# Acculturation and spirituality

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Spirituality is understood to be a protective factor for mental health, and is also understood to be highly present in immigrants from the developing world. Acculturation to the host culture, on the other hand, would imply lowered levels of spirituality as the immigrant adopts the habits and customs of the host culture. Conceptually, it is unclear how spirituality and acculturation interact in relation to mental health. The notions of acculturation and acculturative stress as well as the relationship between migration and mental health are elucidated in order to shed light on the complex relationship between spirituality and acculturation, which is analyzed in the context of the acculturative stress process. It will be suggested that spirituality comprises an important coping strategy that may be enacted prior to or as a response to mental distress, thus functioning differentially as a protective factor versus coping response. Further, research reviewed demonstrates that the social context of the immigrant group in question has an effect on how spirituality and acculturation impact mental health. It is concluded that the relationship between spirituality and acculturation is complex and multifactorial.

**Key words:** Acculturation, Spirituality, Acculturative stress, Immigration, Mental health

## Aculturación y espiritualidad

La espiritualidad es entendida como factor de protección en salud mental, y se reconoce como muy presente en inmigrantes del mundo en vías de desarrollo. La aculturación a la cultura anfitriona, por otro lado, podría implicar un descenso de los niveles de espiritualidad, al adoptar el inmigrante los hábitos y costumbres de la cultura anfitriona. Conceptualmente, no está claro como la espiritualidad y la aculturación interactúan en relación con la salud mental. La noción de aculturación y de estrés aculturativo, así como la relación entre migración y salud mental está elucidada para dar luz en la compleja relación entre la espiritualidad y la aculturación, lo que es analizado en el contexto del proceso de estrés aculturativo. Se sugerirá que la espiritualidad implica una importante estrategia de afrontamiento que puede ser activada a priori o como una respuesta al malestar mental, funcionando así diferencialmente como factor de protección versus la respuesta de afrontamiento. Más allá de esto, la investigación revisada demuestra que el contexto social del grupo inmigrante en cuestión tiene efecto en cómo la espiritualidad y la aculturación impactan en la salud mental. Se concluye que la relación entre espiritualidad y aculturación es compleja y multifactorial.

**Palabras clave:** Aculturación, Espiritualidad, Estrés aculturativo, Inmigración, Salud mental

Spirituality and religiosity are increasingly being incorporated in the conceptualization of mental health, to the extent that a "biopsychosociospiritual" model may be tenable. In general, spirituality is approached from both a "health" and a "pathology" approach. On the one hand, religiosity and spirituality are understood to be comprise important protective factors for mental well-being, and, on the other, various sorts of spiritual or religious beliefs can be viewed as symptomatic of mental illness. The bulk of recent attention in psychiatry and psychology to these issues has focused on the protective and functional aspects of spirituality and religion.[1-4]

A common thread running through much of the literature is that "traditional" societies—non "Western" ones—are more religious and/or spiritual,[5] and that religion and spirituality play an important protective and health affirming role, functioning as a coping strategy. Acculturation, understood as incorporation of host culture norms, language, and customs, is generally understood to be related to better mental health.[6, 7] Such of view of acculturation holds that it involves a movement away from more traditional, home-culture values, of which spirituality

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and religiosity are important parts to the ones of the host culture, which are lower in spirituality and religiosity. Thus the literature suggests two apparently contradictory perspectives on the relationship between acculturation and spirituality, both complex constructs, interact multifactorially in their relationship with mental health which will be explored in greater detail in this article.

## Spirituality and religiosity

Spirituality and religion*, one way or the other, are both related to the transcendent in the context of existence and meaning in life. Indeed, commentators note that there is considerable overlap between the constructs, to the extent that Zinnbauer and Pargament[8] hold that:

> Spirituality is defined as a personal or group search for the sacred. Religiousness is defined as a personal or group search for the sacred that unfolds within a traditional sacred context (p. 35).

Although some proponents of spirituality assert that it is an eminently personal process, Zinnbauer and Pargament argue that:

> Spirituality always manifests within a context…culture, community, society, family, and tradition exist as the crucible within which spirituality unfolds, or the background from which it differentiates (pp. 35-36).

In the context of immigration, this is evidently even more germane, and research indicates that this link between spirituality and its cultural context impacts its very manifestation, as shall be developed below. An important distinction for the purposes of this paper has to do with *extrinsic* versus *intrinsic* religion. The former is the more formalistic approach, also known as spiritual ends, which concerns non-sacred goals, and the latter, also known as spiritual means, concerns that which is focused directly on the sacred or transcendent.[9] To that end, spirituality, regardless of whether or not it is associated with a particular religion, is more subjective and ephemeral, rendering it elusive to measurement, whereas religion, at least as extrinsic, is clearly more concrete, as it includes specific actions such as Church attendance or prayer.

## Spirituality and mental health

The pertinence of culture for mental health, particularly in the context of spirituality, can be understood in the context of experience, expression, and explanation of emotion and distress, as well as the expectations concerning treatment, course, and outcome. The considerable variability involved across cultures means that even the most basic understanding of the mental health of culturally different patients may be difficult given the diversity involved. In a nutshell, cultural variability calls into question the identification of psychiatric symptoms and their relationship to mental disorder.

### *Experience*

From a variety of conceptual and empirical perspectives, there is increasing evidence that experience, even at the physical level, is mediated. Research on the so-called "cultural brain" and neuronal plasticity holds that interactions with the environment—culture—from birth and beyond, influences experience and how information is processed.[10] What this means, then, is that a how a person experiences a particular external or internal state is by no means neutral, but culturally conditioned. In the context of spirituality, this may mean that what is experienced as "natural" in one cultural context may be experienced as "magical" in another.

### *Expression*

It is reasonably well established that mental suffering is expressed through culturally normative "idioms of distress".[11] Both the level and form of expressivity is variable across cultures, as can be seen in the stoic northern European versus the emotive southern European. One of the common criticisms of western nosological systems is that they enshrine locally normative expression as universal.[12] The expression of distress—a symptom—is in part culturally normative, meaning that in a culture in which spirituality is more present, one can expect that the expression of distress will follow suit. Belief in spirits, for example, can result in a person talking with deceased ancestors. From a Western perspective, this could be viewed as symptomatic of hallucinations or delusions, however, from many other cultural perspectives it is not only normative but functional. Spiritual expression related to distress can be difficult to decipher for Western trained clinicians given that what may be normative and functional in the cultural context of the patient is pathological in that of the clinician.

### *Explanation*

Explanations about mental distress are culturally contingent.[13] Psychiatry is a decidedly modernist endeavour, in which causality is a function of the laws of nature, locus of control is internal, and the human being is at the center of the universe. In contrast, many immigrant patients are from cultures characterized by a pre-classical epistemic perspective, which posits a supernatural causality, which is frequently related to an external locus of control, with God

* Although there are clear differences between spirituality and religiosity, for the purposes of this article the two terms will be used interchangeably.

(or the equivalent thereof) at the center of the universe.[14] The very notions of "mental" and "psyche" are predicated on Cartesian dualism, which is by no means universal.[15, 16] Thus the way in which mental distress is understood and explained can vary considerably across cultures, particularly when a person is high in spirituality. A spiritual or supernatural explanation for suffering may, well appear, to be symptomatic of psychopathology and as such call all to easily lead to misdiagnosis. Further, a "clash of explanatory models" can also result in clinical comments such as "patient has poor insight" or "denies pathology" or "has problems with reality testing" when in fact the patient is rather clear about his or her problems, just from a perspective distinct from that of the clinician.

## *Expectations*

Mental health treatment is predicated on the epistemic foundations of science and medicine, and to that end treatment is "biopsychosocial".[16-19] Psychiatric and psychological interventions assume that treatment must address biological, psychological, and/or social dynamics, all of which is what is more or less expected by a patient who shares the same epistemic outlook. However, if a person experiences and understands the problem as spiritual, with a supernatural causality, then it is likely that he or she will expect treatment to have a concordant focus. To that end, a biological or psychosocial treatment may not be expected or desired, which could thus result in early termination and/or poor adherence to treatment.

Clearly, all of these "exes" are related, and, taken together, can result in a series of complications, *the more the immigrant patient is "spiritual" in their worldview*. As shall be shown below, the research that does exist on acculturation and spirituality indicates that spirituality is associated with greater perceived distance, ethnic identity, and a lesser degree of host culture adaptation.

Low acculturation is associated with more of the "exes". It is also associated with greater perceived distance from both the host culture as well as mainstream mental health. Low acculturation and spirituality are also associated with greater use of complementary or traditional healing.[20, 21] This may be in parallel to use of mainstream mental health services; however, it is often used as a first stop. Given the contrasting "exes", low acculturation and high spirituality are associated with lower and/or later use of mental health services, as well as false positives, given that expression and explanation are not normative for psychiatry. Taken together, this means that there may well be greater distress due to late entry into services, misdiagnosis, and, relatedly, erroneous or inadequate treatment.

## *Spirituality and immigration*

In general, multicultural experts consider spirituality to be a positive force for immigrants, in as much as it serves a series of protective functions, which can be understood in terms of both "intrinsic" and "extrinsic" religion.[22, 23] Intrinsically, spirituality can provide relief in the face of the sort of existential crisis that immigration may bring on by way of the losses, the changes, and pain. Where the migratory process can undermine a sense of meaning in life given the complexity and difficulty involved, spirituality can provide answers and a space of contemplation. Extrinsically, attending religious services, for example, can provide a concrete space of safety and security that is familiar, as well as an activity that keeps a person in touch with and engaged, avoiding isolation. The more an immigrant feels isolated from the mainstream culture, the more likely he or she is to immerse herself or himself in religious practices.[24] Further, the more a person identifies with the culture of origin, the more he is she is involved religiously. All of this makes perfect sense: Religion and spirituality function as both a sacred and a profane relief from distress.

Questions remain, however, as to the directionality. It may be the case that those immigrants who are more spiritual enjoy fewer mental health problems, inasmuch as spirituality serves a protective function. It may also be the case, however, that high spirituality is a related to poorer adaptation to the host culture, which in turn can have a negative impact on mental health. It could also be that those immigrants who perceive greater distance due to discrimination or cultural differences suffer distress and turn to spirituality and/or religion as a coping strategy. Indeed, as shall be seen below, the research suggests that it may be a combination of all of these factors.

The very question as to the relationship between spirituality and acculturation may itself be predicated on the Western notion that there is a "non-spiritual" aspect of being, as exemplified in the Church-State division. If such a differentiation does not exist, then being "encultured" into one's culture by definition also means that one is religious or spiritual, which could confound the research findings discussed below.

## *Migration and mental health*

The relationship between migration and mental health can be understood from two different perspectives, each of which runs counter to the other. One possibility, the "acculturation hypothesis", holds that time in host country is positively correlated with mental health. The idea is that in the immediate aftermath of arrival in a new country, immigrants face considerable difficulties in the adaptation to a new culture, which, over time, diminishes, and,

concomitantly, mental health improves. Greater adaptation to the host country is beneficial, and that migration in and of itself is a risk factor.[7] From such a perspective, spiritual involvement would likely decrease over time as the immigrant becomes more acculturated to the host culture.

The "immigrant paradox" is counterintuitive, with its assertion that time in host country is inversely related to mental health.[25, 26] The idea is that rather than stress reducing with adaptation to the host country, stress increases as the individual finds that exposure to the host country and culture itself is problematic, given the discrimination, difficulties in realizing the immigration expectations, and the like, which rather than decrease with time become more salient. The immigrant, who, on arrival was armed with positive expectations and culturally specific protective factors such as strong group bonds, finds that despite all efforts, he or she is still viewed as an "outsider", still finds that the "dream" is not all that easy to achieve, resulting in higher mental distress.

Research on this front is divided, however, it may well be that this is a function of specific population groups in specific contexts: Latinos in the United States would appear to follow the "immigrant paradox" model,[25] whereas Moroccans and Turks in Belgium follow the acculturation hypothesis.[27] Indeed these "contradictory" findings further indicate the complexity of the relationship between migration and mental health, and, to that end, suggest that multiple variables need to be factored in to the equation.

## Acculturation

Acculturation was originally introduced as an anthropological, group level process pertaining to changes that come about in the context of cultural contact. The notion of psychological acculturation is more recent, and concerns the impact of cultural contact at the individual level. Conventionally, and in common parlance, "acculturation" is the process of adaptation to a new culture, typically that of the host country or the majority group.[26] This perspective is captured in the earlier "unidimensional" approaches, which contemplated acculturation as a sort of zero-sum process, in which greater host culture adaptation was inversely related to diminishing home-culture identification. Generally speaking, unidimensional approaches have been replaced by bidimensional (or indeed multidimensional approaches), in which home and host culture adaptation are deemed to be orthogonal. From this perspective, one can have any combination of home and host culture immersion, from separation (high home culture, low host culture) to assimilation (low home culture, high host culture) to integration (high on both).[28] A fourth "option" is that of marginalization, which is low on both cultures, however, this construct is contested as being conceptually weak.[29]

A criticism of the notion of "acculturation strategies", and one that the author of the most popular bidimensional model, John Berry takes into account, is that the integration option is only feasible in socio-political contexts in which there is some sort of "true" acceptance of immigration and members of minority groups. If there is high anti-immigrant sentiment in the host country, with minimal multicultural or pluricultural legislation, home and host cultures are set in opposition, rendering any sort of integration of the two highly problematic[28] (see Rudmin 2003[29] for a comprehensive critique of the Berry model). This paper will use the term in its less technical sense, referring to greater immersion in the host culture.

### *Acculturation and mental health*

The received wisdom is that integration is the optimal acculturation strategy for mental health, followed by assimilation and separation, although, admittedly, these strategies would be tempered by the sociocultural context. However, a growing body of research places some important questions in the works. Researchers began to note what they termed the "immigrant health paradox" in which immigrants were found to have better mental health than native born, and, indeed, that time in the host country was negatively correlated with mental health.[25, 30] The research in this area is not definitive, however, significant epidemiological studies carried out in the US have found not only that immigrants have better mental health than native born, however, that the children of immigrants, who could be understood to be reasonably well adapted, show worse mental health than their immigrating parents.[31] Further, research shows that "ethnic density"—higher proportions of immigrants from the same region—functions as a protective factor, further indicating that "integration" in and of itself is not necessarily relevant for mental health.[32, 33] Acculturation, however it is understood, is deemed to be related to mental health the degree to which the particular strategy used puts an individual at greater or lesser risk.[28]

## *Acculturative stress: Risk and protective factors*

Researchers have increasingly endorsed "buffering" models, in which a host of factors are understood to mediate and/or moderate the relationship between migration and mental health, perhaps best explained in the context of stress-process.[34] From such a perspective, it is not acculturation *per se* that is better or worse for mental health, but rather the stress associated with the migratory process. To that end, researchers have increasingly focused attention on acculturative stress, which pertains to stress engendered by the migratory process.[26, 35-37] Drawing from Lazarus and Folkman's[38] transactional stress model and Pearlin's[39] stress-process model, immigrant stress is a complex process that is largely a function not so much of

the particular event or condition that may give rise to stress but rather the individual's capacity to manage the event or condition as a function of the internal and external resources available as well as the overall social context. Spirituality can be understood to be both an internal (or psychological) resources—a coping strategy—as well as an external resource—the degree that participation in religious services provide entry to a social network.

## *Religious Coping*

Spirituality and religion can provide a response to the powerful existential crisis that immigration can provoke related to challenges to role, identity, status, and the like. Further, religion provides not only existential meaning, but also a sense of belonging, community, social support, and a sense of moral legitimacy. Religious or spiritual coping has been operationalized as a means of making sense of life during times of crisis. Pargament et al.[40] identified two sorts of religious coping, one which is marked by positive response to religion, in which religion serves a supportive function, and the other negative, in which the individual questions key and fundamental aspects of her or his religion.

In a study carried out in Holland with native Dutch, immigrants from Turkey, Morocco and Suriname/Antilles, Braam et al.[41] examined religious coping, religious behavior, and depression. Immigrants relative to the native Dutch endorsed positive coping more than negative coping. The most common negative coping strategy was punishment reappraisal, especially amongst Turks and Moroccans. Turks were particularly prone to feel that they had been abandoned by God, which the authors consider to be related to the secularization process undergone in Turkey during the last century. Doubt in the existence of God was minimal in Turks and Moroccans, which may be a function of concern that the interviewer would view them as unMuslim. The low negative coping scores of the Moroccans may be a function of collectivism and the relative importance of religion in daily life.

Positive religious coping was associated with subthreshold depression, suggesting that people take recourse to religious coping in the face of mental distress, and that religious coping is an effective means of keeping the intensity of depression at bay. The authors also found a correlation between the frequency of prayer and positive religious coping, suggesting that there is indeed spirituality occurs in a particular context. Negative religious coping was positively associated with depressive symptoms and depression, particularly in the face of feeling abandoned by God. ....

Prayer and Mosque attendance were associated with lower levels of depressive symptoms in Moroccans suggesting either that these extrinsic religious activities are effective coping strategies or that depressed Moroccans do not participate in religious activities. Conversely, prayer and Mosque or temple attendance was associated with *higher* levels of depressive symptoms in Muslims and Hindus from Surinam. This could indicate that for the Surinamese extrinsic religious activities are ineffective, or that depressed individuals make use of religious activities as a means of coping, supported in part by the finding that religious activities were not associated with depressive disorder.

Dunn and O'Brien[42] examined religious coping, perceived stress, social support and psychological health in a reasonably well adapted Central American immigrant population from El Salvador and Guatemala. Although perceived stress was associated with anxiety and depression, levels were low to moderate in the sample. Religious coping and social support, contrary to what was expected, were not associated with mental health. The authors suggest that this may be because of the relatively low levels of stress, anxiety, and depression; had they been higher, then religious coping would have played a more important role.

From the research available, it would appear that religious coping is of relevance in the face of mental distress, that is, if life is more or less unproblematic, religious coping is not deployed, a notion that lends credence to the stress-process model.

## *Acculturation, spirituality and mental health*

The few studies that examined the relationship between acculturation, spirituality, and mental health approached the issue with opposing hypotheses. In a study carried out in the United States with Mexican immigrants in California, Ellison et al.[43] found that religious salience and religious attendance were inversely associated with depressive symptoms, on the one hand, and, on the other, that religiousness served to exacerbate the positive association between acculturative stress and depressive symptoms. Curiously, the authors in this study did not contemplate the possibility that this association may be related to difficulties in adaption that result in depression, which, in turns leads the individual to seek solutions through religion.

Friedman and Saragolou,[24] in a study carried out in Belgium, hypothesized that immigrant religiosity would be negatively perceived by the host culture, leading to a perception of greater perceived cultural different, which in turn would be associated with lower levels of acculturation. Further, they anticipated that religiosity would thus be negatively associated with self-esteem and positively associated with depression. The authors found support for the acculturation effect of perceived distance and spirituality in both stigmatized (Muslim) immigrants and non-stigmatized immigrants, however, the relationship to self-esteem and depression was only found in Muslim

immigrants. Conversely, Amer and Hovey,[44] in a study examining Arab immigrants to the US, found that Christian Arab immigrants showed patterns consistent with acculturation theory (greater acculturation is associated with mental health), whereas for Muslims, integration was not associated with mental health, and, and religiosity was associated with family functioning and mental health. Muslim immigrants would appear to be particularly impacted by the social context; Awad[45] found that whereas integrated Christians Arab immigrants perceived lower levels of discrimination, integrated Muslim Arab immigrants perceived higher discrimination. One can conclude from this research that the relationship between acculturation and spirituality is complex, and that social context must be taken into consideration in its analysis. The degree to which immigrants are discriminated against—or at least perceive as much—by the host culture has a considerable impact on the role cultural adaptation has on mental health, on the one hand, and how much spirituality and religion serve as a protective factor as against a coping strategy.

## CONCLUSIONS

From the research reviewed in this article, it is as yet unclear how spirituality and acculturation are related. On the one hand, it may be the case that those immigrants who have a more difficult time adapting to the host country and suffer associated stressors, take recourse to religion and/or spirituality as means of coping. Conversely, it may be the case that those immigrants who are more spiritually or religiously oriented are either protected from mental distress, or, conversely, are more marginalized from the host culture and as such suffer more. Either way, the research does suggest that spirituality and religion may play an important role in how an immigrant deals with their mental distress.

It is unclear the extent to which "spirituality" and "cultural affiliation" can be separated, that is, are they two distinct constructs, or, are they indeed one and the same. Thus it may be the case that higher levels of spirituality are *really* nothing more than higher levels of cultural affiliation. On the other hand, it could be that higher levels of spirituality *are* higher levels of ethnic identity.

The specific social contexts in which immigration—and acculturation—take place are also of considerable importance. The relationship between acculturation, spirituality, and mental health must be understood in the context of the specific socio-cultural and political situation in which the migration occurs. For those immigrant groups for whom perceptions of distance and antagonism from the host culture are minimal, the relationship between spirituality and acculturation will be different than for those immigrant groups who feel discriminated against and rejected on the basis of their culture and religion. For such groups, spirituality is protective in that it is a refuge against the stressors of intercultural contact.

Although not discussed extensively in the article, the specific "meaning" and associated measurement of spirituality and religion is problematic for research and the understanding of the complex relationship between acculturation, spirituality, and mental health. Future research will need to find a way to reconcile these complex issues, such that "equivalence" of constructs is found so that what is being measured has the same meaning for all cultural groups involved.[46]

## Implications for treatment

The "four exes" reviewed indicate that the clinical presentation of mental distress in the context of spirituality is highly culturally circumscribed, to the extent that the clinician runs the very real risk of an ethnocentric diagnostic process such that the interpretive filter used to make sense of the patient's distress is sufficiently biased to result in misdiagnosis. Clearly, the upshot is that a solid foundation in cultural competence is a necessary component of psychiatric competence.[17] Given the rather limited time available to most clinicians, perhaps the most tenable means of increasing cultural sensitivity is through attention to the doctor-patient relationship.[47] This is particularly important given that immigrant patients with spiritual orientations may be reluctant to acknowledge as such to their doctor due to shame or discomfort. Were this to be the case, and given that many immigrant patients are from cultures that are hierarchical, the patient will be reluctant to contradict or question (overtly) the clinician. Thus the patient may well overtly accept the diagnosis and treatment recommendation, however, with no intention of following up. The development of a solid therapeutic relationship is perhaps the most proficient means by which to side-step such a problem, in which the patient's lived experience is taken seriously and incorporated into the treatment process.

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