the results of the multiple hierarchical regression analyses conducted for variables predicting personal and perceived stigma in the three groups. For personal stigma in Step 1 a significant model emerged with 21% of the variation in personal stigma scores being predicted (adjusted $R^2 = 0.191$; $F = 11.57$; $df = 4$; $p < 0.001$). Significant

independent predictors included age, gender, and level of depression. The inclusion of Anglo-Australian group membership and Russian non-immigrant group membership variables in Step 2 resulted in an additional 17% of the variance being explained (R^2 change = 0.168) with the overall model accounting for 36% of the variance (Adjusted R^2 = 0.356; F = 17.48; df = 6; $p < 0.001$). Significant independent predictors included age, gender, and education. Anglo-Australian group membership was a significant predictor of personal stigma.

For perceived stigma, a significant model emerged at Step 1 with 10% of the variance in perceived stigma scores being explained (Adjusted R^2 = 0.108; F = 6.34; df = 4; $p < 0.001$). Significant predictors included education and level of depression. The inclusion of the of Anglo-Australian group membership and Russian non-immigrant group membership variables in Step 2 resulted in an additional 2% of the variance being explained (R^2 change = 0.020) with the overall model accounting for 12% of the variance being explained for perceived stigma (Adjusted R^2 = 0.119; F = 4.96; df = 6; $p < 0.001$). Significant independent predictors of perceived stigma were education, level of depression, and Russian immigrant group membership.

Table 7.3

Summary of Hierarchical Regression Analysis for Variables Predicting Personal and Perceived Stigma (N = 180)

	Personal Stigma			Perceived Stigma		
	B	*SE B*	*β*	*B*	*SE B*	*β*
Step 1						
Age	-0.17	0.06	-.20**	-0.05	0.06	-.06
Gender	-3.76	1.09	-.26**	0.20	1.06	.02
Education	0.24	1.15	.02	2.84	1.08	.19**
Depression	0.90	0.04	.16*	-0.14	0.04	-.27***
Step 2						
Age	-0.13	0.06	-.16*	-0.07	0.06	-.09
Gender	-3.48	0.99	-.24**	-0.13	1.07	-.01
Education	2.59	1.09	.16*	2.22	1.14	.15*
Depression	0.02	0.04	.03	-0.11	0.04	-.22**
RNI group	-.54	0.98	-.041	-1.53	1.06	-.13
AA group	5.87	1.10	.45***	-2.39	1.20	-.19*

Note: AA = dummy coded variable for Anglo-Australian group; RNI = dummy coded variable for Russian non-immigrant status. The reference group for AA and RNI is the Russian immigrant group. *$p <$ .05. **$p <$ .01. *** $p <$ .001.

Table 7.4 displays the hierarchical regression analyses for the variables predicting psychological help seeking for the three groups. For the psychological openness variable Step

1 produced a significant model with 16% of the variation in this variable being predicted (Adjusted R^2 = 0.140; F = 8.29; df = 4; p < 0.001). Gender was the only significant independent predictor. The inclusion of the Anglo-Australian and Russian non-immigrant group membership variables in Step 2 resulted in an additional 7% of the variance being explained (R^2 change = 0.07) with the final model accounting for 23% of the variance (Adjusted R^2 = 0.210; F = 8.94; df= 6; p < 0.001). Anglo-Australian group membership and gender remained significant predictors of psychological openness. For the help seeking propensity, Step 1 produced a significant model with 11% of the variation in this variable being predicted (Adjusted R^2 = 0.093; F = 5.56; df = 4; p < 0.000). Gender was a significant independent predictor. The inclusion of the Anglo-Australian and Russian non-immigrant group membership variables in Step 2 resulted in an additional 3% of the variance being explained (R^2 change = 0.033) with the final model accounting for 14% of the variance (Adjusted R^2 = 0.116; F = 4.92; df = 6; p < 0.001). Anglo-Australian group membership and gender were significant predictors of help-seeking propensity. For indifference to stigma, Step 1 produced a significant model with 9% of the variance being predicted (Adjusted R^2 = 0.088; F = 5.29; df = 4; p < 0.000). Level of depression was a significant independent predictor. The inclusion of the Anglo-Australian and Russian non-immigrant group membership variables in Step 2 resulted in an additional 1% of the variance being explained (R^2 change = 0.013) with the final model accounting for 10% of the variance (Adjusted R^2 = 0.091; F = 3.98; df = 6; p < 0.001). Level of depression remained the only significant independent predictor.

Table 7.4

Summary of Hierarchical Regression Analysis for Variables Predicting Psychological Help Seeking (N = 180)

	Openness			Propensity			Stigma		
	B	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Step 1									
Age	-0.05	0.06	-0.06	-0.01	0.06	-.01	-0.11	0.07	-.12
Gender	-5.65	1.16	-0.37**	-5.17	1.20	-.34***	-2.70	1.23	-.17
Education	0.23	1.19	0.01	0.17	1.23	.01	-0.34	1.26	-.02
Depression	-0.02	0.04	-0.00	-0.03	0.04	-.06	-0.18	0.04	-.30***
Step 2									
Age	-0.01	0.06	-0.01	0.01	0.06	0.01	-0.11	0.07	-.12
Gender	-5.20	1.14	-0.34***	-4.71	1.21	-0.31***	-2.69	1.26	-.17*
Education	1.88	1.21	0.11	1.18	1.29	0.07	0.30	1.32	.01
Depression	-0.06	0.04	-0.10	-0.07	0.04	-0.13	-0.20	0.04	-.34***
RNI group	1.40	1.13	.10	1.65	1.21	.12	-.48	1.26	-.035
AA group	5.12	1.28	.38***	3.53	1.37	.26*	1.50	1.41	.108

Note: AA = dummy coded variable for Anglo-Australian group; RNI = dummy coded variable for Russian non-immigrant status. The reference group for AA and RNI is the Russian immigrant group. *$p < .05$. **$p < .01$. *** $p < .001$.

Analyses using the Russian immigrant sample

We examined Russian and Australian acculturation in the Russian immigrant group using the Language, Identity and Behaviour (LIB) Acculturation scale for both the Australian and Russian culture. The Russian immigrant group had a total mean score of 81.10 (SD = 10.10) on the total Russian acculturation scale and a total mean score of 78.20 (SD = 9.70) on the total Australian acculturation scale.

Table 7.5 shows the results of the regression analyses for variables predicting personal and perceived stigma for the Russian-immigrant sample. With all the variables in the model, 14% of the variation in personal stigma scores could be predicted (Adjusted R^2 = 0.143; F = 2.39; df = 6; $p < 0.05$). As can be seen from Table 7.5, gender was the only significant predictor. For perceived stigma, with all the variables in the model, 2% of the variation in scores could be predicted (Adjusted R^2 = 0.015; F = 1.12; df = 6; $p > 0.05$). There were no significant independent predictors.

Table 7.5

Summary of Regression Analyses for Variables Predicting Personal and Perceived Stigma for Russian Immigrant Sample (N = 50)

	Personal Stigma			Perceived Stigma		
	B	*SE B*	*β*	*B*	*SE B*	*β*
Age	-.16	.16	-.15	-.12	.16	-.13
Gender	-5.45	1.9	-.43**	-1.93	1.77	-.17
Depression	.12	.11	.14	-.13	.11	-.18
RAI	-.04	.09	-.06	-.1	.09	-.17
AAI	-.02	.105	-.03	.06	.1	.1
PLA	7.28	9.28	.14	-1.39	8.85	-.03

Note: RAI = Russian Acculturation Index; AAI = Australian Acculturation Index; PLA = Proportion of Life in Australia. ** $p < .01$.

Table 7.6 shows the results of the regression analyses for variables predicting psychological help-seeking attitudes for the Russian-immigrant sample. For psychological openness, with all the variables in the model 18% of the variation in scores could be predicted (Adjusted $R^2 = 0.182$; $F = 2.85$; $df = 6$; $p < 0.05$). As can be seen from Table 7.6, gender was the only significant predictor. For help seeking propensity, with all the variables in the model, 7% of the variance could be predicted (Adjusted $R^2 = 0.073$; $F = 1.65$; $df = 6$; $p > 0.05$), with gender being the only significant predictor (see Table 7.6). Similarly, for indifference to stigma, with all the variables in the model, 13% of the variance could be predicted (Adjusted $R^2 = 0.132$; $F = 2.27$; $df = 6$; $p > 0.05$), with gender being the only significant predictor (see Table 7.6).

Table 7.6

Summary of Regression Analyses for Variables Predicting Psychological Help Seeking for Russian Immigrant Sample (N = 50)

	Openness			Propensity			Stigma		
	B	*SE B*	*β*	*B*	*SE B*	*β*	*B*	*SE B*	*β*
Age	-.13	.18	-.11	-.06	.15	-.06	-.11	.15	-.11
Gender	-6.76	2.08	-.47**	-5.34	1.74	-.46**	-3.73	1.76	-.33*
Depression	.13	.13	.14	.13	.11	.17	-.10	.11	-.14
RAI	-.01	.1	-.01	-.08	.09	-.14	.02	.09	.04
AAI	.09	.12	.13	-.08	.1	-.13	.09	.1	.16
PLA	13.4	10.39	.23	9.6	8.7	.20	4.3	8.78	.09

Note: RAI = Russian Acculturation Index; AAI = Australian Acculturation Index ; PLA = Proportion of Life in Australia. *$p < .05$. **$p < .01$.

Discussion

The main aim of the study was to compare Russian-speaking immigrants, Russian-speaking non-immigrants and Anglo-Australians on depression stigma and psychological help-seeking attitudes, while controlling for socio-demographic factors and levels of depression. Another aim was to evaluate whether acculturation factors were related to depression stigma and help-seeking attitudes for the Russian-speaking immigrant group.

Results indicated that the Russian-speaking immigrants were more likely to have more perceived stigma, and less personal stigma than Australian sample. Anglo-Australians were found to be higher on Psychological Openness and Help-seeking Propensity than Russian immigrants, while Russian non-immigrants and Russian immigrants did not differ from each other on these variables. No relationship between acculturation factors, depression, stigma and attitudes towards psychological help-seeking was found in the present study.

Russian-speaking immigrants were more likely than Australians to believe that others in the community would have stigmatizing attitudes towards a person with depression (perceived stigma), However, Russian-speaking immigrants reported lower levels of personal stigma compared to the Anglo-Australian sample. This finding is similar to previous research which found that perceived stigma was higher in Yugoslavian immigrants to Australia compared to an Anglo-Australian group (Copelj & Kiropoulos, 2011). Many previous studies have not distinguished between personal and perceived stigma, and showed that in general immigrants hold higher stigmatizing attitudes towards people with mental illness (Duong-Ohtsuka & Ohtsuka, 2001; Masuda, et al., 2009). Similarly, British respondents were found to be significantly more tolerant towards people with mental illness than Russian-speaking participants (Shulman & Adams, 2002). However, other studies with Russian-speaking

participants showed that they were more tolerant towards people with mental illness than other cultural groups (Dietrich, et al., 2004; Schomerus, et al., 2006).

Anglo-Australians were found to be higher than Russian immigrants on Psychological Openness and Help-seeking Propensity, while Russian non-immigrants and Russian immigrants did not differ from each other on these variables, after socio-demographic variables and level of depression were taken into account. These findings are similar to previous studies which showed that Russian-speaking immigrants tend not to seek help for psychological problems (Aroian & Norris, 2002; Team, 2006), and consistent with research with other immigrant groups in Australia (Wynaden, et al., 2005) and in the US (Morgan & Robinson, 2003).

Lower levels of personal stigma found in Russian-speaking immigrants compared to Australian participants can reflect the fact that traditionally people in Russia had tolerant attitudes towards mentally ill, regarded them as holy fools, respected and accepted them (Shulman & Adams, 2002). At the same time, high perceived stigma levels in Russian-speaking immigrants can be explained with the practices endorsed by FSU medical system which Russian-speaking immigrants would have been exposed to, where a person with a psychiatric diagnosis, even after recovery, continued to be registered and discriminated against, for example, in his or her ability to find a job (Polyakova & Pacquiao, 2006; Shulman & Adams, 2002). This could have contributed to the perception that others in the community have high stigma against people with mental illness in Russian-speaking immigrant group.

Participants in the Anglo-Australian group were more inclined to have positive attitudes towards seeking psychological help than the Russian-speaking immigrants. In Australia, mental health awareness campaigns have been promoted for many years now, with public beliefs about mental health and depression literacy changed noticeably over the past decade (Reavley & Jorm, 2011). In FSU countries, on the other hand, mental health literacy is not as

widely promoted at the state level and there is lack of general public knowledge of the area, and about accessing appropriate services. It can be argued that immigrants who have lived in Australia for a considerable amount of time would have had exposure to these mental health promotional campaigns. However, skilled immigrants from the FSU are a relatively new group in Australia, who started to arrive in the 1990s. Immigrants often maintain beliefs from their country of origin and it might take longer for the immigrant group, specifically for a relatively small one and not targeted by the awareness campaigns, to adopt host culture attitudes towards mental health and help-seeking.

Typically in Russia, it is expected that the family, in particular woman, will care for a loved one with a physical or mental disability (Mirsky, et al., 2002; Polyakova & Pacquiao, 2006; Team, 2006). Also, Russian immigrants tend to minimize mental illness, thinking of it as 'stress' or common outcome of immigration or living through war (Polyakova & Pacquiao, 2006; Team, 2006). Moreover, for many reasons, such as lack of English and lack of understanding the system, many immigrants are not aware of the opportunities available for support outside of immediate family (Team, 2006). The health system in Australia is very different from the health system in FSU countries, and understanding the operation of the system and the roles of different health specialists can take a long time. Another issue with low help-seeking attitudes in Russian-speaking immigrants from FSU is their mistrust of psychologists and psychiatrists, which might be connected with the past abuse of psychiatric diagnosis in the USSR (Bonnie, 2002; Polyakova & Pacquiao, 2006; Slonim-Nevo, et al., 1999; Voren, 2010). Russian-speaking immigrants often believe that host culture mental health workers do not understand Russian culture and traditions (Polyakova & Pacquiao, 2006). And while there are many Russian-speaking GPs, there are few Russian-speaking psychiatrists and psychologists in Australia, which can also impede psychological help-seeking attitudes.

No relationship between acculturation factors, such as acculturation to Russian and Australian culture, depression stigma and psychological help-seeking attitudes was found in the present study. This finding is inconsistent with previous research, which found a relationship between psychological help-seeking attitudes, stigma and acculturation to either native or host culture (Copelj & Kiropoulos, 2011; Kim & Omizo, 2003; Zhang & Dixon, 2003). These current findings can be due to the number of factors including scale format. Many previous studies which found the relationship between acculturation with mental health, employed unidimensional scales, for example Kumar and Nevid (2010), Zhang and Dixon (2003), while the scale employed in the current study was bidimensional. Also, some previous researchers employed a correlational design, which does not take into account the influence of the other variables in the equation (Copelj & Kiropoulos, 2011), while the current study used regression analysis.

Other factors contributing to depression stigma and psychological help-seeking attitudes were investigated in this study as well. We found that male participants were less likely than female participants to seek psychological help, similarly to previous research (Judd, et al., 2006; Mackenzie, Gekoski, & Knox, 2006; Sheikh & Furnham, 2000; ten Have, et al., 2010). Male participants had less personal stigma in our study, in contrast to the previous results (Griffiths, et al., 2008). Education did not play a role in psychological help-seeking attitudes, which is consistent with some previous findings (Fung & Wong, 2007; Zhang & Dixon, 2003), but contrary to Sheikh and Furnham's (2000) findings. Higher education in our overall sample was related to more personal and perceived stigma, contrary to Griffiths and colleagues'(2008) findings. Age was not related to psychological help-seeking attitudes, similar to some previous findings (Fung & Wong, 2007; Jang, Chiriboga, & Okazaki, 2009; Zhang & Dixon, 2003), whereas many other studies showed that age was an important factor (Mackenzie, et al., 2006). Younger age was associated with more personal stigma in our study, contrary to the results reported by Griffiths and colleagues (2008), where older

participants had more personal stigma. Those with less symptoms of depression had higher perceived stigma in this study, contrary to several previous findings (Griffiths, et al., 2008; Pyne et al., 2004).

Limitations impacting on generalization of the current findings include small sample size, use of self-rating scales in an online format, and non-random sampling which may not be representative of the wider Russian-speaking community. As this study is cross-sectional, it is impossible to make causal inferences and observe acculturation over time.

Future research should employ larger sample sizes so the results can be generalized to a wider Russian-speaking population in Australia. In addition, examination of other variables, implied in previous research, may be important. For example, previous encounters with mental health professionals were shown to be related to stigma (Griffiths, et al., 2008); religiosity was shown to be related to psychological help-seeking (Sheikh & Furnham, 2000; Team, 2006). Previous studies showed that gender depicted in the stories influenced causal beliefs about mental illness in Asian Indian immigrants in the US (Kumar & Nevid, 2010). Future studies should include stories with both male and female protagonists depicted in the case vignettes.

References

Aroian, K. J., & Norris, A. (2002). Assessing risk for depression among immigrants at two-year follow-up. *Archives of Psychiatric Nursing, 16*(6), 245-253.

Atkinson, D. R., & Gim, R. H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 2*, 209-212.

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry, 40*(1), 51-54.

Bayer, J. K., & Peay, M. Y. (1997). Predicting intentions to seek help from professional mental health services. *Australian and New Zealand Journal of Psychiatry, 31*(4), 504-513.

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*, 697-712.

Birman, D., & Trickett, E. J. (2001). Cultural Transitions in First-Generation Immigrants: Acculturation of Soviet Jewish Refugee Adolescents and Parents. *Journal of Cross-Cultural Psychology, 32*, 456-477.

Bonnie, R. J. (2002). Political abuse of psychiatry in the Soviet Union and in China: Complexities and controversies. *Journal of the American Academy of Psychiatry and the Law* , 30, 136-144.

Brown, C., Conner, K. O., Copeland, V. C., Grote, N., Beach, S., Battista, D., et al. (2010). Depression stigma, race, and treatment seeking behavior and attitudes. *Journal of Community Psychology, 38*(3), 350-368.

Chen, A. W., Kazanjian, A., & Wong, H. (2009). Why do Chinese Canadians not consult mental health services: health status, language or culture? *Transcultural Psychiatry, 46*(4), 623-641.

Chen, A. W., Kazanjian, A., Wong, H., & al., e. (2010). Mental health service use by Chinese immigrants with severe and persistent mental illness. *Canadian Journal of Psychiatry, 55*, 35-42.

Copelj, A., & Kiropoulos, L. (2011). Knowledge of depression and depression related stigma in immigrants from Former Yugoslavia. *Journal of Immigrant and Minority Health, 13*(6), 1013-1018.

Department of Immigration and Citizenship (2008). *Visas, Immigration and Refugees.* Retrieved January 21, 2011, from http://www.immi.gov.au/skilled/general-skilled-migration/

Dietrich, S., Beck, M., Bujantugs, B., Kenzine, D., Matschinger, H., & Angermeyer, M. (2004). The relationship between public causal beliefs and social distance toward mentally ill people. *Australian and New Zealand Journal of Psychiatry, 38*, 348 - 354.

Duong-Ohtsuka, T., & Ohtsuka, K. (2001). Differences in attitudes towards psychological help among Vietnamese- and Australian-born respondents. In A. Blaszczynski (Ed.), *Culture and gambling phenomenon: The proceedings of the11th National Conference of the National Association for Gambling Studies, Sydney* (pp. 119 - 127). Alphington, Australia: The National Association for Gambling Studies.

Fischer, E. H., & Turner, J. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*, 79-89.

Fung, K., & Wong, Y.-L. R. (2007). factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International Journal of Social Psychiatry, 53*(3), 216-231.

Griffiths, K., & Christensen, H. (2004). Commentary on 'The relationship between public causal beliefs and social distance toward mentally ill people. *Australian and New Zealand Journal of Psychiatry, 38*, 355-357.

Griffiths, K., Christensen, H., & Jorm, A. F. (2008). Predictors of depression stigma. *BMC Psychiatry*, *8*(25).

Griffiths, K., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F., & Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry*, *6*(21).

Ingleby, D. (2011). *Adapting mental health services to the needs of migrants and ethnic minorities*. New York: Cambridge University Press.

Jang, Y., Chiriboga, D. A., & Okazaki, S. (2009). Attitudes toward mental health services: Age-group differences in Korean American adults. *Aging & Mental Health, 13*(1), 127-134.

Judd, F., Jackson, H., Komiti, A., Murray, G., Fraser, C., Grieve, A., et al. (2006). Help-seeking by rural residents for mental health problems: the importance of agrarian values. *Australian and New Zealand Journal of Psychiatry*, *40*(9), 769-776.

Kim, B. S., & Omizo, M. M. (2003). Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counselor. *The Counseling Psychologist, 31*, 343-361.

Kiropoulos, L.A., Griffiths, K.M., & Blashki, G. (2011). Effects of a multilingual information website intervention on the levels of depression literacy and depression-related stigma in Greek-born and Italian-born immigrants living in Australia: A randomized controlled trial. *Journal of Medical Internet Research, 13(2)*

Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems. *Social Psychiatry and Psychiatric Epidemiology, 41*(9), 738-745.

Kumar, A., & Nevid, J. S. (2010). Acculturation, Enculturation, and Perceptions of Mental Disorders in Asian Indian Immigrants. *Cultural Diversity & Ethnic Minority Psychology, 16*(2), 274-283.

Leaf, P. J., Bruce, M. L., Tischler, G. L., & Holzer, C. E. (1987). The relationship between demographic factors and attitudes toward mental health services. *Journal of Community Psychology, 15*(2), 275-284.

Li, H. Z., & Browne, A. J. (2000). Defining mental illness and accessing mental health services: perspectives of Asian Canadians. *Canadian Journal of Community Mental Health, 19*(1), 143-159.

Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging & Mental Health, 10*(6), 574-582.

Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology, 34*(11), 2410-2433.

Masuda, A., Hayes, S. C., Twohig, M. P., Lillis, J., Fletcher, L. B., & Gloster, A. T. (2009). Comparing Japanese International College Students' and US College Students' Mental-Health-Related Stigmatizing Attitudes. *Journal of Multicultural Counseling and Development, 37*(3), 178-189.

Masuda, A., Suzumura, K., Beauchamp, K. L., Howells, G. N., & Clay, C. (2005). United States and Japanese college students' attitudes toward seeking professional psychological help. *International Journal of Psychology, 40*(5), 303-313.

Mental health policy and practice across Europe: the future direction of mental health care (2007). England, UK Open University Press.

Mirsky, J., Baron-Draiman, Y., & Kedem, P. (2002). Social support and psychological distress among young immigrants from the former Soviet Union in Israel. *International Social Work, 45*(1), 83-97.

Morgan, N. T., & Robinson, M. (2003). Students' help-seeking behaviours by gender, racial background, and student status. *Canadian Journal of Counselling, 37*(2).

Nguyen, Q. C. X., & Anderson, L. P. (2005). Vietnamese Americans' attitudes toward seeking mental health services: Relation to cultural variables. *Journal of Community Psychology, 33*(2), 213-231.

Panganamala, N. R., & Plummer, D. L. (1998). Attitudes toward counseling among Asian Indians in the United States. *Cultural Diversity and Mental Health, 4*, 55-83.

Papadopoulus, C., Leavey, G., & Vincent, C. (2002). Factors influencing stigma: A comparison of Greek-Cypriot and English attitudes. *Social Psychiatry and Psychiatric Epidemiology, 37*, 430-434.

Polyakova, S. A., & Pacquiao, D. F. (2006). Psychological and mental illness among elder immigrants from the Former Soviet Union. *Journal of Transcultural Nursing, 17*(1), 40-49.

Pyne, J. M., Kuc, E. J., Schroeder, P. J., Fortney, J. C., Edlund, M., & Sullivan, G. (2004). Relationship between perceived stigma and depression severity. *The Journal of Nervous and Mental Disease, 192*(4), 278-283.

Radloff, L. S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401.

Reavley, N. J., & Jorm, A. F. (2011). Recognition of mental disorders and beliefs about treatment and outcome: findings from an Australian National Survey of Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry, 45*(11), 947-956.

Reavley, N. J., Yap, M. B. H., Wright, A., & Jorm, A. F. (2011). Actions taken by young people to deal with mental disorders: findings from an Australian national survey of youth. *Early Intervention in Psychiatry, 5*(4), 335-342.

Ritsner, M., Ponizovsky, A., Kurs, R., & Modai, I. (2000). Somatization in an immigrant population in Israel: A community survey of prevalence, risk factors, and help-seeking behavior *American Journal of Psychiatry, 157,* 385-392.

Schomerus, G., Matschinger, H., Kenzin, D., Breier, P., & Angermeyer, M. C. (2006). Public attitudes towards mental patients: a comparison between Novosibirsk, Bratislava and German cities. *European Psychiatry, 21*(7), 436-441.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology, 35*(7), 326-334.

Shulman, N., & Adams, B. (2002). A comparison of Russian and British attitudes towards mental health problems in the community. *International Journal of Social Psychiatry, 48*(4), 266-278.

Slonim-Nevo, V., Sharaga, Y., & Mirsky, J. (1999). A culturally sensitive approach to therapy with immigrant families: The case of Jewish emigrants from the Former Soviet Union. *Family Process, 38*(4), 445-462.

Team, V. (2006). *Health and Caregiving Experiences of Russian-speaking Women Migrants.* The University of Melbourne, Melbourne.

ten Have, M., de Graaf, R., Ormel, J., Vilagut, G., Kovess, V., Alonso, J., et al. (2010). Are attitudes towards mental health help-seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. *Social Psychiatry and Psychiatric Epidemiology, 45*(2), 153-163.

Ting, J. Y., & Hwang, W. C. (2009). Cultural Influences on Help-Seeking Attitudes in Asian American Students. *American Journal of Orthopsychiatry, 79*(1), 125-132.

Voren, R. v. (2010). Political Abuse of Psychiatry—An Historical Overview. *Schizophrenia Bulletin, 36*(1), 33-35.

Wong, Y. J., Tran, K. K., Kim, S.-H., Van Horn Kerne, V., & Calfa, N. A. (2010). Asian Americans' lay beliefs about depression and professional help seeking. *Journal of Clinical Psychology, 66*(3), 317-332.

Wrigley, S., Jackson, H., Judd, F., & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry, 39*(6), 514 - 521.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing, 14*(2), 88-95.

Zhang, N. J., & Dixon, D. N. (2003). Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of multicultural counseling and development, 31*(3), 205-222.

PART IV

INTEGRATED DISCUSSION

Chapter 8

General discussion

This research focused on mental health, acculturation, depression stigma and psychological help-seeking among Russian-speaking skilled immigrants living in Australia. There were three broad aims of the study:

(1) to examine the levels of depression and anxiety symptoms in Russian-speaking skilled immigrants in Australia compared to non-immigrants living in FSU, and an Anglo-Australian group, while controlling for socio-demographic and other factors;

(2) to explore relationships between measures of Russian and Australian acculturation and immigration stress, measured with the Demands of Immigration Scale. I was also interested in examining whether immigration stress uniquely contributes to measures of Australian and Russian acculturation and whether Russian immigrants living in Australia endorse a bidimensional acculturation model; and

(3) to examine levels of depression related stigma and psychological help seeking in adult immigrants from the FSU living in Australia and compare these with Russian non-immigrants and Anglo-Australians, while controlling for socio-demographic factors and level of depression, and to examine the relationship between acculturation factors, depression stigma and psychological help-seeking attitudes in a Russian-speaking immigrant sample, while controlling for socio-demographic factors and level of depression.

Three empirical papers presented in this thesis correspond to these three broad aims. The research was largely exploratory; no previous studies had been conducted with the same population in Australia. I discuss the major findings in this chapter.

Research Aim One: Comparison of depressive and anxiety symptoms in three groups

The first paper provided some background and statistical information regarding immigration to Australia, specifically skilled immigration and immigration from Russia and the FSU. To be able to proceed with my aim, I reviewed studies regarding mental health problems of immigrants to Australia and other host nations. Generally, the majority of studies outlined in Australia and internationally reported more mental health issues in immigrants than in the host country population, with some exceptions, for example, with Latin-American immigrant groups (Ataca, 1998; Escobar et al., 1998; Kiropoulos, Klimidis, & Minas, 2004; Oh, Koeske, & Sales, 2002; Pernice & Brook, 1996; Tang, Dennis, & Comino, 2009; Thompson, 2002; Vega et al., 1998). A gap in research was identified, with virtually no studies looking at adaptation of skilled Russian immigrants in Australia.

Previous findings regarding the mental health of Russian-speaking immigrants were presented next. The majority of the findings with Russian-speaking immigrants in other countries indicate that this group reported higher levels of psychopathology than their host counterparts, and their distress is typically longstanding (Aroian & Norris, 1999; Aroian & Norris, 2002; Flaherty, Kohn, & Levav, 1988; Gutkovich et al., 1999; Kohn, Flaherty, & Levav, 1989; Miller & Chandler, 2002; Ponizovsky et al., 1998; Ritsner & Ponizovsky, 1999; Ullman & Tatar, 2001). Only a few studies showed that Russian-speaking immigrants did not have higher levels of psychopathology and instead, were adapting better than some other immigrant groups (Blomstedt, Johansson, & Sundquist, 2007).

To examine the levels of depressive and anxiety symptoms in Russian-speaking skilled immigrants in Australia and to compare their symptoms with non-immigrants living in FSU and an Anglo-Australian group, three groups were compared with around 60 participants in

each group. All three groups completed a number of questionnaires online, with a selection from the questionnaires being included for analysis for the purposes of the first paper. The questionnaires assessed socio-demographic background, levels of depressive and anxiety symptoms, and social support. Participants were compared on a number of parameters. Factors to be controlled for in the exploration of depressive and anxiety symptoms were identified based on differences in socio-demographic factors between groups and previous research findings.

The results indicated that Russian-speaking skilled immigrants reported lower levels of depressive and anxiety symptoms than Russian-speaking non-immigrants and Anglo-Australians, while Russian-speaking non-immigrants reported higher depression and anxiety scores than the immigrant group. The difference remained significant after controlling for demographic variables such as age, gender, relationship status, highest educational level, employment and health status, and perceived stress. The findings were somewhat unexpected, given the vast literature regarding immigrants and their usually higher levels of mental health issues compared to host counterparts (Ataca, 1998; 1998; Kiropoulos, Klimidis, & Minas, 2004; Oh, Koeske, & Sales, 2002; Pernice & Brook, 1996; Tang, Dennis, & Comino, 2009; Thompson, 2002). In particular, the majority of previous studies with Russian-speaking immigrants indicated that this group reported higher levels of psychopathology (Khavarpour & Rissel, 1997; Krupinski, 1981; McDonald, Vechi, Bowman, & Sanson-Fisher, 1996; Thompson, 2002; Tang, Dennis, & Comino, 2009). However, other studies with immigrants, and in particular Russian-speaking immigrants, did not show more psychopathology than other immigrant groups or the host population (Ali, 2002; Alpass et al., 2007; Blomstedt, Johansson, & Sundquist, 2007; Escobar et al., 1998; Gee, Kobayashi, & Prus, 2004; Hoffmann et al., 2006; Vega et al., 1998).

In the discussion section for the first article, we provided several possible explanations

for these results. We argued that our sample had characteristics which distinguished it from the samples of Russian-speaking participants employed in previous research, due to the specifics of skilled visa requirements. Participants in our sample migrated to Australia voluntarily, were generally younger and better employed, had good social support and health compared to the Russian-speaking participants in the past studies (Aroian & Norris, 1999; Gutkovich et al., 1999; Kohn, Flaherty, & Levav, 1989; Miller & Chandler, 2002; Ponizovsky et al., 1998). Another possible explanation of our results was that our Anglo-Australian sample had higher levels of depressive and anxiety symptoms compared to previous national studies (Kiropoulos, Klimidis, & Minas, 2004; Khan, Marlow, & Head, 2008; Poltavski & Ferraro, 2003; Radloff, 1977; Simpson, Schumaker, Dorahy, & Shrestha, 1996) with the possibility of on-line sampling attracting people with more mental health issues in Australia.

Research Aim Two: Acculturation in skilled immigrants from the FSU living in Australia

We defined acculturation, and described both the unidimensional and bidimensional acculturation framework, and measures of acculturation. The value of a bidimensional model was highlighted, as a more widely used framework, and as a framework which was supported by the current results. Factors associated with acculturation were described, with particular emphasis on Russian-speaking immigrants. Gender, length of residency, education, employment and social support were shown to be related to the acculturation of Russian-speaking immigrants in the US and Israel (Birman & Trickett, 2001; Birman, Trickett, & Vinokurov, 2002; Birman & Tyler, 1994; Miller & Chandler, 2002). Immigration stress was another important variable shown to be related to the bidimensional process of acculturation in Russian-speaking immigrants in the US and Finland (Birman & Trickett, 2001; Birman, Trickett, & Buchanan, 2005; Jasinskaja-Lahti, Liebkind, & Solheim, 2009; Mähönen, Jasinskaja-Lahti, & Liebkind, 2011; Roytburd & Friedlander, 2008; Vinokurov, Trickett, &

Birman, 2002). Though previous studies with Russian-speaking immigrants explored the link between immigration stress and acculturation, no studies were conducted in Australia. This article aimed to fill in this gap in the literature. This is important for further advancing of our knowledge of acculturation processes in skilled immigrants, which can affect development of various programs and services.

To explore relationships between measures of Russian and Australian acculturation and immigration stress, 65 Russian-speaking skilled immigrants living in Australia were selected from the overall sample. We selected only specific scales and questions for analysis from the total questionnaire, based on the aims of the second paper. The scale and questions selected included socio-demographic questions, acculturation, immigration stress and social support scales. The relationship between acculturation, specifically the Russian Acculturation Index and the Australian Acculturation Index, and immigration stress, was examined through hierarchical multiple regression, controlling for socio-demographic factors identified in previous research. Correlations between Russian and Australian indices were computed to see if dimensions of the two cultures were independent.

Our results indicated that immigration stress was related to the retention of Russian culture and decrease of Australian acculturation, after controlling for socio-demographic factors. Other factors related to an increase in Australian acculturation, included longer proportion of life in Australia and not being married, whereas higher social support was associated with increased Russian acculturation. Our findings were in line with many previous studies, with acculturation and immigration stress related in a similar fashion in Russian-speaking immigrants living in the US (Birman & Trickett, 2001; Birman, et al., 2005; Miller & Chandler, 2002; Roytburd & Friedlander, 2008; Vinokurov, et al., 2002). Other variables found to be important in the acculturation process of Russian-speaking immigrants in Australia were demonstrated in other studies with Russian-speaking immigrants, such as

proportion of life in Australia and social support (Birman & Trickett, 2001; Birman, et al., 2005; Miller, Wang, Szalacha, & Sorokin, 2009; Vinokurov, Birman, & Trickett, 2000). However, we were unable to locate a study with Russian-speaking immigrants where relationship status was included as a predictor of acculturation. We explained the relationship between Australian acculturation and relationship status with the pattern of immigration within the Russian community, where the majority of immigrants typically arrive to Australia with a partner from the same cultural background, which might hinder Australian acculturation. Not having a partner, on the other hand, might facilitate friendship and social life outside the Russian community, thus increasing acculturation into the Australia/host nation way of life.

Overall, we did not find an association between Russian and Australian dimensions of acculturation, which lends support to a bidimensional framework discussed in many past studies (Berry, 1980, 2006; Hutnik, 1986; La Fromboise, Coleman, & Gerton, 1993), and suggests that acculturation can occur independently along both host and native dimensions of acculturation.

Research Aim Three: Stigma and help seeking in Russian-speaking skilled immigrants

The third and final empirical paper of the thesis focuses on depression stigma and psychological help-seeking attitudes in immigrants from the FSU living in Australia, and how they compare with Anglo-Australian and Russian non-immigrant group on these measures. Some previous research showed that many immigrant groups have low psychological help-seeking behaviours. Several factors were outlined as important in help-seeking behaviours and service utilisation, among them help-seeking attitudes and stigma towards mental illness. Low help-seeking attitudes and higher stigma levels were found in different immigrant groups

in past research, both in Australia and internationally (Copelj & Kiropoulos, 2011; Duong-Ohtsuka & Ohtsuka, 2001; Masuda et al., 2009; Wynaden et al., 2005). Factors associated with psychological help-seeking attitudes and stigma towards people with mental illness were multifold, including causation attribution, education and familiarity with mental health, age, gender, current distress, and past experiences in seeking psychological help (Dietrich et al., 2004; Griffiths, Christensen, & Jorm, 2008; Leaf, Bruce, Tischler, & Holzer, 1987; Masuda, Suzumura, Beauchamp, Howells, & Clay, 2005; Shulman & Adams, 2002).

Though many studies exist which have examined stigma towards mental illness and psychological help-seeking in a variety of immigrant groups, no studies appear to have been conducted in Australia specifically investigating psychological help-seeking behaviours and depression stigma in Russian-speaking skilled immigrants. Research conducted mostly in the US and Israel showed that Russian-speaking immigrants have low help-seeking behaviour and high stigmatizing attitudes towards mental illness (Aroian & Norris, 2002; Mirsky, Baron-Draiman, & Kedem, 2002; Polyakova & Pacquiao, 2006; Shulman & Adams, 2002). On the other hand, traditionally certain types of people with mental illness were regarded as holy fools, and respected and cared for in the Russian community (Shulman & Adams, 2002). This might be reflected in studies where Russians were found to be more tolerant than people of some other cultures towards those who are mentally ill (Dietrich, et al., 2004; Schomerus, Matschinger, Kenzin, Breier, & Angermeyer, 2006). Another issue important to mention here is that mistrust towards mental health services, in particular of psychologists and psychiatrists, was prominent in the USSR and this could have been influenced by the Soviet abuse of the diagnosis of mental illness in the mid 20th century (Bonnie, 2002; Voren, 2010). Understanding of Russian culture by mental health workers was mentioned as important for successful psychological help-seeking in Russian-speaking immigrants (Polyakova & Pacquiao, 2006).

Another aim of this article was to explore how acculturation influences depression stigma and psychological help-seeking. Previous studies have demonstrated that acculturation was related to help-seeking, attitudes towards help-seeking, and stigma in different immigrant groups in the US and Australia (Atkinson & Gim, 1989; Copelj & Kiropoulos, 2011; Kim & Omizo, 2003; Kumar & Nevid, 2010; Nguyen & Anderson, 2005; Panganamala & Plummer, 1998; Wong, Tran, Kim, Van Horn Kerne, & Calfa, 2010). However, no studies have been conducted with Russian-speaking immigrants examining the relationship between these three variables.

The three groups, Russian-speaking skilled immigrants living in Australia, Russian-speaking non-immigrants living in FSU, and an Anglo-Australian group, were selected for the purpose of the study, with around 60 participants in each group. All three groups completed a number of questionnaires online, with a selection being analysed for the purposes of the third paper. The questionnaires examined depressive symptoms, depression stigma, psychological help-seeking attitudes, acculturation to Russian and Australian cultures, and socio-demographic questions. The three groups were compared through hierarchical multiple regression, controlling for socio-demographic factors identified in the previous research. The relationships between Russian Acculturation Index and Australian Acculturation Index, depression stigma and psychological help-seeking were examined through hierarchical multiple regression only in the Russian-speaking immigrant group, controlling for socio-demographic factors identified in the previous research.

Russian-speaking immigrants were more likely than Australians to believe that others in the community had higher levels of stigma related to mental problems, but they reported lower personal stigma. Previous research findings with Russian groups have been equivocal, with some research reporting this group to be significantly less tolerant towards people with mental illness compared to their host counterparts (Shulman & Adams, 2002), and other

research showing them to be more tolerant towards people with mental illness compared to other cultural groups (Dietrich, et al., 2004; Schomerus, et al., 2006). Based on the literature reviewed, we suggested that lower levels of personal stigma in the Russian-speaking immigrants compared to Australian participants may reflect the traditionally tolerant attitudes Russian people have towards the mentally ill (Shulman & Adams, 2002), while high perceived stigma may be explained with the practices endorsed by the FSU medical system, where a person with psychiatric diagnosis, even after recovery, continued to be registered and discriminated against, for example, in his or her ability to find a job (Polyakova & Pacquiao, 2006; Shulman & Adams, 2002). This could have led to the perception that others in the community have high stigma against people with mental illness.

Anglo-Australians were found to be higher on help-seeking attitudes than the two Russian groups, similarly to previous studies showing that Russian-speaking immigrants tend not to seek help for psychological problems (Aroian & Norris, 2002; Team, 2006). One explanation of this may relate to media promotion of mental health and seeking help in Australia, under the auspices of *beyondblue,* while in the FSU countries mental health campaigns such as beyond blue are much less prominent. Other suggested explanations are a typical expectation of family care of someone with a physical or mental disability (Mirsky, et al., 2002; Polyakova & Pacquiao, 2006; Team, 2006), minimization of mental illness by Russians (Polyakova & Pacquiao, 2006; Team, 2006), lack of understanding of the health system in the host country (Team, 2006), and, as discussed above, traditional mistrust of psychiatric care (Bonnie, 2002; Polyakova & Pacquiao, 2006; Slonim-Nevo, Sharaga, & Mirsky, 1999; Voren, 2010).

No relationship between acculturation to Russian and Australian cultures, depression stigma and psychological help-seeking was found in the present study, contrary to previous research in the other cultural groups (Copelj & Kiropoulos, 2011; Kim & Omizo, 2003;

Zhang & Dixon, 2003). One explanation we suggested was a difference between the scale formats (bidimensional versus unidimensional) used in the previous studies and in our own work (Kumar & Nevid, 2010, Zhang & Dixon, 2003).

Limitations

The current research included the use of self-rating scales with non-random sampling using an on-line response format. It is typical for research employing immigrant groups to use non-random sampling. However, as a consequence, it is difficult to generalise our results to a wider population. It was impossible to select a random sample, given that we needed to recruit specific subgroup from Russian-speaking group - those who arrived on skilled immigrant visa. In addition, although I collected significant data on demographic variables, I did not collect data on location (rural or urban); this may be interesting to explore in the future.

Our results regarding depressive and anxiety symptoms, depression stigma, and psychological help-seeking in Russian-speaking immigrants may also be influenced by the scales used, which were developed and validated in English-speaking (and primarily US) populations. The concepts used in these scales, even with valid translation, can be unfamiliar or seem strange to those of a Russian background. Indeed, when culturally derived diagnostic measures were used with Vietnamese non-immigrants and Vietnamese immigrants to Australia, the prevalence rates for mental disorders for both groups increased (Steel et al., 2009). Scales which allow for culturally relevant expressions of psychological distress may have rendered different results to those obtained in the current study. The use of self-rated scales can represent another problem, which might be addressed in the future by combining self-rating and objective measures, for example, psychiatric interviews as well as the administration of a depression scale.

The current research used an on-line questionnaire which was advertised through

various web forums and as a result, we had no influence over the sampling. There are many advantages of online research, such as reduced costs, creation of an automatic database, large population access and no time limitations (Campos, Zucoloto, Bonafé, Jordani, & Maroco, 2011; Riva, Teruzzi, & Anolli, 2003). Many previous studies have explored the validity of Internet-based surveys compared to paper-and-pencil ones, and found that online format was indeed viable in psychological research (Campos, Zucoloto, Bonafé, Jordani, & Maroco, 2011; Riva, Teruzzi, & Anolli, 2003). Some researchers mention that online data collection can increase reporting of sensitive information by participants (Kaysa, Gathercoalb, & Buhrowc, 2012; Kreuter, Presser, & Tourangeau, 2008). However, there are many caveats to online data collection, such as difficulty controlling study environments and monitoring participants (Riva, Teruzzi, & Anolli, 2003). Access to the Internet can still be overrepresented by those with college degrees (Granello, & Wheaton, 2004). Our sample consisted of more female respondents, in particular in the Anglo-Australian and Russian non-immigrant groups. Males and females might use internet for different reasons and searching for different types of information, and females might be more likely to use Internet for searching for information for depression. Some of the previous studies found that female and male are slightly different on how they respond to sensitive items from the surveys, including mental health questions, with males have more missing data on sensitive items (Kaysa, Gathercoalb, & Buhrowc, 2012). The possibility can be that male participants tend to participate less in surveys including sensitive items, which can be another explanation for the gender inbalance in the current study.

We did not explore if participants in our study were diagnosed with depression or anxiety disorders in the past or present, which may have affected study one and three in particular. It is possible that in Australia, it is more common for people with high levels of anxiety and depression symptoms or a diagnosed mental health problem to search and access

information via the Internet, while it might be less likely for Russian-speaking people to use the Internet for this purpose. Thus, those who may have a mental health problem or who had high levels of anxiety and depressive symptoms in Australia may have been more inclined to respond to and complete our web-based survey on this topic.

Many immigrants, including Russian-speaking immigrants, have been shown to manifest their anxiety and depressive symptoms through a more somatic presentation (Aroian & Norris, 1999; Kleinman, 2004Kohn et al., 1989; Ritsner, Ponizovsky, Kurs, & Modai, 2000). Reporting of somatic symptoms can be viewed as more culturally acceptable in many ethnic groups rather than communicating their psychological difficulties, especially in primary health care settings (Aragona et al., 2010; Kleinman, 2004). However, in the current study, we did not use any specific somatization scales to examine whether the current group of immigrants were somatizing symptoms of depression and anxiety. This could have affected the results of the first study.

Implications

The current study is original in several aspects. There are virtually no studies examining the mental health, acculturation, depression stigma and psychological help-seeking among Russian-speaking immigrants, nor with any other skilled immigrant groups in Australia. Our findings suggest that skilled immigrants might have very different trajectories of adaptation compared to other migrant groups, such as refugees or other humanitarian settlers. The current study found that Russian-speaking skilled immigrants were shown to report fewer mental health problems and thus appear to adapt better than many other immigrant groups in Australia.

The study also contributes to the understanding of acculturation. Support of Berry's bidimensional acculturation model was found in this study, indicating that Russian-speaking

immigrants acculturate along two dimensions – to both Australian and Russian cultures. However, further replications of our findings are needed in the Australian context.

Measures developed specifically for the Russian-speaking population, such as acculturation (Birman & Trickett, 2001) and immigration stress measures (Aroian, Norris, Tran & Schappler-Morris, 1998), have been developed relatively recently and are not as widely used, possibly due to the relatively small numbers of Russian-speaking immigrants compared to many other immigrant groups. The current study has also provided psychometric evaluations and further exploration of the reliability of these measures.

Finally, the data collected has implications for policy and program development and psychotherapy targeted at skilled immigrants. Even though the results of the current thesis showed that Russian-speaking immigrants do not have high levels of anxiety and depressive symptoms, it is important to understand the cultural specifics of this group when they present for counselling. Being white, with a high education and good jobs, may mislead mental health workers that people within this group do not experience discrimination, which may influence their acculturation to the host society. Education about discrimination and options for immigrants of how to deal with it can be suggested. Knowledge of factors implied in the process of acculturation such as immigration stress can help mental health workers to devise individual programs for these immigrants. Russian speaking participants can be highly educated and be employed in professional settings, but they may still be resistant to seeking psychological help, as the current study showed. This knowledge may be important for GPs and mental health professionals when they assess patients for psychological therapy, as without some extra psychoeducation, these patients might never proceed with the therapy. National immigration policies and acculturation programs for skilled immigrants should be informed by the research with this group, as there are unique factors, highlighted in this thesis, which contribute to acculturation of this particular group. Our findings can also inform

program development targeting Russian-speaking immigrants, and suggest the value of looking at different immigrant populations separately.

Future Research

Future research is required with Russian-speaking skilled immigrants, as well as other skilled-immigrant groups in Australia, to validate the current results and examine acculturation further. I also collected more data than reported in the current thesis, which can be explored in the future studies.

Future research might examine the acculturation and immigration stress relationship in more detail. For example, specific domains of acculturation, such as language, behaviour and identity can be investigated in relation the domains of immigration stress, such as loss, novelty, occupational adjustment, language difficulties, discrimination, and not feeling at home. Understanding the specifics of this relationship can inform the programs delivered to help immigrants' acculturation process.

Longitudinal studies will help to answer questions about the variability of adjustment difficulties over time, which areas along the way require most help, and which factors contribute to the resolution of the difficulties at different stages of life in the host country. For example, anxiety symptoms may be most prominent during the initial stage of resettlement, while depressive symptoms may appear at a later stage. Social support, in particular, instrumental social support, may serve as a protective factor at the start of resettlement, while emotional support may play more of an important role in the later stages.

Future research should employ larger sample sizes so the results can be generalized to a wider Russian-speaking population in Australia. In addition, an examination of other variables, implied in previous research, may be important. For example, previous encounters with mental health professionals were shown to be related to stigma (Griffiths, et al., 2008),

how religious the person is was also related to psychological help-seeking (Sheikh & Furnham, 2000; Team, 2006), and personality factors such as hardiness were shown to be important for psychological adaptation (Ataca, 1998).

Other adaptation outcomes, such as economic adaptation, family life, or domains of well-being, such as satisfaction in life, may paint a better picture of immigrant acculturation in the Australian context. Past studies have shown the importance of including varied types of outcome measures. Future research should also include culturally sensitive measures which take into account somatic presentation of psychological distress, validated in both English and Russian languages.

References

Abbassi, A., & Stacks, J. (2007). Culture and anxiety: a cross-cultural study among college students. *Journal of Professional Counseling, Practice, Theory, & Research 35*, 26-37.

Adelman, M. B. (1988). Cross-cultural adjustment: A theoretical perspective on social support. *International Journal of Intercultural Relations, 12,* 183-205.

Alati, R., Najman, J. M., Shuttelwood, G. J., Williams, G. M., & Bor, W. (2003). Changes in mental health status amongst children of migrants to Australia: a longitudinal study. *Sociology of Health & Illness, 25*(7), 866-888.

Alba, R., & Nee, V. (1997). Rethinking assimilation theory for a new era of immigration. (Special Issue: Immigrant Adaptation and Native-Born Responses in the Making of Americans). *International Migration Review, 31*(4), 826-84).

Ali, J. (2002). *Mental health of Canada's Immigrants. Supplement to Health Reports, (Cat. No.. 82-003)*. Ottawa: Statistics Canada.

Alpass, F., Flett, R., Trlin, A., Henderson, A., North, N., Skinner, M., et al. (2007). Psychological wellbeing in three groups of skilled immigrants to New Zealand. *Australian Journal of Rehabilitation Counselling, 13* (1), 1-13.

Angel, J., Buckley, C. J., & Karl, F. B. (2001). Nativity and self-assessed health among pre-retirement age Hispanic and non-Hispanic whites. *International Migration Review, 35*(3), 784-803.

Arends-Toth, J. V., & Fons, J. R. v. d. (2006). Assessment of psychological acculturation. In J. W. Berry & D. L. Sam (Eds.), *The Cambridge Handbook of Acculturation Psychology*. Cambridge, UK: Cambridge University Press.

Aroian, K. J., & Norris, A. (2002). Assessing risk for depression among immigrants at two-year follow-up. *Archives of Psychiatric Nursing, 16*(6), 245-253.

Aroian, K. J., & Norris, A. (2003). Depression trajectories in relatively recent immigrants. *Comprehensive Psychiatry*, *44*(5), 420-427.

Aroian, K. J., & Norris, A. E. (1999). Somatization and depression among former Soviet immigrants. *Journal of Cultural Diversity, 6*(3), 93-101.

Aroian, K. J., Norris, A. E., & Chiang, L. (2003). Gender differences in psychological distress among immigrants from the former Soviet Union. *Sex Roles, 48*(1-2), 39-51.

Aroian, K. J., Norris, A., Tran, T. V., & Schappler-Morris, N. (1998). Development and psychometric evaluation of the Demands of Immigration Scale. *Journal of Nursing Measurement, 6*(2), 175 - 194.

American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text rev.).* Washington, DC: American Psychological Association.

Ataca, B. (1998). *Psychological, sociocultural, and marital adaptation of Turkish immigrant couples in Canada.* Queen's University, Ontario.

Atkinson, D. R., & Gim, R. H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 2*, 209-212.

Australian Bureau of Statistics. (2010). *Perspectives on Migrants.* Retrieved February 25, 2012, from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3416.0Main+Features4June%202010?OpenDocument#Anchor4

Australian Bureau of Statistics (2011a). *Australian Demographic Statistics Mar 2011.* Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0

Australian Bureau of Statistics. (2011b). *Media Release. 6 million migrants call Australia home.* *R*etrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3412.0Media%20Release12009-10?opendocument&tabname=Summary&prodno=3412.0&issue=2009-10&num=&view=

Australian Bureau of Statistics (2011c). *Media release: Two-thirds of recent migrants and temporary residents employed*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/6250.0Media%20Release1Nov%202010?opendocument&tabname=Summary&prodno=6250.0&issue=Nov%202010&num=&view=.

Australian Bureau of Statistics. (2008). Cat. No. 2068.0 2006 Census Tables: Language spoken at home (a) by sex. Retrieved from http://www.immi.gov.au/settlement/#sr=step_1

Aycan, Z., & Berry, J. W. (1996). Impact of employment-related experiences on immigrants' psychological well-being and adaptation to Canada. *Canadian Journal of Behavioural Science, 28*, 240-251.

Baek Choi, J., & Thomas, M. (2009). Predictive factors of acculturation attitudes and social support among Asian immigrants in the USA. *International Journal of Social Welfare, 18*(1), 76-84.

Barnes, L. L. B., Harp, D., & Jung, W. S. (2002). Reliability generalization of scores on the Spielberger State-Trait Anxiety Inventory. *Educational and Psychological Measurement, 62*(4), 603-618.

Bayer, J. K., & Peay, M. Y. (1997). Predicting intentions to seek help from professional mental health services. *Australian and New Zealand Journal of Psychiatry, 31*(4), 504-513.

Beiser, M., Barwick, C., Berry, J. W., & Wood, M. (1988). *After the door has been opened*. Ottowa: Multiculturalism and Citizenship and Health and Welfare.

Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. Padilla (Ed.), *Acculturation: Theory, models, and findings* (pp. 9–25). Boulder, CO: Westview

Berry, J. W. (1990). Psychology of acculturation: Understanding individuals moving between cultures. In R. Brislin (Ed.), *Applied cross-cultural psychology* (pp. 232-253). Newbury Park, CA: Sage.

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46*, 5-34.

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations, 29*, 697-712.

Berry, J. W. (2006). Design of acculturation studies. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology*. Cambridge, UK: Cambridge University Press.

Berry, J. W. (2006a). Contexts of acculturation. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology*. Cambridge, UK: Cambridge University Press.

Berry, J. W. (2006b). Stress perspectives on acculturation. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 43-57). Cambridge, UK: Cambridge Univeristy Press.

Berry, J. W., & Lonner, W. (1986). *Field methods in cross-cultural research.*Beverly Hills Sage Publications

Berry, J. W., Phinney, J. S., Sam, D. L., & Vedder, P. (2006). Immigrant youth: Acculturation, identity and adaptation. *Applied Psychology: An International Review, 55*, 303-332.

Berry, J. W., Poortinga, Y. H., Breugelmans, S. M., Chasiotis, A., & Sam, D. L. (2011). *Cross-cultural psychology: Research and applications (3rd ed.)*. Cambridge: Cambridge University Press.

Betts, K. (1991). Australia's distorted immigration policy. In D. Goodman, D. J. O'Hearn & C. Wallace-Crabbe (Eds.), *Multicultural Australia: the challenges of changes* (pp. 149-177). Newham, Australia: Scribe.

Birman, D. (1998). Biculturalism and perceived competence of Latino immigrant adolescents. *American Journal of Community Psychology, 26*(3), 335-354.

Birman, D., & Trickett, E. J. (2001). Cultural transitions in first-generation immigrants: Acculturation of Soviet Jewish refugee adolescents and parents. *Journal of Cross-Cultural Psychology, 32*, 456-477.

Birman, D., & Tyler, F. B. (1994). Acculturation and alienation of Soviet Jewish refugees in the United States. *Genet Genetic, Social and General Psychology Monographs, 120*(1), 101-115.

Birman, D., Trickett, E. J., & Buchanan, R. (2005). A tale of two cities: replication of a study on the acculturation and adaptation of immigrant adolescents from the Former Soviet Union in a different community context. *American Journal of Community Psychology,, 35*(1-2), 83-101.

Birman, D., Trickett, E. J., & Vinokurov, A. (2002). Acculturation and adaptation of Soviet Jewish refugee adolescents: predictors of adjustment across life domains. *American Journal of Community Psychology, 30*, 585-607.

Blomstedt, Y., Johansson, S. E., & Sundquist, J. (2007). Mental health of immigrants from the former Soviet Bloc: a future problem for primary health care in the enlarged European Union? A cross-sectional study. *BMC Public Health, 7*.

Boneva, B. S., & Frieze, I. H. (2001). Toward a concept of migrant personality. *Journal of Social Issues, Immigrants and Immigration 57*, 477-491.

Bonnie, R. J. (2002). Political Abuse of Psychiatry in the Soviet Union and in China: Complexities and Controversies. *Journal of the American Academy of Psychiatry and the Law, 30*, 136-144.

Bourhis, R. Y., Moïese, L. A., Perrault, S., & Senécal, S. (1997). Towards an interactive acculturation model: Social psychological approach. *International Journal of Psychology, 32*, 369-386.

Brown, C., Conner, K. O., Copeland, V. C., Grote, N., Beach, S., Battista, D., et al. (2010). Depression stigma, race, and treatment seeking behavior and attitudes. *Journal of Community Psychology, 38*(3), 350-368.

Campos, J. A. D. B., Zucoloto, M. L., Bonafé, F. S. S., Jordani, P. C., & Maroco, J. (2011). Reliability and validity of self-reported burnout in college students: A cross randomized comparison of paper-and-pencil vs. online administration. *Computers in Human Behavior, 27*(5), 1875-1883.

Chae, M. H., & Foley, P. F. (2010). Relationship of ethnic identity, acculturation, and psychological well-being among Chinese, Japanese, and Korean Americans. *Journal of Counseling and Development, 88*(4), 466-476.

Chen, A. W., Kazanjian, A., & Wong, H. (2009). Why do Chinese Canadians not consult mental health services: health status, language or culture? *Transcultural Psychiatry, 46*(4), 623-641.

Chen, A. W., Kazanjian, A., Wong, H., & al., e. (2010). Mental health service use by Chinese immigrants with severe and persistent mental illness. *Canadian Journal of Psychiatry, 55*, 35-42.

Chen, C., Lee, S., & Stevenson, H. W. (1995). Response style and cross-cultural comparisons of rating scales among East Asian and North American students. *Psychological Science, 6*(*3*), 170-175.

Christa, B. (2001). Russians. In J. Jupp (Ed.), *The Australian People - An Encyclopedia of the Nation, Its People and Their Origins* (pp. 636-642). Cambridge: Cambridge University Press.

Chung, R. H. G., Kim, B. S., & Abreu, J. M. (2004). Asian American multidimensional acculturation scale: Development, factor analysis, reliability, and validity. *Cultural Diversity and Ethnic Minority Psychology, 10*, 66-80.

Cohen, S., & Hoberman, H. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology, 13*, 99-125.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*, 385-396.

Cohen, S., Memelstein, R., Kamarck, T., & Hoberman, H. (1985). Measuring the functional components of social support. In I. G. Sarason & B. Sarason (Eds.), *Social support: Theory, research and application* (pp. 73-94). The Hague, Holland: Martinus Nijhoff.

Collins, J. (2008). Globalisation, immigration and the second long post-war boom in Australia. *Journal of Australian Political Economy*, 61, 244-266.

Copelj, A., & Kiropoulos, L. (2011). Knowledge of depression and depression related stigma in immigrants from Former Yugoslavia. *Journal of Immigrant and Minority Health, 13*(6), 1013-1018.

Corrigan, P. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*, 48-67.

Cuellar, I., Bastida, E., & Braccio, S. M. (2004). Residency in the United States, subjective well-being, and depression in an older Mexican-Origin sample. *Journal of Aging and Health, 16*, 447-466.

Davies, L. C., & McKelvey, R. S. (1998). Emotional and behavioral problems and competencies among immigrant and non-immigrant adolescents. *Australian and New Zealand Journal of Psychiatry, 32*(5), 658-665.

Demographic yearbook of Russia of 1999. (2000). Russia: Moscow.

Department of Immigration and Citizenship. (n.d.). *Community information summary Russian Federation-born.* Retrieved January 25, 2011, from http://www.immi.gov.au/media/publications/statistics/comm-summ/_pdf/russian-federation.pdf

Department of Immigration and Citizenship (2008). *Visas, Immigration and Refugees.* Retrieved January 21, 2011, from http://www.immi.gov.au/skilled/general-skilled-migration/

Department of Immigration and Citizenship. (2010). *How new migrants fare: Analysis of the Continuous Survey of Australia's migrants.* Retrieved from http://www.immi.gov.au/media/publications/research/_pdf/csam-results-2010.pdf

Dietrich, S., Beck, M., Bujantugs, B., Kenzine, D., Matschinger, H., & Angermeyer, M. (2004). The relationship between public causal beliefs and social distance toward mentally ill people. *Australian and New Zealand Journal of Psychiatry, 38,* 348 - 354.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chavez, E., Katontoka, S., et al. (2011). Global Mental Health 6 Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *Lancet, 378*(9803), 1664-1675.

Duong-Ohtsuka, T., & Ohtsuka, K. (2001). Differences in attitudes towards psychological help among Vietnamese- and Australian-born respondents. In A. Blaszczynski (Ed.), *Culture and gambling phenomenon: The proceedings of the11th National Conference of the National Association for Gambling Studies, Sydney* (pp. 119 - 127). Alphington, Australia: The National Association for Gambling Studies.

Escobar, J. I., Gara, M., Silver, R. C., Waitzkin, H., Holman, A., & Compton, W. (1998). Somatisation disorder in primary care. *British Journal of Psychiatry, 173,* 262-266.

Escobar, J. I., Nervi, C. H., & Gara, M. A. (2000). Immigration and mental health: Mexican Americans in the United States. *Harvard Review of Psychiatry, 8*(2), 64-72.

Evans, R. (2001). The White Australia Policy. In J. Jupp (Ed.), *The Australian People - An Encyclopedia of the Nation, Its People and Their Origins* Cambridge: Cambridge University Press.

Fischer, E. H., & Turner, J. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology*, 35, 79-89.

Flaherty, J. A., Kohn, R., & Levav, I. (1988). Demoralization in Soviet-Jewish immigrants to the United States and Israel. *Comprehensive Psychiatry, 29,* 588-597.

Flannery, W. P., Reise, S. P., & Yu, J. (2001). An empirical comparison of acculturation models. *Personality and Social Psychology Bulletin, 27*, 1035-1045.

Flores, E., Tschann, J. M., Dimas, J. M., Bachen, E. A., Pasch, L. A., & Groat, C. L. d. (2008). Perceived discrimination, perceived stress, and mental and physical health among Mexican-origin adults. *Hispanic Journal of Behavioral Sciences, 30*, 401 - 424.

Flores, G., & Brotanek, J. (2005). The healthy immigrant effect. *Archives of Pediatric and Adolescent Medicine, 159,* 295-297

Furnham, A., & Shiekh, S. (1993). Gender, generational and social support correlates of mental health in Asian immigrants. *International Journal of Social Psychiatry, 39*(1), 22-33.

Furukawa, T. (1997). Depressive symptoms among international exchange students, and their predictors. *Acta Psychiatrica Scandinavica, 96*, 242-246.

Gee, E. M., Kobayashi, K. M., & Prus, S. G. (2004). Examining the healthy immigrant effect in mid- to later life: findings from the Canadian Community Health Survey. *Canadian Journal of Aging, 23* (1),S61-S69.

Gil, A. G., Wagner, E. F., & Vega, W. A. (2000). Acculturation, familism, and alcohol use among Latino adolescent males: Longitudinal relations. *Journal of Community Psychology*, *28*(4), 443-458.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice-Hall.

Gonidakis, F., Korakakis, P., Ploumpidis, D., Karapavlou, D.-A., Rogakou, E., & Madianos, M. G. (2011). The relationship between acculturation factors and symptoms of depression: A cross-sectional study with immigrants living in Athens. *Transcultural Psychiatry, 48*(4), 437-454.

González, H., Haan, M. N., & Hinton, L. (2001). Acculturation and the prevalence of depression in older Mexican Americans: Baseline results of the Sacramento area Latino study on aging. *Journal of the American Geriatrics Society, 49*(7), 948-953

Goot, M. (1993). Multiculturalism, monoculturalists and the many in between: Attitudes to cultural diversity and their correlates. *Australian and New Zealand Journal of Sociology, 29*(2), 226-253.

Gordon, M. M. (1964). *Assimilation in American life*. New York: Oxford University Press.

Govor, E. V. (1997). *Australia in the Russian mirror: changing perceptions 1770-1919.* Carlton, Vic. : Melbourne University Press

Granello, D., & Wheaton, J. E. (2004). Online Data Collection: Strategies for Research. *Journal Of Counseling & Development, 82*(4), 387-393.

Graves, T. D. (1967). Psychological acculturation in a tri-ethnic community. *Southwestern Journal of Anthropology, 23*(4), 337 -350

Griffiths, K., & Christensen, H. (2004). Commentary on 'The relationship between public causal beliefs and social distance toward mentally ill people. *Australian and New Zealand Journal of Psychiatry, 38*, 355-357.

Griffiths, K., Christensen, H., & Jorm, A. F. (2008). Predictors of depression stigma. *BMC Psychiatry, 8*(25), 1-12.

Griffiths, K., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F., & Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry, 6*(1), 1-12.

Gutkovich, Z., Rosenthal, R. N., Galynker, I., Muran, C., Batchelder, S., & Itskhoki, E. (1999). Depression and demoralization among Russian-Jewish immigrants in primary care. *Psychosomatics, 40*, 117-125.

Halbertstadt, A. (1996). A model assessment of an émigré family from the Former Soviet Union. *Journal of Jewish Communal Services, 72*, 298-309.

Haritatos, J., & Benet-Martínez, V. (2002). Bicultural identities: The interface of cultural, personality, and socio-cognitive processes. *Journal of Research in Personality, 36*, 598-606.

Hener, T., Weller, A., & Shor, R. (1997). Stages of acculturation as reflected by depression reduction in immigrant nursing students. *International Journal of Social Psychiatry, 43*(4), 247-256.

Ho, J., & Birman, D. (2010). Acculturation gaps in Vietnamese immigrant families: Impact on family relationships. *International Journal of Intercultural Relations, 34*(1), 22-23.

Ho, R., Niles, S., Penney, R., & Thomas, A. (1994). Migrants and multiculturalism: A survey of attitudes in darwin *Australian Psychologist, 29*(1), 62 - 70

Holton, R. (1997). *Research Paper No. 1. Immigration, Social Cohesion and National Identity.* Research Paper No. 1 1997-98 . Retrieved 25 January 2012 from http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/RP9798/98rp01

Hutnik, N. (1986). Patterns of ethnic minority identification and modes of social adaptation. *Ethnic and racial studies, 9*, 150-167.

Huynh, Q.-L., Howell, R. T., & Benet-Martínez, V. (2009). Reliability of bidimensional acculturation scores. *Journal of Cross-Cultural Psychology, 40*(2), 256-274.

Ingleby, D. (2011). *Adapting mental health services to the needs of migrants and ethnic minorities*. New York: Cambridge University Press.

Iwata, N., & Higuchi, H. R. (2000). Responses of Japanese and American university students to the STAI items that assess the presence or absence of anxiety. *Journal of Personality Assessment, 74*, 48-62.

Jasinskaja-Lahti, I. (2000). *Psychological acculturation and adaptation among Russian-speaking immigrant adolescents in Finland.* University of Helsinki, Helsinki.

Jasinskaja-Lahti, I., & Liebkind, K. (1998). Content and predictors of the ethnic identity of Russian-speaking immigrant adolescents in Finland. *Scandinavian Journal of Psychology, 39*, 209-219.

Jasinskaja-Lahti, I., & Liebkind, K. (2000). Predictors of actual degree of acculturation of Russian speaking immigrant adolescents in Finland. *International Journal of Intercultural Relations, 24*, 503-518.

Jasinskaja-Lahti, I., & Liebkind, K. (2007). A structural model of acculturation and well-being among immigrants from the former USSR in Finland. *European Psychologist, 12*(2), 80-92.

Jayasuriya, L., Lang, D., & Fielding, A. (1992). *Ethnicity, Immigration and Mental Illness: A critical review of Australian research*. Canberra: Bureau of Immigration Research.

Jordens, A.-M. (2001). Immigration since the Second World War. In J. Jupp (Ed.), *The Australian People - An Encyclopedia of the Nation, Its People and Their Origins* Cambridge: Cambridge University Press.

Judd, F., Jackson, H., Komiti, A., Murray, G., Fraser, C., Grieve, A., et al. (2006). Help-seeking by rural residents for mental health problems: the importance of agrarian values. *Australian and New Zealand Journal of Psychiatry, 40*(9), 769-776.

Jupp, J. (2001). Changes in Immigration Patterns since 1972. In J. Jupp (Ed.), *The Australian People - An Encyclopedia of the Nation, Its People and Their Origins* Cambridge: Cambridge University Press.

Kang , S. M. (2006). Measurement of acculturation, scale formats, and language competence: Their implications for adjustment. *Journal of Cross-Cultural Psychology, Journal of Cross-Cultural Psychology, 37*(6), 669-693.

Kaysa, K., Gathercoalb, K., & Buhrowc, W. (2012). Does survey format influence self-disclosure on sensitive question items? *Computers in Human Behavior, 28*(1), 251-256.

Kessler, R. C., Turner, J. B., & House, J. S. (1987). Intervening processes in the relationship between unemployment and health. *Psychological Medicine, 17*, 949-961.

Khavarpour, F., & Rissel, C. (1997). Mental health status of Iranian migrants in Sydney. *Australian and New Zealand Journal of Psychiatry*(31), 828-834.

Kim, B. S., & Omizo, M. M. (2003). Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counselor. *The Counseling Psychologist, 31*, 343-361.

Kiropoulos, L. A., & Bauer, I. (2011). Explanatory models of depression in Greek-born and Italian-born immigrants living in Australia: Implications for service delivery and clinical practice. *Asia-Pacific Psychiatry, 3(1),* 23-29

Kiropoulos, L.A., Griffiths, K.M., & Blashki, G. (2011). Effects of a multilingual information website intervention on the levels of depression literacy and depression-related stigma

in Greek-born and Italian-born immigrants living in Australia: A randomized controlled trial. *Journal of Medical Internet Research, 13*(2): e34

Kiropoulos, L. A., Klimidis, S., & Minas, H. (2004). Depression and anxiety: a comparison of older-aged Greek-born immigrants and Anglo-Australians. *Australian & New Zealand Journal of Psychiatry, 38*(9), 714-724.

Klimidis, S., Stuart, G., & Minas, I. H. (1994). Immigrant status and gender effects on psychopathology and self-concept in adolescents: a test of the migration-morbidity hypothesis. *Comprehensive Psychiatry*, *35*(39), 404.

Knapp, M., McDaid, D., Mossialos, E., & Thornicroft, G. (Eds.) (2007). *Mental health policy and practice across Europe: the future direction of mental health care* England, UK: Open University Press. Retrived from http://www.euro.who.int/__data/assets/pdf_file/0007/96451/E89814.pdf

Koch, M. W., Bjerregaard, P., & Curtis, C. (2003). Acculturation and mental health - empirical verification of J.W. Berry's model of acculturative stress. *Circumpolar Health, 63(5),* 371-376.

Kohn, R., Flaherty, J. A., & Levav, I. (1989). Somatic symptoms among older Soviet immigrants: an exploratory study. *International Journal of Social Psychiatry, 35*, 350-360.

Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems. *Social Psychiatry and Psychiatric Epidemiology, 41*(9), 738-745.

Koneru, V. K., Weisman de Mamani, A. G., Flynn, P. M., & Betancourt, H. (2007). Acculturation and mental health: Current findings and recommendations for future research. *Applied and Preventive Psychology, 12*(2), 76-96.

Kosic, A. (2004). Acculturation strategies, coping process and acculturative stress. *Scandinavian Journal of Psychology, 45*(4), 269-278.

Kreuter, F., Presser, S., & Tourangeau, R. (2008). Social desirability bias in CATI, IVR, and Web surveys: the effect of mode and question sensitivity. *Public Opinion Quarterly, 72*(5), 847-865.

Krupinski, J. (1981). Epidemiology and social psychiatric research. In R. Banchevska, A. MacKenzie & J. Krupinski (Eds.), *Psychiatric Research in Victoria: 25 years from 1956-1981. Special Publication No. 9.* Melbourne: Mental Health Research Institute, Health Commission of Victoria.

Kumar, A., & Nevid, J. S. (2010). Acculturation, enculturation, and perceptions of mental disorders in Asian Indian immigrants. *Cultural Diversity & Ethnic Minority Psychology, 16*(2), 274-283.

La Fromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin, 114*, 395-412.

Laireiter, A., & Baumann, U. (1992). Network structures and support functions: Theoretical and empirical analyses. In H. O. F. Veiel & U. Baumann (Eds.), *The meaning and measurement of social support* (pp. 33-55). Washington, DC: Hemisphere.

Lambert, W. E., Mermigis, L., & Taylor, D. M. (1986). Greek Canadians' attitudes toward own group and other Canadian ethnic groups: A test of the multiculturalism hypothesis. *Canadian Journal of Behavioral Science, 18*, 35-51.

Lara, M., Gamboa, C., Kahramanian, M. I., Morales, L. S., & Bautista, D. E. (2005). Lara M, Gamboa C, Kahramanian MI, Morales LS, Bautista DE. *Annual Review of Public Health, 26*, 367-397.

Laroche, M., Kim, C., Hui, M. K., & Joy, A. (1996). An empirical study of multidimensional ethnic change. *Journal of Cross-Cultural Psychology, 27*(1), 114-131.

Lauber, C., Nordt, C., Falcato, L., & Rossler, W. (2004). Factors influencing social distance toward people with mental illness. *Community Mental Health Journal, 40*(3), 265-274.

Lazarus, R. S., & Folkman, S. (1984). *Stress, coping and appraisal*. New York: Springer.

Leaf, P. J., Bruce, M. L., Tischler, G. L., & Holzer, C. E. (1987). The relationship between demographic factors and attitudes toward mental health services. *Journal of Community Psychology, 15*(2), 275-284.

Lee, J. S., Koeske, G. F., & Sales, E. (2004). Social support buffering of acculturative stress: A study of mental health symptoms among Korean international students. *International Journal of Intercultural Relations, 28*, 399-414.

Lee, S.-K., Sobal, J., & Frongillo, E. A. (2003). Comparison of models of acculturation. *Journal of Cross-Cultural Psychology, 34*(3), 282-296.

Li, H. Z., & Browne, A. J. (2000). Defining mental illness and accessing mental health services: perspectives of Asian Canadians. *Canadian Journal of Community Mental Health, 19*(1), 143-159.

Liebkind, K. (1996). Acculturation and stress: Vietnamese refugees in Finland *Journal of Cross-Cultural Psychology, 27*(2), 161-180.

Linacre, S. (2007). Migration: permanent additions to Australia's population (Cat. No. 4102.0). Retrieved from

http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/C91452EF314864A8CA25732F001C92F8/$File/41020_Migration%20-%20permanent%20additions%20to%20Australia's%20population%20_2007.pdf

Livingston, I. L., Neita, M., Riviere, L., & Livingston, S. L. (2007). Gender, acculturative stress and Caribbean immigrants' health in the United States of America - An exploratory study *West Indian Medical Journal, 56*(3), 213 -222.

Loue, S. (1998). Defining the immigran. In S. Loue (Ed.), *Handbook of Immigrant Health* (pp. 19-36). New York: Plenum Press.

Ma, A. X., Griffin, M. T. Q., Capitulo, K. L., & Fitzpatrick, J. J. (2010). Demands of immigration among Chinese immigrant nurses. *International Journal of Nursing Practice, 16*(5), 443-453.

Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging & Mental Health, 10*(6), 574-582.

Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology, 34*(11), 2410-2433.

Madianos, M. G. (2010). Acculturation and Mental Disorders among Immigrants. In L. Sher & A. Vilens (Eds.), *Immigration and Mental Health: Stress, Psychiatric Disorders and Suicidal Behavior Among Immigrants and Refugees* (pp. 101-112). New York: Nova Science Publishers.

Mähönen, T. A., Jasinskaja-Lahti, I., & Liebkind, K. (2011). Cultural discordance and the polarization of identities. *Group Processes & Intergroup Relations, 14*(4), 505-515.

Mak, W. W. S., Xiaohua Chen, S., Wong, E., & Zane, N. S. (2005). A psychosocial model of stress-distress relationship among Chinese Americans. *Journal of Social and Clinical Psychology*, *24*, 422-444.

Masgoret, A. M., & Ward, C. (2006). The cultural learning approach to acculturation. In D. L. Sam & J. W. Berry (Eds.), *Cambridge handbook of acculturation psychology* (pp. 58-77). Cambridge, UK: Cambridge University Press.

Maskarinec, G., & Noh, J. J. (2004). The effect of migration on cancer incidence among Japanese in Hawaii. *Ethnicity and Disease, 14*, 431-439.

Masuda, A., Hayes, S. C., Twohig, M. P., Lillis, J., Fletcher, L. B., & Gloster, A. T. (2009). Comparing Japanese International College Students' and US College Students' Mental-Health-Related Stigmatizing Attitudes. *Journal of Multicultural Counseling and Development, 37*(3), 178-189.

Masuda, A., Suzumura, K., Beauchamp, K. L., Howells, G. N., & Clay, C. (2005). United States and Japanese college students' attitudes toward seeking professional psychological help. *International Journal of Psychology, 40*(5), 303-313.

Maydell-Stevens, E., Masgoret, A. M., & Ward, T. (2007). Problems of psychological and sociocultural adaptation among Russian-speaking immigrants in New Zealand. *Social Policy Journal of New Zealand*, *30*, 178-198.

McDonald, R., Vechi, C., Bowman, J., & Sanson-Fisher, R. (1996). Mental health status of a Latin American community in New South Wales. *Australian and New Zealand Journal of Psychiatry, 30*, 457-462.

Mellor, D., Carne, L., Shen, Y.-C., McCabe, M., & Wang, L. (2012). Stigma Toward Mental Illness: A Cross-Cultural Comparison of Taiwanese, Chinese Immigrants to Australia and Anglo-Australians. *Journal of Cross-Cultural Psychology.*

Mellor, D., Hapidzal, F. M., Teh, K., Ganesan, R., Yeow, J., Latif R.A., Roslina & Cummins, R. (2012). Strong spiritual engagement and subjective well-being : a naturalistic investigation of the Thaipusam festival. *Journal of Spirituality in Mental Health*, 14 (*3*), 209-225.

Miller, A. M., & Chandler, P. J. (2002). Acculturation, resilience, and depression in midlife women from the former Soviet Union. *Nursing Research, 51*(1), 26-32.

Miller, A. M., Sorokin, O., Wang, E., Feetham, S., Choi, M., & Wilbur, J. E. (2006). Acculturation, social alienation, and depressed mood in midlife women from the former Soviet Union. *Research in Nursing & Health, 29*, 134–146.

Mirsky, J. (2009). Mental health implications of migration. *Social Psychiatry and Psychiatric Epidemiology, 44*(3), 179-187.

Mirsky, J., Baron-Draiman, Y., & Kedem, P. (2002). Social support and psychological distress among young immigrants from the former Soviet Union in Israel. *International Social Work, 45*(1), 83-97.

Mirsky, J., Slonim-Nevo, V., & Rubinstein, L. (2007). Psychological wellness and distress among recent immigrants: A four-year longitudinal study in Israel and Germany. *International Migration Review, 45*(1), 151-175.

Morawska, E. (1994). In defense of the assimilation model. *Journal of American Ethnic History, 13*(2), 76-87.

Murphy, H. B. M. (1977). Migration, culture and mental health. *Psychological Medicine, 7*, 677-684.

Museum Victoria. (n.d.) History of immigration from Russian Federation. Retrieved from http://museumvictoria.com.au/origins/history.aspx?pid=50

Naughton, M. J., & Wiklund, I. (1993). A critical review of dimension-specific measures of health-related quality of life in cross-cultural research. *Quality of Life Research, 2*, 397–432.

Nguyen, H. H., & von Eye, A. (2002). The acculturation scale for Vietnamese adolescents (ASVA): A bidimensional perspective. *International Journal of Behavioral Development,, 26*, 202-213.

Nguyen, H. H., Messé, L. A., & Stollak, G. E. (1999). Toward a more complex understanding of acculturation and adjustment. *Journal of Cross-Cultural Psychology*, *30*(1), 5-31.

Nguyen, Q. C. X., & Anderson, L. P. (2005). Vietnamese Americans' attitudes toward seeking mental health services: Relation to cultural variables. *Journal of Community Psychology*, *33*(2), 213-231.

Oberg, K. (1960). Cultural shock: adjustment to new cultural environments. *Practical Anthropology*, *7*, 177-182.

Oh, Y., Koeske, G. F., & Sales, E. (2002). Acculturation, stress and depressive symptoms among Korean immigrants in the United States. *The Journal of Social Psychology, 142*, 511-526.

Orshan, S. A. (1996). Acculturation, perceived social support, and self-esteem in Primigravida Puerto Rican teenagers. *Western Journal of Nursing Research, 18*(4), 460-473.

Oxford English Dictionary. (2011). Retrieved from http://www.oed.com/view/Entry/1259?redirectedFrom=acculturation#eid

Padilla, A., & Perez, W. (2003). Acculturation, social identity, and social cognition: A new perspective. *Hispanic Journal of Behavioral Sciences, 25*(1), 35-55.

Panganamala, N. R., & Plummer, D. L. (1998). Attitudes toward counseling among Asian Indians in the United States. *Cultural Diversity and Mental Health, 4*, 55-83.

Papadopoulus, C., Leavey, G., & Vincent, C. (2002). Factors influencing stigma: A comparison of Greek-Cypriot and English attitudes. *Social Psychiatry and Psychiatric Epidemiology, 37*, 430-434.

Pernice, R., & Brook, J. (1996). Refugees' and immigrants' mental health: association of demographic and post-immigration factors. *Journal of Social Psychology, 136*(4), 511-519.

Phinney, J. S. (1990). Ethnic identity in adolescents and adults: A review of research. *Psychological Bulletin, 108*, 499-514.

Phinney, J. S., & Devich-Navarro, M. (1997). Variations in bicultural identification among African American and Mexican American adolescents. *Journal of Research on Adolescence, 7*, 3-32.

Phinney, J. S., Madden, T., & Santos, L. J. (1998). Psychological variables as predictors of perceived ethnic discrimination among minority and immigrant adolescents. *Journal of Applied Social Psychology, 28*(11), 937-953.

Riva, G., Teruzzi, T., & Anolli, L. (2003). The use of the internet in psychological research: Comparison of online and offline questionnaires. *CyberPsychology & Behavior, 6*(1), 73-80.

Polek, E., van Oudenhoven, J. P., & ten Berge, J. M. F. (2008). Attachment styles and demographic factors as predictors of sociocultural and psychological adjustment of Eastern European immigrants in the Netherlands. *International Journal of Psychology, 43*(5), 919-928.

Polyakova, S. A., & Pacquiao, D. F. (2006). Psychological and mental illness among elder immigrants from the former Soviet Union. *Journal of Transcultural Nursing, 17*(1), 40-49.

Ponizovsky, A., Ginath, Y., Durst, R., Wondimeneh, B., Safro, S., & Minuchin-Itzigson, S. (1998). Psychological distress among Ethiopian and Russian Jewish immigrants to Israel: A cross-cultural study. *International Journal of Social Psychiatry, 44*, 35-45.

Ponizovsky, A. M., Radomislensky, I., & Grinshpoon, A. (2009). Psychological distress and its demographic associations in an immigrant population: findings from the Israeli National Health Survey. *Australian and New Zealand Journal of Psychiatry, 43(1*), 68-75.

Porter, R. (1991). *Faber Book of Madness*. London: Faber and Faber.

Radloff, L. S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401.

Reavley, N. J., Yap, M. B. H., Wright, A., & Jorm, A. F. (2011). Actions taken by young people to deal with mental disorders: findings from an Australian national survey of youth. *Early Intervention in Psychiatry, 5*(4), 335-342.

The IPSOS Mackay report (2010). *SBS immigration nation thought leadership research final report.* Retrieved from http://media.sbs.com.au/home/upload_media/site_20_rand_556105992_sbs_immigration_nation_summary_for_gbtwycf.pdf

Richardson, S., Miller-Lewis, L., Ngo, P., & Ilsley, D. (2002). *The settlement experiences of new migrants : a comparison of wave one of LSIA 1 and LSIA 2*. Adelaide, Australia: National Institute of Labour Studies, Flinders University.

Ritsner, M., & Ponizovsky, A. (1999). Psychological distress through immigration: The two-phase temporal pattern? *International Journal of Social Psychiatry, 45*(2), 125-139.

Ritsner, M., Modai, I., & Ponizovsky, A. (2000). The stress-support patterns and psychological distress of immigrants. *Stress Medicine, 16*(3), 139-147.

Ritsner, M., Ponizovsky, A., & Ginath, Y. (1997). Changing patterns of distress during the adjustment of recent immigrants: A 1-year follow-up study. *Acta Psychiatrica Scandinavica, 95*, 494-499.

Ritsner, M., Ponizovsky, A., & Ginath, Y. (1999). The effect of age on gender differences in the psychological distress ratings of immigrants. *Stress Medicine, 15*(1), 17-25.

Ritsner, M., Ponizovsky, A., Kurs, R., & Modai, I. (2000). Somatization in an immigrant population in Israel: A community survey of prevalence, risk factors, and help-seeking behavior. *American Journal of Psychiatry, 157*, 385-392.

Ritsner, M., Ponizovsky, A., Nechamkin, Y., & Modai, I. (2001). Gender differences in psychosocial risk factors for psychological distress among immigrants. *Comprehensive Psychiatry, 42*(2), 151-160.

Rodriguez Le Sage, M., & Townsend, A. (2004). Acculturation and depressive symptoms in Mexican American couples. *Journal of Human Behavior in the Social Environment, 10*, 131-154.

Rodriguez, C. P., & Nebot, T. K. (2011). Migratory stress and depressive symptoms: the mediating role of coping. *Revista Mexicana De Psicologia, 28*(2), 151-160.

Roytburd, L., & Friedlander, M. L. (2008). Predictors of Soviet Jewish refugees' acculturation: Differentiation of self and acculturative stress. *Cultural Diversity & Ethnic Minority Psychology, 14*(1), 67-74.

Rudmin, F. W. (2003a). Critical history of the acculturation psychology of assimilation, separation, integration, and marginalization. *Review of General Psychology, 7*(1), 3-37.

Rudmin, F. W. (2003b). Field notes from the quest for the first use of "acculturation". *Cross-Cultural Psychology Bulletin, 37*(4), 24-31.

Rudmin, F. W., & Ahmadzadeh, V. (2001). Psychometric critique of acculturation psychology: The case of Iranian migrants in Norway. *Scandinavian Journal of Psychology, 42*(1), 41-56.

Ryder, A. G., Alden, L. E., & Paulhus, D. L. (2000). Is acculturation unidimensional or multidimensional? A head-to-head comparison in the prediction of personality, self-identity, and adjustment. *Journal of Personality and Social Psychology, 79*, 49-65.

Sam, D. L. (1994). The psychological adjustment of young immigrants in Norway. *Scandinavian Journal of Psychology, 35*(3), 240-253.

Sam, D. L. (2006). Acculturation: conceptual background and core components. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 11-25). Cambridge, UK: Cambridge Univeristy Press.

Sam, D. L., & Berry, J. W. (1995). Acculturative stress among young immigrants in Norway. *Scandinavian Journal of Psychology, 36*(1), 10 - 24.

Sam, D. L., & Berry, J. W. (2010). Acculturation: When Individuals and Groups of Different Cultural Backgrounds Meet. *Perspectives on Psychological Science, 5*, 472-481.

Sanchez, J., & Fernandez, D. (1993). Acculturative stress among Hispanics: A bidimensional model of ethnic identification. *Journal of Applied Social Psychology, 23(8),* 654-658

Sang, D., & Ward, C. (2006). Acculturation in Australia and New Zealand. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology*. Cambridge, UK: Cambridge University Press.

Sayegh, L., & Lasry, J.-C. (1993). Immigrants' adaptation in Canada: assimilation, acculturation, and orthogonal cultural identification. *Canadian Psychology, 34*(1), 98-109.

Schomerus, G., Matschinger, H., Kenzin, D., Breier, P., & Angermeyer, M. C. (2006). Public attitudes towards mental patients: a comparison between Novosibirsk, Bratislava and German cities. *European Psychiatry, 21*(7), 436-441.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology, 35*(7), 326-334.

Shen, B.-J., & Takeuchi, D. T. (2001). A structural model of acculturation and mental health status among Chinese Americans. *American Journal of Community Psychology, 29*, 387-418.

Shulman, N., & Adams, B. (2002). A comparison of Russian and British attitudes towards mental health problems in the community. *International Journal of Social Psychiatry, 48*(4), 266-278.

Slonim-Nevo, V., Sharaga, Y., & Mirsky, J. (1999). A culturally sensitive approach to therapy with immigrant families: the case of jewish emigrants from the former Soviet Union. *Family Process, 38*(4), 445-462.

Sluzki, C. E. (1986). Migration and family conflict. In R. H. Moos (Ed.), *Coping with Life Crises* (pp. 277-288). New York: Plenum.

Spielberger, C. D., Gorsuch, R. L., & R.E., L. (1970). *Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.

Steel, Z., Silove, D., Giao, N. M., Phan, T. T. B., Chey, T., Whelan, A., et al. (2009). International and indigenous diagnoses of mental disorder among Vietnamese living in Vietnam and Australia. *British Journal of Psychiatry, 194*(4), 326-333.

Tang, G. W. G., Dennis, S., & Comino, E. (2009). Anxiety and depression in Chinese patients attending an Australian GP clinic. *Australian Family Physician, 38*(7), 552-555.

Team, V. (2006). *Health and Caregiving Experiences of Russian-speaking Women Migrants.* Unpublished DPH thesis, School of Public Health, The University of Melbourne, Melbourne.

ten Have, M., de Graaf, R., Ormel, J., Vilagut, G., Kovess, V., Alonso, J., et al. (2010). Are attitudes towards mental health help-seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. *Social Psychiatry and Psychiatric Epidemiology, 45*(2), 153-163.

Thompson, S., Hartel, G., Manderson, L., Woelz-Stirling, N., & Kelaher, M. (2002). The mental health status of Filipinas in Queensland. *Australian and New Zealand Journal of Psychiatry, 36*(5), 674-680.

Titzmann, P. F., Silbereisen, R. K., Mesch, G. S., & Schmitt-Rodermund, E. (2011). Migration-Specific Hassles Among Adolescent Immigrants From the Former Soviet Union in Germany and Israel. *Journal of Cross-Cultural Psychology, 42*(5), 777-794.

Ullman, C., & Tatar, M. (2001). Psychological adjustment among Israeli adolescent immigrants: A report on life satisfaction, self-concept, and self-esteem *Journal of Youth and Adolescence, 30*(4), 449-465.

United Nations, Department of Economic and Social Affairs, Population Division. (2009). *Trends in International Migrant Stock: The 2008 Revision.* Retrieved from http://www.un.org/esa/population/migration/UN_MigStock_2008.pdf

van Oudenhoven, J. P. (2006). Immigrants. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology* (pp. 163-180). Cambridge, UK: Cambridge University Press.

Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry, 55*, 771-778.

Vinokurov, A., Birman, D., & Trickett, E. (2000). Psychological and acculturation correlates of work status among Soviet Jewish refugees in the United States. *International Migration Review, 34*(2), 538-559.

Vinokurov, A., Trickett, E. J., & Birman, D. (2002). Acculturative hassles an immigrant adolescents: A life-domain assessment for Soviet Jewish refugees. *Journal of Social Psychology, 142*(4), 425-445.

Virta, E., Sam, D. L., & Westin, C. (2004). Adolescents with Turkish background in Norway and Sweden: A comparative study of their psychological adaptation. *Scandinavian Journal of Psychology, 45*, 15-25.

Vishnevskiy, A., & Zaychonkovskaya, Z. (1991). *Migratin from the USSR: the fourth wave. Demographic notes. Issue 3.* Moscow.

Voren, R. v. (2010). Political Abuse of Psychiatry—An Historical Overview. *Schizophrenia Bulletin, 36*(1), 33-35.

Ward, C., & Kennedy, A. (1992). Locus of control, mood disturbance and social difficulty during cross-cultural transitions. *International Journal of Intercultural Relations 16*, 175-194.

Ward, C., & Kennedy, A. (1993). Psychological and socio-cultural adjustment during cross-cultural transitions: A comparison of secondary students at home and abroad. *International Journal of Psychology, 28*(2), 129.

Ward, C., & Rana-Deuba, A. (1999). Acculturation and adaptation revisited. *Journal of Cross-Cultural Psychology, 30*(4), 422-442.

Ward, C., Bochner, S., & Furnham, A. A. (2001). *The psychology of culture shock.* London: Routledge.

Ward, C., Okura, Y., Kennedy, A., & Kojima, T. (1998). The U-Curve on trial: a longitudinal study of psychological and sociocultural adjustment during Cross-Cultural transition *International Journal of Intercultural Relations, 22*(3), 277-291

Westbrook, M. T., Legge, V., & Pennay, M. (1993). Attitudes towards disabilities in a multicultural society. *Social Science & Medicine 36*(5), 615-623

Westermeyer, J., Neider, J., & Callies, A. (1989). Psychosocial adjustment of Hmong refugees during their first decade in the United States. *The Journal of Nervous and Mental Disease, 177*(3), 132-139.

Winthrop, R. H. (Ed.) (1991). Dictionary of concepts in physical anthropology. New York: Greenwood.

World Health Organisation. (2005). *End human rights violations against people with mental health disorders*. Retrieved from http://www.who.int/mediacentre/news/releases/2005/pr68/en/

Wrigley, S., Jackson, H., Judd, F., & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry, 39*(6), 514 - 521.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. *International Journal of Mental Health Nursing, 14*(2), 88-95.

Zak, I. (1973). Dimensions of Jewish-American identity. *Psychological Reports, 33*, 891-900.

Zhang, N. J., & Dixon, D. N. (2003). Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of Multicultural Counseling And Development, 31*(3), 205-222.

APPENDICES

Appendix A

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date:	**17 August 2009**
Project Number:	**CF09/1131 - 2009000552**
Project Title:	**Assessment of psychosocial factors in immigrants from the Former Soviet Union**
Chief Investigator:	**Dr Litza Kiropoulos**
Approved:	**From: 17 August 2009 to 17 August 2014**

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.**
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Ben Canny
Chair, MUHREC

Cc: Dr Kathryn Gilson; Alla Demutska

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
Telephone +61 3 9905 5490 Facsimile +61 3 9905 3831
Email muhrec@adm.monash.edu.au www.monash.edu/research/ethics/human/index/html
ABN 12 377 614 012 CRICOS Provider #00008C

Appendix B

Действительно ли Вы - русскоязычный иммигрант, живущий в Австралии?

Проект

Мы интересуемся опытом иммиграции русскоязычных иммигрантов, в настоящее время живущих в Австралии.

Ваша причастность к данному исследованию поможет нам понять, с какими психологическими проблемами сталкиваются русскоязычные иммигранты, живущие в Австралии.

Кто может принять участие?

Мы ищем:

- участников от 20 до 60 лет
- прибывших в Австралию по программе квалифицированная иммиграция (Skilled migration visa stream)
- включенных в анкету в качестве главного заявителя (main applicant) или супруга(и) главного заявителя (main applicant's spouse)

В чем заключается исследование?

Нам нужна Ваша помощь в проекте. Вам нужно будет ответить на многочисленные вопросы онлайн, что может занять приблизительно 60-90 минут.

Участники будут включены лотерею на получение книжного ваучера Бордерс ($50)

Чтобы принять участие, пожалуйста, воспользуйтесь ссылкой:

За дополнительной информацией обращайтесь:

Исследователь:

Алла Демуцкая (английский и русский)

Электронная почта: [redacted]

Translation

Are you a Russian-speaking immigrant living in Australia?

The Project

We are interested in understanding the immigration experience in Russian-speaking immigrants currently living in Australia.

Your involvement in this research will help us understand the relationship between immigration and mental health issues relevant for Russian immigrants living in Australia.

Who is Eligible?

We are looking for:

- people who are aged between 20-60 years;
- people who have arrived in Australia under the skilled-migration program from one of the Former Soviet Union countries (Belarus, Ukraine, Russia)

You must be included in the skilled-migration application as a main applicant or main applicant's spouse

What does the Study Involve?

We would like your assistance in doing this research which involves answering questions online which will take approximately 60-90 minutes to complete.

Participants will be included into the draw to receive one from three $50 vouchers

To participate, please follow the link below:

Contact

To find out more please contact:

Researcher:

Ms Alla Demutska (English and Russian Speaking)

Email: [redacted]

Appendix C

Are you of an Anglo-Celtic background?

The Project

You are invited to take part in a research project that is investigating mental health issues, and knowledge and attitudes about mental health. We are interested in understanding these issues in Anglo-Australians, Russian immigrants living in Australia and Russian-speaking people living in the Former Soviet Union.

Who is Eligible?

We are looking for:

- people who are aged between 20-60 years;
- people who have been born in Australia and whose parents and grand-parents are of an Anglo-Celtic background (i.e., from England, Scotland, Ireland, Wales)

BOTH YOUR PARENTS OR BOTH SETS OF GRANDPARENTS must be born in Australia or England, Scotland, Wales, or Ireland

What does the Study Involve?

We would like your assistance in doing this research which involves answering questions online which will take approximately 60 minutes to complete.

Participants will be included into the draw to receive one from three 50$ vouchers

To participate, please follow the link below:

Contact

To find out more please contact:

Researcher:

Ms Alla Demutska (English and Russian Speaking)

Email: [redacted]

Appendix D

Действительно ли Вы - русскоязычный человек, живущий в России, Украине, или Белоруссии?

Проект

Данный проект направлен на исследование психологического здоровья, знаний и отношений к психологическим проблемам у иммгрантов из бывшего Советского Союза, проживающих в Австралии. Мы также интересуемся их опытом иммиграции.

Кто может принять участие?

Мы ищем:

- людей от 20 до 60 лет
- проживающих в настоящее время в Белоруссии, Украине и России

Вы должны говорить и читать по-русски

В чем заключается исследование?

Нам нужна Ваша помощь в этом проекте. Вам нужно будет ответить на многочисленные вопросы онлайн, что может занять приблизительно 60-90 минут.

Чтобы принять участие, пожалуйста, воспользуйтесь ссылкой:

За дополнительной информацией обращайтесь:

Исследователь:

Алла Демуцкая (английский и русский)

Электронная почта: [redacted]

Appendix D

Translation

Are you a Russian-speaking person living in Russia, Ukraine, or Belarus?

The Project

As part of this research we are investigating mental health issues, and knowledge and attitudes about mental health. We are also interested in understanding the immigration experience in Russian-speaking immigrants living in Australia.

Your involvement in this research will help us understand the relationship between immigration and mental health issues relevant for Russian immigrants living in Australia.

Who is Eligible?

We are looking for:

- people who are aged between 20-60 years;
- people living in Belarus, Ukraine and Russia.

You must speak and read Russian

What does the Study Involve?

We would like your assistance in doing this research which involves answering questions online which will take approximately 60-90 minutes to complete.

To participate, please follow the link below:

(link of website provided here when it becomes available)

Contact

To find out more please contact:

Researcher:

Ms Alla Demutska (English and Russian Speaking)

Email: [redacted]

Appendix E

Соглашение

Название проекта: Оценка влияния психологических и социальных факторов на иммигрантов из бывшего СССР

Замечание: Эта форма соглашения будет храниться у исследователей для их отчетов

Я согласен/согласна принять участие в научно-исследовательской работе при университете Монаш на указанную выше тему. Я понимаю, в чем заключается проект, и я прочитал(а) Информационный листок, который я могу загрузить и сохранить. Я понимаю, что решение принять участие в проекте означает, что:

- я согласен/ согласна заполнить опросники онлайн, в которых содержатся вопросы о моем психологическом здоровье, о признаках депрессии и тревожности, о моем опыте иммиграции (для русскоязычных участников, живущих в Австралии). **Да** **Нет;**

- я понимаю, что мое участие добровольно, и я могу отказаться участвовать во всем проекте или его части, а также могу прекратить участие на любой стадии проекта без последствий для себя;

- я понимаю, что любые данные, которые исследователь может извлечь из опросников для использования в публикациях или отчетах, не будут содержать имена или детали, по которым меня можно идентифицировать;

- я понимаю, что любая информация, которую я предоставляю, является конфиденциальной, и что любая информация, которая могла (сможет или смогла бы) привести к идентификации участника, не будет использоваться ни в каких отчетах о проекте, не будет обсуждаться вне команды исследователей;

- я согласен/ согласна, что данные, полученные из предоставленной мной информации, могут быть использованы для исследований и публикаций в будущем. **Да** **Нет;**

Я понимаю, что данные опросников будут сохранены в безопасном месте и доступны только исследовательской команде. Я также понимаю, что данные будут уничтожены после 5-летнего периода, если только не будет получено соглашение на их использование для дальнейших исследований.

Project Title: **An assessment of psychosocial factors in immigrants from the Former Soviet Union**

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I can download and keep for my records. I understand that agreeing to take part means that:

I agree to complete online questionnaires asking me about my mental health, including whether I am experiencing symptoms of depression and anxiety, and my immigration experience (for Russian-speaking participants living in Australia only) ☐ **Yes** ☐ **No**

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the online questionnaire for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I consent for my data from the online questionnaire to be used in future research or for future research projects / publications. ☐ **Yes** ☐ **No**

I understand that data from the online questionnaire will be kept in a secure storage and will be accessible only to the research team. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

Appendix F

Соглашение

Введением моего имени, электронной почты, телефонного номера и даты я подписываюсь в согласии принять участие в этом исследовании.

Имя участника:

Электронная почта:

Город и страна:

Дата:

Consent form for all participants

By completing the details of my name, e-mail, phone number and date at the space provided I am consenting to take part in this study.

Participant’s name:

E-mail:

City and Country:

Date:

Appendix G

Automatic e-mail to Russian immigrants (anxiety):

Дорогой Участник,

Спасибо за Ваши ответы на онлайн опросники, которые являются частью научно-исследовательской работы по оценке психологических и социальных факторов в иммигрантах из бывшего Советского Союза.

Вы знаете, что онлайн опросники включали различные вопросы, касающиеся Вашего отношения к Вашему здоровью, включая вопросы о том, испытываете ли Вы в настоящее время признаки депрессии и тревожности.

Я пишу Вам, потому что, согласно Вашим ответам, Ваш результат по шкале тревожности был высоким. Мы рекомендуем, чтобы Вы проконсультировались с Вашим терапевтом о получении направления к профессионалу в области психологического здоровья или если у Вас уже есть контактные данные такого профессионала, связаться с ним/ней.

Что такое тревожные расстройства?
Тревожные расстройства очень распространены среди населения. Есть несколько типов таких расстройств, такие как:

Простая фобия - это чрезмерные и необоснованные страхи перед объектами, такими как пауки или змеи, или ситуациями, такие как полет или инъекции.
Социальная фобия - интенсивный страх перед социальными ситуациями, что часто приводит к уклонению от всех или от некоторых социальных ситуаций.
Генерализованное тревожное расстройство- *чрезмерные* и не поддающиеся контролю беспокойство о ежедневных жизненных событиях, таких как страх что близкие люди заболеют, беспокойство об обществе или мировые событиях, финансах, отношениях.
Паническое расстройство- характеризуется внезапными и повторяющимися приступами паники и страхом перед будущими приступами.
Обсессивно-компульсивное расстройство – связано с тем, что у людей возникают нежелательные навязчивые мысли, которые заставляют их выполнять вынужденные действия (например, проверка, мытье рук и т.д).
Посттравматический стресс развивается в результате попадания в страшную травмирующую ситуацию, что часто приводит к кошмарам, воспоминаниям, ретроспективным образам, и уклонением от обстоятельств, связанных с ситуацией.

Больше информации о признаках тревожных расстройств мы можете получить на следующем вебсайте (на английском языке)
<http://www.anxietybc.com/>

Дальнейшая информация на русском языке о тревожных расстройствах доступна на:
<http://www.krugosvet.ru/enc/gumanitarnye_nauki/psihologiya_i_pedagogika/TREVOZHNIE_RASSTROSTVA.html>

Не повредит также обратиться к профессионалу в области психологического здоровья, чтобы помочь Вам понять, испытываете ли Вы вышеупомянутые симптомы.

Automatic e-mail to Anglo-Australian participants (anxiety):

An assessment of psychosocial factors in immigrants from the Former Soviet Union

Dear Participant,

Thank you for completing the online survey as part of the research project which is assessing psychosocial factors in immigrants from the Former Soviet Union.

As you are aware the online survey asked various questions relating to your attitudes towards your health including questions about whether you are currently experiencing symptoms of depression and anxiety.
I am writing to you because, according to the responses you have given, your overall score on the anxiety questionnaire was high. We recommend that you see your general practitioner about getting a referral to a mental health professional or if you already have the contact details of a mental health professional to get in contact with them.

What are anxiety disorders?

Anxiety disorders are very common among the general population. There are several types of anxiety disorders that people may experience. They are:

Specific Phobias - characterised by excessive and unreasonable fears of objects, such as spiders or snakes or situations, such as flying or receiving injections.
Social Anxiety Disorder - characterised by an intense fear of social situations, leading to avoiding some or any social situations.
Generalized Anxiety Disorder - characterized by *excessive* and uncontrollable worries about daily life events, such as close people becoming ill, community or world matters, finances, and relationships.
Panic Disorder - characterised by sudden and repeated panic attacks and fear of having more panic attacks in the future.
Obsessive Compulsive Disorder - characterized by people having unwanted intrusive thoughts which make them to engage in compulsive behaviors (i.e. checking, hand-washing etc).
Post Traumatic Stress Disorder is developed after being involved in a frightening traumatic event, which often leads to nightmares, memories, flashbacks, and avoiding the situations related to the event.

More information about symptoms of anxiety can also be obtained from:
http://www.anxietybc.com/

It is a good idea to see a mental health professional to help you understand whether you are experiencing any of the above.

Can anxiety disorders be treated?

Anxiety disorders can be effectively treated by a variety of methods, including medication and/or psychological therapy.
Speak to a mental health professional and your general practitioner will help you make an informed decision about what the best treatment option is for you.

Можно ли лечить тревожные расстройства?

Тревожные расстройства может эффективно лечить разными методами, включая медикаментозное лечение и/или психологическую терапию.
Поговорите с профессионалом в области психологического здоровья, и Ваш терапевт поможет Вам сделать информированный выбор лечения.

Где я могу получить помощь?

Как обсуждалось раннее, мы рекомендуем, чтобы Вы рассказали своему терапевту или профессионалу в области психологического здоровья о том, как Вы себя чувсвуете. Мы также подготовили список контактов, представленных ниже, с которыми Вы можете связаться.

Контакты:

Лайфлайн: 13 11 14
Лайфлайн предоставляет бесплатную, конфиденциальную помощь опытными волонтерами, которые принимают звонки 24-часа в день, в любой день недели и отовсюду в Австралии. Для тех, кто не говорит по-английски, могут быть подключены переводчики.

Телефон доверия по вопросам самоубийства: 1300 651 251
Телефон доверия по вопросам самоубийства обеспечивает конфиденциальную телефонную помощь, поддержку и направление к соответсвующим службам 24 часа в день, семь дней в неделю, по всей Виктории по стоимости внутригородского звонка.

Телефонная помощь детям: 1800 551 800
Телефонная помощь детям обеспечивает бесплатную, конфиденциальную и анонимную телефонную и онлайн помощь для молодых людей в возрасте между 5 и 25 годами. Волонтеры с опытом могут принять ваш звонок 24 часа в день, в любой день недели отовсюду в Австралии.

Или проконсультируйтесь с вашим местным терапевтом.

В случае критического положения или если Вы нуждаетесь в срочной помощи, пожалуйста наберите 000 немедленно.

Вы также можете найти психолога на сайте Австралийской психологической ассоциации:
http://www.psychology.org.au/FindaPsychologist/Default.aspx?ID=1204

С уважением,
Алла Демуцкая
кандидат на звание доктор психологии (клинической)
университет Монаша

Where can I get help?

As discussed above we recommend you speak to your general practitioner or a mental health professional about the way you are feeling. We have also compiled a list of services you can contact which are listed below.

Lifeline: 13 11 14
Lifeline provides free, confidential counselling by trained volunteers who are ready to take calls 24-hour a day, any day of the week from anywhere in Australia.

Suicide helpline: 1300 651 251
Suicide helpline provides confidential telephone counselling, support and referral 24 hours a day, seven days a week, throughout Victoria for the cost of a local call.

Kids Help Line: 1800 551 800
Kids Help Line provides free, confidential and anonymous telephone and online counselling specifically for young people aged between 5 and 25 years. Trained volunteers can take your call 24 hours a day, any day of the week from anywhere in Australia.

You can also find a psychologist at the website of Australian Psychological Society:
http://www.psychology.org.au/FindaPsychologist/Default.aspx?ID=1204

In an event of an emergency please dial 000

Regards,

Alla Demutska
Doctor of Psychology (Clinical) candidate
Monash University
School of Psychology and Psychiatry

Automatic e-mail to Russian immigrants (depression):

Дорогой Участник,

Спасибо за Ваши ответы на онлайн опросники, которые являются частью научно-исследовательской работы по оценке психологических и социальных факторов в иммигрантах из бывшего Советского Союза.

Вы знаете, что онлайн опросники включали различные вопросы, касающиеся Вашего отношения к Вашему здоровью, включая вопросы о том, испытываете ли Вы в настоящее время признаки депрессии и беспокойства.

Я пишу Вам, потому что, согласно Вашим ответам, Ваш результат по шкале депрессии был высоким. Мы рекомендуем, чтобы Вы проконсультировались с Вашим терапевтом о получении направления к профессионалу в области психологического здоровья или если у Вас уже есть контактные данные такого профессионала, связаться с ним/ней.

Что такое депрессия?

Депрессия – очень часто встречающаяся проблема психологического здоровья. Депрессия может принимать разные формы и включать множество признаков. Некоторые люди могут чувствовать печаль, в то время как другие практически не испытывают удовольствия или интереса в том, что они делают. Признаки депрессии типично включают несколько из следующих симптомов:

- Чувство беспомощности и безнадежности
- Потеря интереса в ежедневных занятиях
- Аппетит или изменения веса
- Нарушение сна
- Физическое замедление или чувства беспокойства
- Потеря энергии
- Отвращение к себе
- Проблемы с концентрацией

Больше информации о признаках депрессии мы можете получить на следующем вебсайте (на английском языке):
<http://www.beyondblue.org.au/>

Дальнейшая информация на русском языке о депрессии доступна на:
http://www.depressia.com/page_146.html

Automatic e-mail to Anglo-Australian participants (depression):
An assessment of psychosocial factors in immigrants from the Former Soviet Union

Dear Participant,

Thank you for completing the online survey as part of the research project which is assessing psychosocial factors in immigrants from the Former Soviet Union.

As you are aware the online survey asked various questions relating to your attitudes towards your health including questions about whether you are currently experiencing symptoms of depression and anxiety.

I am writing to you because, according to the responses you have given, your overall score on the depression questionnaire was high. We recommend that you see your general practitioner about getting a referral to a mental health professional or if you already have the contact details of a mental health professional to get in contact with them.

What is depression?

Depression is a very common mental health problem. Depression can take several forms and include a variety of symptoms. Some people can feel sadness, while others experience little enjoyment or interest in most of all activities. Symptoms of depression typically include several of the following:

- Feelings of helplessness and hopelessness
- Loss of interest in daily activities
- Appetite or weight changes
- Sleep changes
- Physical slowing or feelings of restlessness
- Loss of energy
- Self-loathing
- Concentration problems

More information about symptoms of depression can be obtained from:
http://www.beyondblue.org.au/

It is a good idea to see a mental health professional to help you understand whether you are experiencing any of the above.

Can depression be treated?

Depression can be effectively treated by a variety of methods, including medication and/or psychological therapy.
Speak to a mental health professional and your general practitioner will help you make an informed decision

Не повредит также обратиться к профессионалу в области психологического здоровья, чтобы помочь Вам понять, испытываете ли Вы вышеупомянутые симптомы.

Можно ли лечить депрессию?

Депрессию может эффективно лечить разными методами, включая медикаментозное лечение и/или психологическую терапию.
Поговорите с профессионалом в области психологического здоровья, и Ваш терапевт поможет Вам сделать информированный выбор лечения.

Где я могу получить помощь?

Как обсуждалось раннее, мы рекомендуем, чтобы Вы рассказали своему терапевту или профессионалу в области психологического здоровья о том, как Вы себя чувсвуете. Мы также подготовили список контактов, представленных ниже, с которыми Вы можете связаться.

Контакты:

Лайфлайн: 13 11 14
Лайфлайн предоставляет бесплатную, конфиденциальную помощь опытными волонтерами, которые принимают звонки 24-часа в день, в любой день недели и отовсюду в Австралии. Для тех, кто не говорит по-английски, могут быть подключены переводчики.

Телефон доверия по вопросам самоубийства: 1300 651 251
Телефон доверия по вопросам самоубийства обеспечивает конфиденциальную телефонную помощь, поддержку и направление к соответсвующим службам 24 часа в день, семь дней в неделю, по всей Виктории по стоимости внутригородского звонка.

Телефонная помощь детям: 1800 551 800
Телефонная помощь детям обеспечивает бесплатную, конфиденциальную и анонимную телефонную и онлайн помощь для молодых людей в возрасте между 5 и 25 годами. Волонтеры с опытом могут принять ваш звонок 24 часа в день, в любой день недели отовсюду в Австралии.

Или проконсультируйтесь с вашим местным терапевтом.

В случае критического положения или если Вы нуждаетесь в срочной помощи, пожалуйста наберите 000 немедленно.

Вы также можете найти психолога на сайте Австралийской психологической ассоциации:
http://www.psychology.org.au/FindaPsychologist/Default.aspx?ID=1204

С уважением,
Алла Демуцкая
кандидат на звание доктор психологии (клинической)
университет Монаша

about what the best treatment option is for you.

Where can I get help?

As discussed above we recommend you speak to your general practitioner or a mental health professional about the way you are feeling. We have also compiled a list of services you can contact which are listed below.

Lifeline: 13 11 14
Lifeline provides free, confidential counselling by trained volunteers who are ready to take calls 24-hour a day, any day of the week from anywhere in Australia.

Suicide helpline: 1300 651 251
Suicide helpline provides confidential telephone counselling, support and referral 24 hours a day, seven days a week, throughout Victoria for the cost of a local call.

Kids Help Line: 1800 551 800
Kids Help Line provides free, confidential and anonymous telephone and online counselling specifically for young people aged between 5 and 25 years. Trained volunteers can take your call 24 hours a day, any day of the week from anywhere in Australia.

You can also find a psychologist at the website of Australian Psychological Society:
http://www.psychology.org.au/FindaPsychologist/Default.aspx?ID=1204

In an event of an emergency please dial 000

Regards,

Alla Demutska
Doctor of Psychology (Clinical) candidate
Monash University
School of Psychology and Psychiatry

Automatic e-mail to Russian non-immigrants (anxiety):

Дорогой Участник,

Спасибо за Ваши ответы на онлайн опросники, которые являются частью научно-исследовательской работы по оценке психологических и социальных факторов в иммигрантах из бывшего Советского Союза.

Вы знаете, что онлайн опросники включали различные вопросы, касающиеся Вашего отношения к Вашему здоровью, включая вопросы о том, испытываете ли Вы в настоящее время признаки депрессии и тревожности.

Я пишу Вам, потому что, согласно Вашим ответам, Ваш результат по шкале тревожности был высоким. Мы рекомендуем, чтобы Вы проконсультировались с Вашим терапевтом о получении направления к профессионалу в области психологического здоровья или если у Вас уже есть контактные данные такого профессионала, связаться с ним/ней.

Что такое тревожные расстройства?
Тревожные расстройства очень распространены среди населения. Есть несколько типов таких расстройств, такие как:

Простая фобия - это чрезмерные и необоснованные страхи перед объектами, такими как пауки или змеи, или ситуациями, такие как полет или инъекции.

Automatic e-mail to Russian non-immigrants (depression):

Дорогой Участник,

Спасибо за Ваши ответы на онлайн опросники, которые являются частью научно-исследовательской работы по оценке психологических и социальных факторов в иммигрантах из бывшего Советского Союза.

Вы знаете, что онлайн опросники включали различные вопросы, касающиеся Вашего отношения к Вашему здоровью, включая вопросы о том, испытываете ли Вы в настоящее время признаки депрессии и беспокойства.

Я пишу Вам, потому что, согласно Вашим ответам, Ваш результат по шкале депрессии был высоким. Мы рекомендуем, чтобы Вы проконсультировались с Вашим терапевтом о получении направления к профессионалу в области психологического здоровья или если у Вас уже есть контактные данные такого профессионала, связаться с ним/ней.

Что такое депрессия?

Депрессия – очень часто встречающаяся проблема психологического здоровья. Депрессия может принимать разные формы и включать множество признаков. Некоторые люди могут чувствовать печаль, в то время как другие практически не испытывают удовольствия или интереса в том, что они делают. Признаки депрессии типично

Социальная фобия - интенсивный страх перед социальными ситуациями, что часто приводит к уклонению от всех или от некоторых социальных ситуаций.
Генерализованное тревожное расстройство- *чрезмерные* и не поддающиеся контролю беспокойство о ежедневных жизненных событиях, таких как страх что близкие люди заболеют, беспокойство об обществе или мировые событиях, финансах, отношениях.
Паническое расстройство- характеризуется внезапными и повторяющимися приступами паники и страхом перед будущими приступами.
Обсессивно-компульсивное расстройство – связано с тем, что у людей возникают нежелательные навязчивые мысли, которые заставляют их выполнять вынужденные действия (например, проверка, мытье рук и т.д).
Посттравматический стресс развивается в результате попадания в страшную травмирующую ситуацию, что часто приводит к кошмарам, воспоминаниям, ретроспективным образам, и уклонением от обстоятельств, связанных с ситуацией.

Больше информации о признаках тревожных расстройств мы можете получить на следующем вебсайте (на английском языке) <http://www.anxietybc.com/>

Дальнейшая информация на русском языке о тревожных расстройствах доступна на: <http://www.krugosvet.ru/enc/gumanitarnye_nauki/psihologiya_i_pedagogika/TREVOZHNIE_RASSTROSTVA.html>

Не повтредит также обратиться к профессионалу в области психологического здоровья, чтобы помочь Вам понять, испытываете ли Вы вышеупомянутые симптомы.

Можно ли лечить тревожные расстройства?

включают несколько из следующих симптомов:

- Чувство беспомощности и безнадежности
- Потеря интереса в ежедневных занятиях
- Аппетит или изменения веса
- Нарушение сна
- Физическое замедление или чувства беспокойства
- Потеря энергии
- Отвращение к себе
- Проблемы с концентрацией

Больше информации о признаках депрессии мы можете получить на следующем вебсайте (на английском языке): <http://www.beyondblue.org.au/>

Дальнейшая информация на русском языке о депрессии доступна на: http://www.depressia.com/page_146.html

Не повтредит также обратиться к профессионалу в области психологического здоровья, чтобы помочь Вам понять, испытываете ли Вы вышеупомянутые симптомы.

Можно ли лечить депрессию?

Депрессию может эффективно лечить разными методами, включая медикаментозное лечение и/или психологическую терапию. Поговорите с профессионалом в области психологического здоровья, и Ваш терапевт поможет Вам сделать информированный выбор лечения.

Где я могу получить помощь?

Тревожные расстройства может эффективно лечить разными методами, включая медикаментозное лечение и/или психологическую терапию.
Поговорите с профессионалом в области психологического здоровья, и Ваш терапевт поможет Вам сделать информированный выбор лечения.

Где я могу получить помощь?

Как обсуждалось раннее, мы рекомендуем, чтобы Вы рассказали своему терапевту или профессионалу в области психологического здоровья о том, как Вы себя чувсвуете. Мы также подготовили список контактов, представленных ниже, с которыми Вы можете связаться.

С уважением,
Алла Демуцкая
кандидат на звание доктор психологии (клинической)
университет Монаша

Как обсуждалось раннее, мы рекомендуем, чтобы Вы рассказали своему терапевту или профессионалу в области психологического здоровья о том, как Вы себя чувсвуете. Мы также подготовили список контактов, представленных ниже, с которыми Вы можете связаться.

Московская служба психологической помощи населению (МСПП) (499)1730909;
(499)7429181
http://www.msph.ru/
Телефон доверия:
Москва (499) 176-83-47
Москва (495) 413-05-35
Москва (495) 933-05-50
Москва (495) 714-76-18
Москва (499) 126-04-51
Москва (495) 205-0550

С уважением,
Алла Демуцкая
кандидат на звание доктор психологии (клинической)
университет Монаша

Appendix H

Respondent name:

Имя участника:

Date of Birth:

Дата рождения:

Date today:

Дата заполнения анкеты:

Gender: M / F

Пол: M/ F

What country are you from? (Note: Computer application will not allow to proceed with questionnaires unless participants are residing in Ukraine, Russia, or Belarus for Russian-speaking non-immigrant group, or live in Australia for Russian-speaking immigrant group and Anglo-Australian group)

Страна рождения

What is your native language?

Родной язык?

What language do you speak at home?

На каком языке Вы говорите дома?

Do you speak and read Russian (for two Russian speaking groups):

- Fluent (Computer application will not allow to proceed with questionnaires unless two Russian-speaking groups answered they are fluent in Russian)
- Basic

Говорите и читаете ли Вы на русском?

- Свободно
- Только базовый русский

Year and month of arrival to Australia (for Russian-speaking immigrant group):

Год и месяц прибытия в Австралию (для Русскоязычной иммигрантской группы):

Are your parents and grandparents of an Anglo-Celtic background (meaning that they have been born in Australia, England, Scotland, Wales or Ireland and consider themselves as being of an Anglo-Celtic

background) (for Anglo-Australian group)?

- Yes
- No (Computer application will not allow to proceed with questionnaires)

Visa category upon arrival (for Russian-speaking immigrant group):

- Skilled migration visa stream
- Humanitarian stream (Computer application will not allow to proceed with questionnaires if Russian-speaking immigrants arrived on humanitarian visa)
- Student visa with subsequent update to skilled immigrant visa

In your skilled visa application were you listed as a (for Russian-speaking immigrant group)::

- main applicant
- main applicant's spouse
- dependant (child, elderly parent) (Computer application will not allow to proceed with questionnaires if Russian-speaking immigrants arrived as dependants)

Marital status:

- Married/de facto
- Widowed
- Divorced/separated

Категория визы по прибытию:

- Квалифицированная виза (Skilled migration visa stream)
- Гуманитарная виза (Humanitarian stream)
- Студенческая виза с последующим переоформлением на кфалифицированную визу

При заявке на визу, вы были включены в анкете в качестве:

- главного заявителя (main applicant)
- супруг(а) главного заявителя (main applicant's spouse)
- зависимое лицо (ребенок, пожилой родитель)

Семейное положение:

- Женат/ замужем/ в гражданском браке
- Овдовевший(ая)
- Разведен(а)
- Никогда не был(а) женат/замужем
-

- Never married

How would you define your health?

- Very good
- Good
- Satisfactory
- Bad
- Very bad

Number of completed school years:

Highest educational level completed

- school
- college

university:

- Bachelor (or equivalent)
- Master's (or equivalent)
- PhD (or equivalent)

Where was your last place of residence in FSU before coming to Australia? (for Russian-speaking immigrant group):

What is your current occupation?

Who lives with you at home? And how many?

Как Вы оценили бы ваше здоровье?

- Очень хорошее
- Хорошее
- Удовлетворительное
- Плохое

Очень плохое

- Сколько лет Вы проучилились в школе?:

Ваш наивысший уровень образования?

- Школа
- Техникум

Университет:

- Бакалавр (или эквивалент)
- Мастер (или эквивалент)
- Аспирантура

Ваше последнее место жительства в бывшем Советском Союзе перед прибытием в Австралию?

Ваша профессия или ваше текущее занятие?

Кто живет с Вами дома? Количество человек?

Супруг
Дети
братья/сестры

Are you working:

- yes, full time
- yes, part time
- no, I am looking for work
- no, I am a housewife
- no, I am unable to work due to illness or injury
- no, I have retired
- other

What is your annual household income?

How many people are supported by this income?

Were you working before immigration? (for Russian-speaking immigrant group):

Is your occupational status/job complexity: (for Russian-speaking immigrant group):

- the same
- higher
- lower

then pre- immigration?

Do you perceive that due to immigration to Australia you have

родители/ родители мужа/ жены

- Другие (пожалуйста, назовите)

Вы работаете:

- На полной занятости
- Частично
- Нет, я ищу работу
- Нет, я – домохозяйка
- Нет, я неспособен работать из-за болезни или травмы
- Нет, я на пенсии

Другое

Каков ваш ежегодный семейный доход?
Сколько людей живет на этот доход?

Вы работали перед иммиграцией?

С тех пор, как вы иммигрировали, находится ли ваш профессиональный статус/ сложность работы на:

- Том же самом уровне
- Выше уровнем
- Ниже уровнем
- Чем до иммиграции?

Думаете ли Вы, что благодаря иммиграции в Австралию Вы:

acquired more: (for Russian-speaking immigrant group):

- gains (e.g. security, freedom) or
- losses (e.g. self-fulfillment, belonging)?

When you were thinking of your settlement in Australia before immigration, did you expect to settle in (for Russian-speaking immigrant group):

-at the same level

-quicker

-slower

than actually happened?

What was your migration motivation to come to Australia? (for Russian-speaking immigrant group):

-I wanted to come (please expand)

-I was forced to come by circumstances (please expand)

-I was ambivalent to come (please expand)

-other (please specify)

- Больше выиграли (например, в плане свободы, безопасности и т.д.)

или потеряли (например, в плане чувства принадлежности к группе, самореализации и т.д.) (

Когда Вы думали о Вашем обустройстве в Австралии перед иммиграцией, ожидали ли вы устроиться:

- На том же уровне
- Быстрее
- Медленее
- чем фактически произошло?

Каково было ваше побуждении для иммиграции?

- Я хотел(а) приехать (пожалуйста, подробнее)
- Я был вынужден приехать обстоятельствами (пожалуйста, подробнее)
- Я был настроен(а) амбивалентно (пожалуйста, подробнее)

Другое (пожалуйста, опишите)

Appendix I

To take the questionnaire, please click the radio button next to the selection which best reflects how each statement applies to you. The items refer to how you have felt and behaved over the last week.

Please note: This test will only be scored correctly if you answer each one of the questions.

The 20 items below refer to how you have felt and behaved during the last week. Choose the appropriate button.

1. I was bothered by things that don't usually bother me.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

2. I did not feel like eating; my appetite was poor.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

3. I felt that I could not shake off the blues even with the help of my family or friends.

- Rarely or none of the time (<1 day)

При заполнении анкеты , пожалуйста, выбирайте ответы, которые лучше всего подходят вам. Вопросы относятся к тому, как вы чувствовали и вели себя на прошлой неделе.

Пожалуйста, отметьте: этот тест будет правильно интерпретирован, только если вы ответите на все вопросы.

20 вопросов далее относятся к тому, как вы чувствовали и вели себя на прошлой неделе. Выберите соответствующий ответ.

1. Я был обеспокоен(-а) вещами, которые обычно не тревожат меня.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

2. Я не испытывал(-а) желания есть; у меня был плохой аппетит.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

3. Я чувствовал(-а), что не мог(-ла) избавиться от плохого настроения даже при помощи моей семьи или друзей.

- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

4. I felt that I was just as good as other people.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

5. I had trouble keeping my mind on what I was doing.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

6. I felt depressed.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

4. Я чувствовал(-а), что я не хуже других людей.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

5. Мне было тяжело конценрироваться на том, что я делал(-а).

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

6. Я чувствовал(-а) себя подавленным/-ной.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

7. I felt everything I did was an effort.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

8. I felt hopeful about the future.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

9. I thought my life had been a failure.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

10. I felt fearful.

- Rarely or none of the time (<1 day)

7. Я чувствовал(-а), что все, что я делал(-а), было через силу.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

8. Я чувствовал(-а) надежду по поводу будущего.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

9. Я думал(-а), что моя жизнь -(прошла зря.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

10. Я чувствовал(-а) страх.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

11. My sleep was restless.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

12. I was happy.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

13. I talked less than usual.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

11. Мой сон был беспокойным.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

12. Я был(-а) счастлив(-а).

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

13. Я говорил(-а) меньше, чем обычно.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

14. Я чувствовал(-а) себя одиноким/-ой.

14. I felt lonely.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

15. People were unfriendly.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

16. I enjoyed life.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

17. I had crying spells.

- Rarely or none of the time (<1 day)

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

15. Люди были недружелюбны ко мне.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

16. Я наслаждался/-ась жизнью.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

17. Я периодически плакал(-а).

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

18. I felt sad.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

19. I felt that people disliked me.

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

20. I could not get "going".

- Rarely or none of the time (<1 day)
- Some or a little of the time (1-2 days)
- Occasionally or a moderate amount of the time (3-4 days)
- Most or all of the time (5-7 days)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

18. Мне было грустно.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

19. Я чувствовал(-а), что не нравлюсь людям.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

20. Мне было тяжело заставить себя что-то делать.

редко или совсем нет (<1 день)

время от времени или немного (1-2 дня)

изредка или умеренное количество времени (3-4 дня)

практически все время (5-7 дней)

Read each statement and then click the relevant box near each statement to indicate how you feel RIGHT NOW, that is, AT THIS MOMENT. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

Прочитайте каждое утверждение и затем кликните на утверждение, которое соответствует тому, что вы чувсвтуете ПРЯМО СЕЙЧАС, то есть В НАСТОЯЩИЙ МОМЕНТ. Здесь нет правильных или неправильных ответов. Не тратьте слишком много времени на каждое из утверждений, дайте ответ, который описывает ваши чувства в данный момент лучше всего.

I feel calm	Я чувствую себя спокойным/-ой
A feel secure	У чувсвую себя защищенным/-ой
I am tense	Я напряжен(-а)
I feel Strained	Я чувствую себя неестественно
I feel at ease	Я чувствую себя непринужденно
I feel upset	Я чувствую себя расстроенным/-ой
I am presently worrying over possible misfortunes	В данный момент я волнуюсь по поводу возможных неудач
I feel satisfied	Я чувствую удовлетворение
I feel frightened	Я чувствую себя испуганным/-ой
I feel comfortable	Я чувствую себя удобно
I feel self-confident	Я чувствую себя уверенным/-ой в себе
I feel nervous	Я нервничаю
I am jittery	Я беспокоюсь
I feel indecisive	Я чувствую себя нерешительным/-ой
I am relaxed	Я расслаблен(-а)
I feel content	Я чувствую себя довольным/-ой
I am worried	Я волнуюсь
I feel confused	Я чувствую замешательство
I feel steady	Я чувствую себя урановешенным/-ой
I feel pleasant	Я чувствую себя хорошо
Instructions: This scale is made up of a **list** of statements each of which may or may not be true about you. For each statement check "definitely true" is you are sure it is true about you and "probably true" if you think it is true but are not absolutely certain. Similarly, you should check "definitely false" if you are sure the statement is false and "probably false" if you think it is false but are not absolutely certain.	Инструкция: эта шкала составлена из списка утверждений, каждое из которых может быть верно или не верно по отношению к вам. Для каждого утверждения отметьте "абсолютно верно" если Вы уверены, что оно верно для вас , и "скорее всего верно", если вы думаете, что оно верно, но не абсолютно в этом уверены. Точно так же отметьте "определенно ложно", если вы уверены, что утверждение ложно, и "скорее всего ложно", если вы думаете, что оно ложно, но не абсолютно в этом уверены
There are several people that I trust to help solve my problems.	Есть несколько человек, на помощь которых я могу рассчитывать в решении моих проблем.
If I needed help fixing an appliance or repairing my car, there is someone who would help me.	Если бы я нуждался/-лась в помощи при ремонте какого-либо прибора или машины, есть человек, который бы мне помог.
When I feel lonely, there are several people I can talk to.	Когда я чувствую себя одиноким/-ой, есть люди, с которыми я могу поговорить.
There is no one that I feel comfortable to talking about intimate personal problems.	Нет никого, с кем бы я мог(-ла) обсудить глубоко личные проблемы, не испытывая дискомфорта.
I often meet or talk with family or friends.	Я часто встречаюсь или разговариваю с семьей или друзьями.
If I needed a ride very early in the morning, I would have a hard time finding someone to take me.	Если бы мне было необходимо, чтобы кто-то меня подвез очень рано утром, мне было бы тяжело найти такого человека.
I feel like I'm not always included by my circle of friends.	Я чувствую, что мой круг друзей не всегда меня принимает.
I have no one who can give me an honest view of how I handle my problems.	У меня нет никого, кто может высказать мне честное мнение о том, как я справляюсь с моими проблемами.
There are several different people I enjoy spending time with.	Есть несколько разных людей, с которыми я люблю проводить время.

If I were sick and needed someone (friend, family member, or acquaintance) to take me to the doctor, I would have trouble finding someone.
If I wanted to go on a trip for a day, I would have a hard time finding someone to go with me.

If I needed a place to stay for a week because of an emergency (for example, water or electricity out in my apartment or house), I could easily find someone who would put me up.

I feel that there is no one I can share my most private worries and fear with.

If I were sick, I could easily find someone to help me with my daily activities.

There is someone I can turn to for advice about handling problems with my family.
If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.
When I need suggestions on how to deal with a personal problem, I know someone I can turn to.

If I needed an emergency loan of $20, there is someone (friend, relative, or acquaintance) I could get it from.
Most people I know do not enjoy the same things that I do.
There is someone I could turn to for advice about changing or seeking a job.
I don't often get invited to do things with others.
If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).

There really is no one I can trust to give me good financial advice.
If I wanted to have lunch with someone, I could easily find someone to join me.
If I was stranded 10 miles from home, there is someone I could call who would come and get me.

No one I know would throw a birthday party for me.
It would be difficult to find someone who would lend me their car for a few hours.
If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.
There is at least one person I know whose advice I really trust.
If I needed some help in moving to a different house or apartment, I would have a hard time finding someone to help me.
John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity

People with a problem like John could snap out of it if they wanted
A problem like John’s is a sign of personal weakness
John’s problem is not a real medical illness
People with a problem like John’s are dangerous
It is best to avoid people with a problem like John’s so that you don't become depressed yourself
People with a problem like John’s are unpredictable

Если бы я был(-а) болен/больна и нуждался/нуждалась в ком-то , чтобы отвезти меня к доктору, то мне было бы тяжело найти помощника для этой цели.
Если бы я хотел(-а) поехать куда-нибудь на день, то мне было бы тяжело найти человека, который бы поехал со мной.
Если бы мне нужно было где-то остановиться на неделю из-за непредвиденных обстоятельств (например, отсутствия воды или электричества в моей квартире или доме), то я мог(-ла) бы легко найти человека, который бы принял меня.
Я чувствую, что нет никого, с кем бы я мог(-ла) разделить мои самые глубоко-личные тревоги и страхи.
Если бы я был(-а) болен/больна, то я мог бы легко найти помощника в моих ежедневных действиях.
Есть человек, к кому я могу обратиться за советом по разрешению проблем с моей семьей.
Если вдруг днем я решаю, что я хотел(-а) бы пойти в кино этим же вечером, я могу легко найти компаньона.
Когда мне нужны советы , как справиться с личной проблемой, я знаю человека, к кому могу обратиться.
Если бы мне срочно нужно было одолжить $20, я легко мог(-ла) бы обратиться к кому-то (другу, родственнику, или знакомому).
Большинство людей, которых я знаю, не любят то, что люблю я.
Есть человек, к кому я мог(-ла) бы обратиться для совета по смене или поиску работы.
Меня не часто приглашают делать что-то с другими.
Если бы я должен/должна был(-а) уехать из города на несколько недель, было бы трудно найти человека, который бы позаботился о моем доме или квартире (растениях, домашних животных, саде, и т.д.).
На самом деле нет никого, кому я могу доверять в получении хорошего финансового совета.
Если бы я хотел(-а) пойти с кем-то на обед, то я мог(-ла) бы легко найти компаньона.
Если бы я оказался/-лась без транспорта в 10 милях от дома, мне есть кому позвонить и попросить приехать за мной.
Я не знаю никого, кто бы организовал вечеринку по поводу моего дня рождения для меня.
Мне трудно найти кого-нибудь, кто предоставит мне свой автомобиль на несколько часов.
В случае семейного кризиса мне было бы трудно найти человека, который мог бы дать мне хороший совет о выходе из критического положения.
Есть по крайней мере один человек, которого я знаю, чьему совету я действительно доверяю.
Если бы я нуждался/-лась в помощи при переезде в другой дом или квартиру, то мне бы было тяжело найти кого-то для помощи.
Джону 30 лет. В течение нескольких прошедших недель он был необычайно грустен и чувствовал себя несчастным. Несмотря на то, что он все время чувствует себя уставшим, у него возникают проблемы со сном практически каждую ночь. У Джона отсутсвует желание есть, он похудел. Он не может концентрироваться на работе и откладывает принятие решений. Даже ежедневные задачи кажутся слишком тяжелыми для него. Это привлекло внимание его босса, который обеспокоен пониженной производительностью труда Джона.

Люди с такой проблемой, как у Джона, моли бы перебороть себя, если бы они хотели
Проблемы Джона – это признак личной слабости
Проблема Джона не является настоящей медицинской болезнью
Люди с проблемой как у Джона опасны
Лучше избегать людей с проблемой как у Джона, чтобы самому не впасть в депрессию
Люди с проблемой как у Джона непредсказуемы

If I had a problem like John's I would not tell anyone
I would not employ someone if I knew they had a problem like John's
I would not vote for a politician if I knew they had suffered a problem like John's

Most people believe that people with a problem like John's could snap out of it if they wanted

Most people believe that a problem like John's is a sign of personal weakness
Most people believe that a problem like John's is not a real medical illness

Most people believe that people with a problem like John's are dangerous
Most people believe that it is best to avoid people with a problem like John's so that you don't become depressed yourself
Most people believe that people with a problem like John's are unpredictable.
Most people would not tell anyone if they had a problem like John's

Most people would not employ someone they knew had suffered a problem like John's

Most people would not vote for a politician they knew had suffered a problem like John's

There are a number of different people, some professional, some not who could possible help John. For each of the following, are the people or services likely to be helpful, harmful, or neither for John? Please tick one response for each question.

A typical family GP or doctor?
A typical chemist (pharmacist)?
A counselor?
Social worker?
Help form close friend?
A naturopath or herbalist?
Psychologist?
Psychiatrist?
The term professional refers to individuals who have been trained to deal with mental health problems (e.g. psychologists, psychiatrists, social workers and family physicians). The term psychological problems refer to reasons one might visit a professional. Similar terms include mental health concerns, emotional problems, mental troubles, and personal difficulties. For each item, indicate whether you
(0)= disagree
(1) = somewhat disagree
(2) = are undecided
(3) = somewhat agree
(4) = agree

There are certain problems which should not be discussed outside of one's immediate family
I would have a very good idea of what to do and who to talk to if I decide to seek professional help for psychological problems

I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems

Если бы у меня была проблема как у Джона, то я не сказал(-а) бы об этом никому
Я не нанял(-а) бы кого-то, если бы знал(-а), что у него/нее такие же проблемы, как у Джона
Я не голосовал(-а) бы за политического деятеля, если бы знал(-а), что он страдал от такой же проблемы, как у Джона
Большинство людей полагает, что люди с проблемой как у Джона могли бы ее перебороть, если бы они захотели
Большинство людей полагает, что проблема как у Джона – это признак личной слабости
Большинство людей полагает, что проблема как у Джона не является настоящей медицинской болезнью
Большинство людей полагает, что люди с проблемой как у Джона опасны
Большинство людей полагает, что лучше избегать людей с проблемой как у Джона, чтобы самому не впасть в депересию
Большинство людей полагает, что люди с проблемой как у Джона непредсказуемы.
Большинство людей не сказало бы никому, если бы у них были такие же проблемы, как у Джона
Большинство людей не наняло бы кого - то, если бы они знали, что у него/нее такие же проблемы, как у Джона
Большинство людей не проголосовало бы за политического деятеля, который страдал от такой же проблемы, как у Джона
Многие люди (как профессионалы, так и нет) могли бы помочь Джону. Отметьте, насколько будут полезны Джону перечисленные ниже занятия или службы.

Обычный семейный терапевт или доктор?
Обычный аптекарь (фармацевт)?
Адвокат?
Социальный работник?
Помощь друга?
Натуропат или фитотерапевт ?
Психолог?
Психиатр?
Слово «профессионал» относится к людям, которые обучались иметь дело с проблемами психологического здоровья (например психологи, психиатры, социальные работники и семейные врачи). Термин «психологические проблемы» относится к причинам, которые могут побудить кого-то обратиться к профессионалу. К похожим терминам относятся «проблемы умственного здоровья», «эмоциональные проблемы», «психологические неприятности» и «личные трудности». Для каждого пункта укажите, если вы:
(0) = не согласны
(1) = отчасти не согласны
(2) = еще не приняли решения
(3) = отчасти согласны
(4) = согласны
Есть определенные проблемы, которые не должны обсуждаться вне узкого семейного круга
У меня было бы достаточно четкое представление относительно того, что делать и с кем поговорить, если бы я решил(-а) искать профессиональную помощь в связи с психологическими проблемами
Я не хотел(-а) бы, чтобы моя «половинка» (супруг, партнер, и т.д.) знала , что я страдаю от психологических проблем

Keeping one's mind on a job is a good solution to for avoiding personal worries and concerns
If good friends asked my advice about a psychological problem, I might recommend that they see a professional
Having been mentally ill carries with it a burden of shame
It is probably best not to know everything about oneself
If I were experiencing a psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy
People should work out their own problems; getting professional help should be a last resort

If I were to experience psychological problems, I could get a professional help if I wanted to

Important people in my life would think less of me if they were to find out that I was experiencing psychological problems
Psychological problems, like many things, tend to work out by themselves
It would be relatively easy for me to find the time to see a professional for psychological problems

There are experiences in my life I would not discuss with anyone
I would want to get professional help if I were worried or upset for long period of time

I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it

Having been diagnosed with a mental disorder is a blot on a person's life
There is something admirable in the attitude of people who are willing to cope with conflicts and fears without resorting to professional help

If I believed I was having a mental breakdown, my first inclination would be to get professional attention
I would feel uneasy going to a professional because of what some people might think

People with strong characters can get over psychological problems by themselves and would have little need for professional help
I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family
Had I received treatment for psychological problems, I would not feel that it ought to be "covered up"

I would be embarrassed if my neighbor saw my going into the office of a professional who deals with psychological problems
The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way.
Use the following scale to record your answers:
(0)=never
(1) = almost never
(2) = sometimes
(3) = fairly often
(4) = very often

Фокусирование на работе - хороший метод избежать личных волнений и проблем
Если бы хорошие друзья спросили моего совета по поводу психологической проблемы, то я бы порекомендовал(-а), чтобы они обратились к профессионалу
Наличие психического заболевания заставляет человека испытывать стыд
Вероятно, лучше не знать все о себе
Если бы я испытывал(-а) психологическую проблему на данном этапе моей жизни, то был(-а) бы уверен(-а) ь, что я мог(-ла) бы найти помощь в психотерапии
Люди должны сами решать свои проблемы; получение профессиональной помощи – это крайнее средство
Если бы мне пришлось испытать психологические проблемы, я мог(-ла) бы получить профессиональную помощь, если бы захотел(-а)
Важные для меня люди думали бы хуже обо мне, если бы обнаружили, что я испытывал(-а) психологические проблемы
Психологические проблемы, как и многие другие, могут решиться сами собой
Для меня было бы относительно легко найти время, чтобы встретиться с профессионалом для решения психологических проблем
В моей жизни были события, которые я бы не стал(-а) обсуждать ни с кем
Я хотел(-а) бы получить профессиональную помощь, если бы я волновался/-валась или был(-а) расстроен на протяжении достаточно длинного промежутка времени
Я бы чувствовал(-а) неловкость, обращаясь за помощью профессионала по поводу психологических проблем, потому что люди в моих социальных или деловых кругах могли бы узнать об этом
Диагноз «расстройство психики» - пятно на жизни человека
Есть что-то замечательное в позиции людей, которые хотят справляться с конфликтами и страхами, не обращаясь к профессиональной помощи

Если бы я думал(-а), что у меня нервный срыв, то мое первое побуждение состояло бы в том, чтобы получить профессиональную помощь
Я чувствовал(-а) бы себя неловко, обращаясь за помощью к профессионалу, -- из-за того, что могут обо мне подумать люди
Люди с сильным характером могут преодолеть психологические проблемы сами и у них нет необходимости обращаться к профессиональной помощи
Я бы охотно доверил(-а) глубоко личные дела профессионалу, если бы думал(-а), что это может помочь мне или члену моей семьи
Если бы меня лечили от психологических проблем, я бы не чувствовал(-а), что это нужно скрывать
Я смутился/-лась бы, если бы мой сосед увидел, как я вхожу в офис профессионала, который имеет дело с психологическими проблемами
Вопросы следующей шкалы - о ваших чувствах и мыслях в течение прошлого месяца. В каждом случае, пожалуйста, укажите, как часто вы чувствовали или думали определенным образом.
Используйте шкалу для записи ответов:
(0) = никогда
(1) = почти никогда
(2) = иногда
(3) = довольно часто
(4) = очень часто

In the last month, how often have you been upset because of something that happened unexpectedly?	В прошлом месяце как часто вы были расстроены из-за того, что случилось что-то неожиданное?
In the last month, how often have you felt that you were unable to control the important things in your life?	Как часто в последний месяц вы чувствовали, что не способны контролировать важные вещи в вашей жизни?
In the last month, how often have you felt nervous and "stressed"?	Как часто в последний месяц вы нервничали и были в состоянии стресса?
In the last month, how often have you felt confident about your ability to handle your personal problems?	Как часто в последний месяц вы чувствовали себя уверенно в вашей способности решать ваши личные проблемы?
In the last month, how often have you felt that things were going your way?	Как часто в последний месяц вы чувствовали, что все идет по-вашему?
In the last month, how often have you found that you could not cope with all the things that you had to do?	Как часто в последний месяц вы обнаруживали , что не можете справляться со всем тем, что вы должны сделать?
In the last month, how often have you been able to control irritations in your life?	Как часто в последний месяц вы были в состоянии справляться с раздражением?
In the last month, how often have you felt that you were on top of things?	Как часто в последний месяц вы чувствовали, что справляетесь со всем?
In the last month, how often have you been angered because of things that were outside of your control?	Как часто в последний месяц вы злились из-за вещей, которые были вне вашего контроля?
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	Как часто в последний месяц вы чувствовали, что трудности накапливались настолько быстро, что вы не могли преодолеть их?

Appendix J

Instructions: Below are a series of statements expressing the difficulties confronted by immigrants. Evaluate each statement as it applies to your recent (within the last three months) personal experience as an immigrant and circle the answer that best describes hoe upset or distressed you are about the experience, described in the statement.

Australians have a hard time understanding my accent.
When I think of my past life, I feel emotional and sentimental.
Even though I live here, it does not feel like my country.
I need advice from people who are more experienced than me to know how to live here.
I am disadvantaged in getting a good job.
My work status is lower than it used to be.
As an immigrant, I am treated as a second class citizen.
I have difficulty doing ordinary things because of language barrier.
Australians don't think I really belong in their country.
I miss the people I left behind in my original country.
I have less career opportunities than Australians.
Talking in English takes a lot of effort.
Australians treat me as an outsider.
I must learn how certain tasks are handled, such as renting an apartment.
I do not feel that this is my true home.
I have to depend on other people to show or teach me how things are done here.
I do not feel at home.
I feel sad when I think of special places back home.
I can not compete with Australians for work in my field.
People with foreign accents are treated with less respect.
The work credentials I had in my original country are not accepted.
I am always facing new situations and circumstances.
When I think of my original country, I get teary.

Инструкция: Ниже приведены утверждения, описывающие трудности, с которыми сталкиваются иммигранты в Австралии. Для каждого из утверждений обведите кружком ответ, который лучше всего описывает степень Вашего согласия или несогласия с этим утверждением применительно к Вашему недавнему (в пределах 3-х последних месяцев) опыту.

Австралийцы с трудом понимают мой акцент.
Когда я думаю о своей прошлой жизни, я становлюсь сентиментальным.
Хотя я живу здесь, я не чувсвую, что это моя страна.
Я нуждаюсь в совете людей более опытных, чем я, чтобы понять как здесь жить.
Мне труднее, чем австралийцам, найти хорошую работу.
Мой рабочий статус ниже, чем был до иммиграции.
Из-за того, что я иммигрант, со мной обращаются как с гражданином второго сорта.
Из-за языкового барьера мне трудно делать самые простые вещи.
Австралийцы не признают меня по-настоящему своим в их стране.
Я скучаю по людям, которых оставил в стране, откуда я родом.
У меня меньше возможностей для профессионального роста, чем у австралийцев.
Разговаривать на английском стоит больших усилий.
Австралийцы обращаются со мной как с посторонним.
Я должен научитья делать определнные дела, например, снимать квартиру.
Я не чувствую, что здесь мой настоящий дом.
Я вынужден полагаться на других, чтобы они показали мне что делать.
Я не чувсвую, что я здесь дома.
Я грущу, когда думаю о памятных мне местах на родине.
Я не могу конкурировать с австралийцами в своей профессиональной области.
К людям, говорящим с иностранным акцентом, относятся менее уважительно.
Бумаги, подтверждающие мою квалификацию, не признают здесь.
Я все время сталкиваюсь с новыми ситуациями и обстоятельствами.
Когда я думаю о своей родине, у меня выступают слёзы на глазах.

I. Адаптация к культуре США

А. Язык

Пожалуйста, прочитайте каждый вопрос и обведите цифру, которая соответствует Вашему мнению.

	Не говорю вообще		**Говорю отлично, как на родном языке**	
Как Вы оцениваете своё умение говорить по-английски:				
1. на работе……	1	2	3	4
2. с австралийскими друзьями……..	1	2	3	4
3. по телефону…….. ……..…	1	2	3	4
4. с незнакомыми людьми……	1	2	3	4
5. вообще…….. …….	1	2	3	4
Как Вы оцениваете своё умение говорить по-русски:				
6. в семье……	1	2	3	4
7. с друзьями из бывшего СССР…….	1	2	3	4
8. по телефону…….……..	1	2	3	4
9. с незнакомыми людьми ……...…	1	2	3	4
10. вообще……..	1	2	3	4
	Вообще не понимаю			Понимаю отлично, Как родной язык
Как хорошо Вы понимаете английскиий язык:				
11. по телевизору или в кино……	1	2	3	4
12. в газетах или журналах……...……	1	2	3	4
13. в песнях ……...	1	2	3	4
14. вообще……..	1	2	3	4
Как хорошо Вы понимаете русский язык				
15. по телевизору или в кино……...…	1	2	3	4
16. в газетах или журналах……..……	1	2	3	4
17. в песнях……..……..	1	2	3	4
18. вообще……...……..	1	2	3	4

Б. Культурная принадлежность.

Как Вы считаете, к какой культуре Вы принадлежите?_____

В следующих вопросах нас интересует насколько Вы считаете себя русским, австралийцем, и(или) евреем. Под термином «русский» мы подразумеваем русскоговогящих беженцев и иммигрантов из бывшего СССР. Мы понимаем, что живя в Советском Союзе Вы могли не быть русским по национальности и, возможно, не жили в РСФСР. Так как большинство австралийцев называют советских эммигрантов «русскими» из-за их языка и культуры, мы будем придерживаться этой терминологии, хотя она и не вполне точна. Отвечая на вопросы ниже, пожалуйста, имейте в виду, что термин «русский» здесь относится к культуре общей для всех выходцев из бывшего СССР.

Насколько следующие утверждения соответствуют Вашему мнению:

		Совсем нет			В значительной степени
1.	Я считаю себя австрлаийцем……..	1	2	3	4
2.	Мне нравится быть австралийцем……..……	1	2	3	4
3.	Мне важно быть австралийцем……...…	1	2	3	4
4.	Я чувствую, что я являюсь частью австралийской культуры……..	1	2	3	4
5.	Если кто-то критикует австралийцев, я считаю, что критикуют меня…….	1	2	3	4
6.	Я полностью ощущаю себя австралийцем…….. .	1	2	3	4
7.	Я горжусь тем что я австралиец…….	1	2	3	4
8.	Я считаю себя русским……	1	2	3	4
9.	Мне нравится быть русским……	1	2	3	4
10.	Мне важно быть русским……..…	1	2	3	4
11.	Я чувствую, что я что я являюсь частью русской культуры ……..…….	1	2	3	4
12.	Если кто-то критикует русских, я считаю, что критикуют меня……	1	2	3	4
13.	Я полностью ощущаю себя русским……	1	2	3	4
14.	Я горжусь тем, что я русский…….	1	2	3	4

IV. Пожалуйста, прочитайте каждый вопрос и обведите одну цифру, которая соответствует Вашему мнению. Опять же, термин «русский», здесь относится к культуре, общей для всех выходцев из бывшего СССР.

	Совсем нет			Очень много
Как часто Вы говорите **по-английски**:				
1. дома?……	1	2	3	4
2. на работе? ……..……	1	2	3	4
3. с друзьями?……..……..	1	2	3	4
Как часто Вы:				
4. читаете австралийские книги, газеты, журналы?……....….	1	2	3	4
5. посещаете австралийские рестораны?…….….....	1	2	3	4
6. смотрите австралийские/ американские фильмы в кино или на видео?.....	1	2	3	4
7. едите австралийскую пищу?…….....	1	2	3	4
8. посещаете австралийские концерты, выставки?……. .. **.....**	1	2	3	4
9. покупаете продукты в австралийских магазинах?…..……....	1	2	3	4
10. обращаетесь к англоговорящим врачам?……..……....	1	2	3	4
11. общаетесь с австралийскими друзьями?…….....	1	2	3	4
Как часто Вы говорите **по-русски:**				
1. дома?…….....	1	2	3	4
2. на работе?…….....	1	2	3	4
3. с друзьями?...…….....	1	2	3	4
Как часто Вы:				
4. читаете русские книги, газеты, журналы? …….	1	2	3	4

5. посещаете русские рестораны?…….....	1	2	3	4
6. смотрите русские фильмы на видеокассетах?…….	1	2	3	4
7. едите русскую пищу?…….....	1	2	3	4
8. посещаете русские концерты, выставки?…….....	1	2	3	4
9. посещаете русские магазины?…….....	1	2	3	4
10. обращаетесь к русскоговорящим врачам?……..	1	2	3	4
11. общаетесь с русскими друзьями?……..…….….....	1	2	3	4

English Translation

For the following statements, please mark one of the four possible answers.

How would you rate your ability to speak ***English***:

	Not at all			**Very well, like a native**
1. at school/work.....	1	2	3	4
2. with Australian friends	1	2	3	4
3. on the phone	1	2	3	4
4. with strangers	1	2	3	4
5. overall	1	2	3	4

How well do you understand ***English***:

6. on TV or at the movies	1	2	3	4
7. in newspapers or in magazines	1	2	3	4
8. in songs	1	2	3	4
9. overall	1	2	3	4

How would you rate your ability to speak ***Russian***:

10. with family…….....	1	2	3	4
11. with Russian friends .....……..….....	1	2	3	4
12. on the phone	1	2	3	4
13. with strangers	1	2	3	4
14. overall	1	2	3	4

How well do you understand ***Russian***:

15. on TV or at the movies	1	2	3	4
16. in newspapers or in magazines	1	2	3	4
17. in songs	1	2	3	4
18. overall	1	2	3	4

How would you describe your cultural/ethnic identity:

In the following questions we would like to know the extent to which you consider yourself Australian, Russian, and Jewish. The term "Russian" is used to describe refugees and immigrants from the former Soviet Union who speak the Russian language. We recognize that when you lived in the former Soviet Union you may not have been of Russian nationality and, in fact, may have lived in one of the other former republics. Since in the Australia most Australians refer to émigrés from the former Soviet Union as "Russian" because of the language and culture, we use that term here, recognizing that it's not completely accurate. In responding to the questions below, please respond to this general definition of the term "Russian", which we intend to apply to that culture which is shared by all refugees from the former Soviet Union.

To what extent are the following statements true of you?

		Not at all			**Very much**
1.	I think of myself as being ***Australian***	1	2	3	4
2.	I feel good about being ***Australian***	1	2	3	4
3.	Being ***Australian*** plays an important part in my life.....	1	2	3	4
4.	I feel that I am part of ***Australian*** culture.....	1	2	3	4
5.	If someone criticizes **Australians** I feel they are criticizing me……	1	2	3	4
6.	I have a strong sense of being ***Australian***.....	1	2	3	4
7.	I am proud of being ***Australian***	1	2	3	4
8.	I think of myself as being ***Russian***	1	2	3	4
9.	I feel good about being ***Russian***	1	2	3	4
10.	Being ***Russian*** plays an important part in my life.....	1	2	3	4
11.	I feel that I am part of ***Russian*** culture.....	1	2	3	4
12.	If someone criticizes ***Russians*** I feel they are criticizing me.....	1	2	3	4
13.	I have a strong sense of being ***Russian***	1	2	3	4
14.	I am proud that I am ***Russian***	1	2	3	4

To what extent are the following statements true about **the things that you do**? Again, we use the term «Russian» to refer to the culture shared by refugees from the former Soviet Union.

	Not at all			**Very much**
How much do you speak *English:*				
1. at home? .....…….....	1	2	3	4
2. with your neighbors.....	1	2	3	4
3. with friends?….....	1	2	3	4
How much do you:				

4. read ***Australian*** books, newspapers, or magazines?.....	1	2	3	4
5. eat at Australian restaurants?.....……..	1	2	3	4
6. watch Australian movies on VCR or in movie theaters?....……..	1	2	3	4
7. eat ***Australian*** food?.....…	1	2	3	4
8. attend Australian concerts, exhibits, etc……	1	2	3	4
9. Buy groceries in Australian stores……	1	2	3	4
10. go to English speaking doctors?…….....…	1	2	3	4
11. socialize with ***Australian***f riends?.....…	1	2	3	4

How much do you speak *Russian*:

1. at home .....….	1	2	3	4
2. with neighbors.....….	1	2	3	4
3. with friends	1	2	3	4

How much do you:

4. read ***Russian*** books, newspapers, or magazines?.....	1	2	3	4
5. eat at Russian restaurants?…….	1	2	3	4
6. watch Russian movies on VCR?……	1	2	3	4
7. eat ***Russian*** food?.....	1	2	3	4
8. attend ***Russian*** concerts, exhibits, etc…….....	1	2	3	4
9. shop at ***Russian*** grocery stores?.....	1	2	3	4
10. go to Russian-speaking doctors?…….....…....	1	2	3	4
11. socialize with ***Russian*** friends?.....	1	2	3	4