Exploring the Acculturation and Quality of Life Between Bangladeshi Immigrants and Their Adult Children

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Author Note

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Table of Contents

List of Tables

Table Page

Abstract

Acculturation is the powerful transitional process that occurs when any ethnic or culture relocates to a new and significant location that has the potential opportunity for that culture or population to thrive within a larger cultural context. The immigration of Bengalis to the United States provides the purpose of this study. There have been multiple studies done on the acculturation and quality of life of immigrants from Southeast Asia in the U.S. However, there is a large gap in the literature when studying these factors specifically among Bangladeshi immigrants. The present study used a cross-sectional design utilizing survey methodology measuring the differences of acculturation and quality of life between first-generation and-second generation Bangladeshis living in the U.S. The first hypothesis for the present study was first-generation Bengalis had low levels of acculturation compared to second generations. Additionally, the second hypothesis was that second-generation had a lower quality of life score compared to the first generation. The study consisted of 102 participants across the United States. The results showed that second-generation had higher levels of acculturation than the first generation. However, there were no significant differences found regarding the quality of life between the generations. These results indicated that both generations are similar in their quality of life and are consistent with previous findings in acculturation. Similar levels of quality of life and acculturation challenges among the first generations in this study suggest the need for further research and implications for mental health interventions within the Bengali community across the United States.

Chapter 1

Literature Review

The immigrant population in the United States (U.S.) is increasing and becoming a substantial subset of the U.S. population. Particularly, the Bangladeshi population has been increasing in the U.S. every year. Since the passage of the Immigration Act of 1965, which eliminated certain national quotas, the number of Bangladeshi immigrants in the U.S. has increased. By 1980, there were an estimated 3,500 Bangladeshi in the U.S. (Dutta & Jamil, 2013). More recent immigration waves after 1980 have brought much larger numbers of immigrants. Between 1982 and 1992, the U.S. Immigration and Naturalization service admitted 28,850 Bangladeshi with some estimates as high as 150,000 (Dutta & Jamil, 2013)

Currently, approximately 500,000 Bangladeshi immigrants live in the U.S. (Migration Policy Institute, 2015). Bangladeshi Americans are the third-largest subgroup of South Asian Americans in the U.S. behind Indians and Pakistanis (Migration Policy Institute, 2015). With these increasing numbers of Bangladeshis in the U.S., Bangladeshi immigrants learn how to adjust to a new culture while having their values and perceptions challenged. These cultural adjustments and challenges are knowns as acculturation and quality of life. Immigrants bring cultural beliefs and values of their home country to the U.S. These beliefs and values could be challenged when coming into contact with the American culture. Immigrating to a new country can cause emotional stress that occurs from entering a new culture while changing personal cultural values (Urzúa et al., 2017).

The study of acculturation and its relationship to immigrant quality of life has increased in the empirical literature (Shen, 2001). Acculturation generally refers to the

adjustment and adaptation to a new culture for individuals from a different culture (Shen, 2001). Several studies have found that acculturation is strongly related to an individual's overall quality of life (QOL: A subjective evaluation of multidimensional well-being), suggesting that more acculturated individuals feel less stress from the demands of adjustment and exhibit a better overall well-being (Shen, 2001; Song et al., 2004). For example, a study comparing first-generation immigrants (foreign-born) and non-first generation immigrants (American-born) all identified as either Caucasian, African-American, and Hispanic found, that first-generation immigrant participants reported less social support from family and friends, less life satisfaction, and more depression symptomatology than non-first-generation participants (Jenkins et al., 2013). Lastly, the study found that being away from one's own birth country may result in a lower QOL (Jenkins et al., 2013). However, these findings have shown to be contradictory with other literature, specifically with the Bangladeshi immigrant population.

Bangladeshis in the U.S. are predominantly first-generation immigrants who are monolingual, and they tend to maintain their cultural beliefs and values. In contrast, their adult children have shown to adjust better to the U.S. based on their English proficiency skills and better adjustments to the American culture. However, Song (2004) found that second-generation Bengali adult children have faced other challenges that their first-generation parents did not encounter such as, the pressure to be successful and their adaptation to their own culture as well as the host culture (Song, 2004). Abouguendia and Noels (2001) studied generational differences between Southeast Asians from Bangladesh, Pakistan, India, Nepal, Tibet, Kashmir, Burma and Sri Lanka who migrated to Canada; they found that second-generation (Canadian-born with foreign-born parents)

experienced more stressors from not feeling accepted by other members from their ethnic group, compared to first-generation immigrants (foreign-born; Abouguendia & Noels, 2001). In contrast, the first-generation group experienced more stressors from their environment and the new society. These findings show acculturation and QOL can be affected in both first- and second-generation immigrants in different ways (Abouguendia & Noels, 2001; Jenkins et al., 2013; Song, 2004;).

Thriving and Struggling

Many Bangladeshi immigrants have been shown to successfully thrive in the U.S. over the years. As Bangladeshis migrated to the U.S., they have achieved successful careers such as becoming doctors, engineers, and building successful businesses (Kibria, 2011). However, although Bengalis have shown to thrive, many Bengalis are also continuing to struggle. Bengalis are living in poverty and due to language barriers, many do not have their basic needs met such as not receiving effective health care. Dutta and Jamil (2013) examined low-income Bengali immigrants who live in poverty in New York City. The researchers found that the relationships between the medical provider and Bengali immigrant patients lack understanding and meaning, which often result in ineffective treatment. Based on these results, first-generation Bengali immigrants are at a disadvantage in obtaining their health needs which affect health factors in their QOL (well-being) and acculturation levels due to language barriers (Dutta & Jamil, 2013).

Concerning second-generation Bengalis in the U.S., many of their Bangladeshi parents value education with a preference and value for having their children attend "good" schools (Dutta & Jamil, 2013). Previous research in Asian cultures has shown similar values (Yang, 2004) and demonstrated that individuals who migrated from Asian

countries to a new country experience pressure to do better in school and be successful, provided additional stressors on second-generation children (Yang, 2004). Additionally, the pressure to be successful is based on their parents' struggles of coming to America and adds further stress to the second-generation immigrant population. These stressors for both generations have shown to affect their overall QOL and acculturation, such as showing an increase of psychological stress and struggles of being accepted in both their own ethnic culture and the host culture (Abouguendia & Noels, 2001; Belizaire & Fuertes, 2011; Yang, 2004)

The Process of Acculturation

John Berry, one of the main researchers of acculturation psychology, defined acculturation as "a process that entails contact between two cultural groups, which results in numerous cultural changes in both parties" (Berry, 2003, p .616). The effects of acculturation can also be seen on multiple levels in both the original and newly adopted cultures. Early models of acculturation are divided into two theoretical approaches. The first approach is viewed as a linear process where traditional cultural values and behaviors fade, and new cultural values are adopted. The goal of the uni-dimensional model of acculturation is assimilation. Assimilation is defined as the rejection of one's own culture and the desire to relate entirely to the host society. The second approach focuses on a bi-directional model where Berry focuses on the maintenance of one's own culture and integrating the new host culture (Adhikari, 2008). Based on this definition, acculturation and assimilation are virtually synonymous with one another. A prime example of assimilation is Gordon's Model of Assimilation (Gordon, 1978). Gordon's model formulated in 1978, examines the effects of acculturation on the macro-level, in

other words how the incoming immigrants affect the larger society. Gordon theorized that there are various stages that the immigrating person experiences: (a) cultural assimilation, (b) structural assimilation, (c) marital assimilation, (d) identificational assimilation, (e) attitude receptional assimilation, (f) behavioral assimilation, and (g) civic assimilation. Every stage is how the immigrating person is assimilated more into the host society (Gordon, 1978). The other branch of acculturation is the bi-modal conceptualization.

The most well-known theoretical approach to acculturation was posited by John Berry. This acculturation model is a bi-directional model where Berry focuses on two main interactions. The first interaction is the degree of an individual's maintenance of their own culture (cultural maintenance). The second interaction is based on how individuals who move to a new country decide how much they want to maintain their traditions and how much they want to participate in the traditions of the new host society (Adhikari, 2008). For instance, individuals may feel pressured to change their customs to the host country which may cause acculturative stress. Acculturative stress can be challenging and lead to such problems as anxiety and depression.

In dealing with the effects of acculturation, a person or group may decide to use acculturation adaptations or strategies (Berry, 2003; Kwak & Berry, 2001). Based on Berry's (2003) theoretical model, there are four hypothesized acculturation strategies: (a) integration, (b) assimilation, (c) separation, and (d) marginalization. The first strategy is integration, which is based on the individual's desire to maintain relationships with people of their own culture and also maintain relationships with members of the dominant culture. Secondly, assimilation is the rejection of one's own culture and the desire to relate entirely to the dominant group. In contrast, separation is the desire to

maintain all the characteristics of one's own culture, while rejecting the dominant culture. Lastly, marginalization is how much the individual feels ambivalent and alienated by one's own culture and the dominant culture (Kwak & Berry, 2001). These acculturation strategies provide the basis for understanding the characteristics of immigration and how each strategy may be adopted. Previous research on these strategies has shown that integration is the most adaptive strategy for immigrants (Castro, 2003). In contrast, the literature suggests that marginalization is the least adaptive strategy.

The Interactive Acculturation Model

The Interactive Acculturation Model (IAM) is a multi-dimensional model developed by Bourhis et al. (1997) and, further examines the relationship between an immigrant's acculturation strategies and the host culture. The IAM consists of three elements: (a) the immigrants' acculturation strategies, (b) host country's attitude toward immigrants, and (c) the product of both of these interactions (Berry, 2003). The difference between the IAM model and Berry's acculturation strategies is marginalization. In IAM, marginalization is divided into two parts: the marginalization of anomie and marginalization as an individual. Bourhis et al. (1997) define anomie as the rejection of both the immigrant's heritage culture and the host society culture. Marginalization on an individual level is defined as when the immigrant is distant from their heritage culture but not the host society's culture (Bourhis et al., 1997).

Due to the various differences within the two theoretical constructs of uni-dimensional and bi-dimensional acculturation models, deciding which model to adhere to is complex. The uni-dimensional model is a simple linear model in which the goal of acculturation is to be fully assimilated into the host culture. The multi-dimensional view

believes that immigrants can maintain a relationship with the host culture while maintaining their cultural traditions. Recent studies have shown an increased interest in bi-modal or multi-dimensional model research (Castro, 2003) and that is where the paradigm appears to be leaning towards. While certain theories such as Berry's have been extensively researched, other newer and intriguing theories, such as Bourhis need further empirical verification (Berry, 1997; Berry, 2003; Bourhis et al., 1997). The present study will conceptualize language preferences, ethnic interactions with either the host country or members of their own ethnic culture, cultural pride, generation identity, and food preferences. These components will help identify Berry's four strategies in acculturation.

Researchers have measured acculturation in various ways. Measures based on the unidimensional model of acculturation focuses on preferences of a cultural continuum ranging from *very much preferring* their culture to *very much preferring* the host culture (Cabassa, 2003). However, unidimensional measures are limited to an individual's acculturative experience and assume that immigrants can only assimilate. Multidimensional models typically consist of two different dimensions that separately measure maintenance of the culture of origin and the adaptation to the host culture.

Generational Differences and Acculturation

Regarding first-and second-generation immigrants, more recent studies have shown that among South Asians in Britain, first-generation immigrants showed a higher preference for the separation strategy (Robinson, 2005). Additionally, other studies showed that second generations had a higher preference for the assimilation strategy (Modood et al., 1994; Stopes-Roe & Cochrane, 1990). A recent study found that South Asian immigrants who came from India, Pakistani, Bangladesh, Nepal, and Sri Lanka, to

the U.S. employed three acculturation strategies, including separation, integration, and assimilation. The study found that South Asian immigrants with higher levels of income, lived longer in the U.S. and those who spoke English well were less likely to use the separation strategy than the assimilation or integration strategies (Needham et al., 2017).

Rumbaut (2004) studied the long-term consequences of immigrants and their children's adaptation to a new country. Rumbaut (2004) found some conflicts arise between first and second-generation Bangladeshis living in the U.S., often relating to the increase in intermarriage for second-generation children, which has shown to complicate the values and views of first-generation parents (Rumbaut, 2004). Another study looked at first-generation immigrants in the U.S. who came from India, Pakistani, Bangladesh, Nepal, and Sri Lanka and found that there was a challenge with language barriers which caused them to have a lower preference for the assimilation strategy and feelings of marginalization (Needham et al., 2017). Additionally, the study found that the participants also showed to have an increase in psychological stress, lower self-esteem, and showed less competence in sociocultural adaptation. In contrast, second-generation individuals have reported higher knowledge of the host language and higher preferences for the assimilation strategy (Needham et al., 2017).

Furthermore, first-and second-generation Bangladeshi immigrants and their adult children differ based on their contrasting upbringings. First-generation parents may need to take second language classes and work harder as an adult to adapt to the U.S. culture (Khaleque et al., 2008). Many first immigrants struggle with building a family and a career even if they had a professional career back in Bangladesh. Thus, they must often take lower status and lower-income jobs because their previous credentials do not meet

the same requirements in the U.S. Second generation children, on the other hand, have the opportunity to adapt to the culture from an early age. Interestingly, a study by Khaleque et al., (2008) found that second-generation children have expressed academic pressure due to the struggles their parents have faced migrating from Bangladesh. Many second-generation children feel pressure to succeed due to the sacrifices made by their parents for their better access to education and opportunities (Khaleque et al. 2008). Lastly, research has shown that the socioeconomic struggles of immigrant parents lead their children (the second generation) to focus more on educational success to avoid the socioeconomic struggles their parents experienced (Kao & Tienda, 1995)

The struggles of navigating first and second-generation differences are not unique to the Bangladeshi community and several studies have found similar generational differences in other populations. For instance, a study by Yang (2004), looked at the educational attainment of Asian Americans (Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam) living in the U.S. across generations. The results from Yang's study showed that as generations continued to grow, the more they tend to embrace the American culture compared to the first generation. What this means is that later generations, such as second, third and fourth generations, show more effort in embracing the American culture and find it easier to adjust (Yang, 2004). Another study by Shapiro et al. (1999), examined the generational differences in psychosocial adaptation and psychological distress in Vietnamese immigrants living in the U.S. The study looked at how the different generations of Vietnamese immigrants and their children adapted to the U.S. and their psychological distress. The study of 184 Vietnamese immigrants was categorized into three groups:

elderly, middle-aged, or young adults. The results in the study found that Vietnamese young adults were most acculturated, healthiest, and least depressed. Although, these results showed that young Vietnamese adults scored significantly higher than other generations for psychological distress when compared to the general population (Shapiro et al., 1999).

These studies indicated that there are differences and struggles faced by different cultures and generations when they migrate to a new country. Yang (2004) highlighted the importance of education and the impact it has on Asian American immigrant families. Their findings indicated that there is a higher pressure on education from immigrant parents compared to U.S born parents. This impacts the Asian American community in that education is viewed differently by immigrant parents. Additionally, the study showed how first- generation immigrants have a harder time adjusting to the American culture (Yang, 2004). Shapiro et al. (1999) highlighted the importance of mental health for Vietnamese immigrants. The study indicated that first-generation Vietnamese immigrants showed poorer mental health outcomes and overall well-being compared to the second generation. This impacts the community by acknowledging the importance of Vietnamese psychological well-being as being lower than the average U.S population (Shapiro et al., 1999). These studies implicate the multiple challenges faced by immigrant families living in the U.S.

As U.S. demographics continue to change, acculturation has shown to be an important factor in understanding ethnic group differences. Unfortunately, there has been a lack of research on acculturation as it is infrequently explored in the psychological literature for various reasons. One issue is the complex construct of acculturation which

still needs to be better understood. Additionally, these acculturation complexities have been applied only to select ethnic groups and not minority groups as a whole. Lastly, research across racial and ethnic groups in the U.S. has historically focused on defining differences as deficits. Thus, the focus of research on acculturation has often been on the origins of deficits rather than on open questions exploring the differences in experiences, environment, and culture (Titzmann & Lee, 2018). Research on immigration has revealed direct impacts on the acculturation process of first and second generations of immigrants.

Mental Health and Healthcare Among Immigrants in the U.S.

Acculturative Stress

Previous research has shown that the level of acculturation can affect acculturative stress, depression, and anxiety in immigrants (Schoppelrey, 2004). Immigrants encounter multiple factors that contribute to acculturative stress and this stress has been shown to affect the psychological well-being of immigrants (Schoppelrey, 2004). Acculturative stress may begin when immigrants' expectations of living in a new community are unfulfilled; for instance, immigrants who moved to the U.S. may have had expectation of the type of life they would live. Bhattacharya and Schoppelrey (2004) interviewed South Asian parents whose children were failing in school. In their interview, they found that the parents' pre-immigration beliefs included having better opportunities, living a more comfortable life, and having a secure job. Their post-immigration experience, however, was not comparable to their expectations. The parents were working jobs well below their educational qualifications and prior work experience. Moreover, they reported having inadequate housing, economic struggles, and difficulties in developing linguistic, social, and vocational skills (Bhattacharya & Schoppelrey,

2004). Additionally, the parents reported believing that their family would not achieve financial prosperity and social prestige unless their children did well in school this put a great emphasis on their children's academic success (Bhattacharya & Schoppelrey, 2004). Their children are also expected to take the role of the family spokesperson: due to the language barrier, children are expected to assist their parents with tasks such as the use of public transportation, interacting with social service agencies, and shopping. As a result, the parent and child both experience additional stress brought on by acculturation (Bhattacharya & Schoppelrey, 2004; Schoppelrey, 2004).

Healthcare

Language barriers are one of the most common challenges among immigrants in accessing healthcare resources (Schoppelrey, 2004). Specifically, language barriers have been an issue for Bengalis in receiving healthcare service, in general. Previous research has shown that Bangladeshis have had difficulty working with the health care system in various countries, including the U.S. These studies have shown that the general immigrant community does not have their voices heard within the healthcare system, which plays a large factor in their QOL in that their health needs are not adequately met (Dutta & Jamil, 2013). Researchers found that the relationships between the medical provider and Bangladeshi immigrant patients lack understanding, meaning rather than developing culturally sensitive communication options for diverse patients, medical care for Bengali immigrants often results in a lack of effective treatment. Based on the results of this study, Dutta and Jamil (2013) concluded that medical providers need more training in listening, dialogic engagement, and attending to the diverse and contradictory worldviews of patients (Dutta & Jamil, 2013).

Finally, a recent study by Blake et al. (2017) explored the underlying reasons for dissatisfaction with services among Bangladeshi and Pakistani social care users. The study found that there was a higher dissatisfaction among Bangladeshi service users; in-depth interviews found dissatisfaction toward the social care system, including accessing care, communication with social workers and the nature of the care received. The results concluded that cultural differences were one of the main factors that affected social care among Bangladeshi immigrants. These cultural differences included gender issues, traditional family roles, language barriers, and showing cultural sensitivity from workers. The results of this study raised awareness within communities to improve culturally sensitive services and encourage more diversity training for the social care workforce (Blake et al., 2017).

Mental Health

The South Asian community has shown resistance to accepting mental health services. Historically, social stigma, religious beliefs and family expectations are factors that have prevented South Asians from seeking professional help for mental health-related problems. Currently, these factors still play a role and mental health services are still stigmatized. Social stigma has been known to be associated with mental health issues for South Asian immigrants. Many immigrants express mental health symptoms through somatic symptoms and approach primary care physicians rather than psychologists (Lai & Shireen, 2013). Stigma may also exist when having to share any personal problems with others outside of the family (Kuo et al., 2008). Immigrants have shown to rely on ethno-specific social agencies that are not designed or funded for formal mental healthcare, which could be an additional barrier in accessing quality mental health care

(Sadavoy et al., 2004). For South Asian immigrants, it has shown to be difficult for them to find services from providers who are trained to be culturally sensitive (Reitmanova & Gustafson, 2009). It has been known that immigrant's mental health can be exacerbated when healthcare workers do not have awareness of the needs of multicultural clients with different cultural backgrounds (Reitmanova & Gustafson, 2009).

Alegría et al. (2007) found that first generations have better physical and mental health compared to second generations among Latino and Asian-Americans in the U.S. This is because the first generation reports better resiliency and less substance abuse compared to second generations (Alegría et al., 2017). However, mental health and healthcare barriers are a continued problem among both generations. Based on these studies, Bangladeshi Americans do not have the most effective and efficient experiences in healthcare and mental health services. Language barriers are one of the main challenges faced by immigrants, which cause lower levels of acculturation. Moreover, several studies have found that acculturation is strongly related to an individual's overall QOL, suggesting that more acculturated individuals feel less stress from the demands of adjustment and have a higher QOL (Shen, 2001; Song et al., 2004).

Quality of Life

The World Health Organization's (WHO) definition of QOL is multidimensional definition in the cross-cultural and psychological literature (Skevington et al., 2004). According to WHO, the definition of QOL is an "individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHO, 2004, p. 28). The WHO (1998) proposed four QOL domains: (a) physical health, (b) psychological, (c) social

relationships, and (d) environment. The physical health domain of QOL includes unpleasant sensations that cause distress and interfere with daily life routines such as, activities of daily living dependence on medicinal substances and medical aids, energy, fatigue, and sleep. The psychological domain includes self-esteem, body image, negative and positive feelings, spirituality, and cognition. The social relationships domain involves satisfaction with marriages and partnerships. Finally, the environment domain focuses primarily on the adequacy of financial resources, physical safety, and social care (Belizaire & Fuertes, 2011; Powers, 1998).

Migrating to a new country involves being exposed to new social, economic, political climates, and culture. Migration involves change and adapting to new customs and lifestyle such as learning a new language; identifying one's own identity between two cultures; losing friends and finding new ones; and, variance in cultural behaviors and attitudes along with differences among generation and new geography. Such changes have been shown to produce consequences on a psychological and social level. For example, studies have shown that feelings of loneliness, lower psychological well-being, and poorer mental health were reported within immigrant populations all of which interfere with one's QOL (Urzúa et al, 2017).

Previous research has shown differences among first-and second-generation immigrants based on their psychological well-being and QOL. One study examined immigrants in Italy and their well-being based on first-generation (foreign-born parents) and second generations (Italian-born children with foreign parents). The immigrants from this study came from Morocco, Egypt, Sub-Saharan Africa and South Asia. The study found that the second generation had lower psychological well-being than first-generation

immigrants due to discrimination being a stronger obstacle for second-generation immigrants than for the first generations (Giuliani et al., 2018). This finding is also consistent with previous research that has demonstrated second generations report lower psychological well-being than first-generation within Asian and Latino groups in the U.S. (Becerra et al., 2013; Kaduvettoor-Davidson & Inman, 2013).

A recent study indicated that for first-generation immigrants, lack of host language fluency, fewer contacts and friendships with host members, the strategy of marginalization, and perceived discrimination are all related to higher psychological distress, lower self-esteem and decreased competence in sociocultural adaptation (Tonsing, 2014). Although second-generation individuals reported higher knowledge of the host language and higher preferences for assimilation strategy, the levels of psychological distress were higher compared with the first-generation group (Tonsing, 2014). The factors that influence these results were that second generations may have a loss of their heritage culture and have to negotiate demands and values from both the host culture and their own culture. Additionally, earlier studies have also observed that first generations who favor the separation strategy and second generations showing a higher preference for either the assimilation or integration mode, often lead to intergenerational conflict or tension (Anwar, 1998; Farver et al., 2002). Lastly, the second generation may have high expectations and feel more distressed, leading to psychological distress (Anwar, 1998; Farver et al., 2002).

People's QOL has been shown to have a direct impact on physical health, psychological, social, and environmental acculturation strategies across first and second-generation immigrants (Skevington et al., 2004). Previous research on immigrants who

migrated to other countries has shown increased psychological distress, challenges to cultural values, and ineffective health treatment (Dutta & Jamil, 2014; Uddin 2015; Urzúa et al., 2017). These limitations have created barriers and affect overall QOL for immigrants, a domain that need to further to be explored within the Bangladeshi population in the U.S.

The World Health Organization Quality of Life-BREF (WHOQOL-BREF; Power, 1998,2004) created a way to provide a cross-cultural measure. It has been used for psychological evaluation and research (Saxena et al., 2001), and has been applied to more than 4,800 respondents around the world and is available in more than 20 languages. QOL is a proxy measure and will be useful for the present study by measuring physical, psychological, social and environmental domains. The WHOQOL-BREF was developed and used to demonstrate adaptive functioning and well-being as a result of acculturation strategies (Power, 1998, 2004).

Purpose of the Study

Previous research has shown the impact acculturation has on immigrants and how that can affect one's QOL. Additionally, the process of acculturation and QOL varies between first and second generation. The present study will aim to measure acculturation levels and the different domains within their QOL. Previous research has shown contradictory results among generational differences in South Asians living in the U.S. The current study will also be investigating the process of acculturation for Bangladeshis in the U.S. and interest in testing Berry's Acculturation Model by determining if the process of acculturation follows the pattern predicted by the model. Due to the number of barriers South Asian immigrants encounter in their health, social and psychological

services, the present study will explore QOL among the Bangladeshi community living in the U.S. As this population increases, it is important to understand how their culture may be affected and ensure this population is receiving adequate services, whether it be health, social or psychological (Amin & Ingman, 2014; Blake et al., 2017; Dutta & Jamil, 2013). Additionally, first-generation and second-generation immigrants have been shown to have different struggles, values, identity and culture.

Research Questions

Little research has addressed the link between acculturation and quality of Bangladeshi immigrants in the U.S. Due to this gap in literature and research findings of challenges faced by immigrants in the U.S., the purpose of this study was to understand Bangladeshi immigrants' acculturation struggles and their QOL in first and second-generation Bangladeshi populations. As mentioned previously, the present study has a twofold purpose: (a) to describe the acculturation and QOL evaluated in the immigrant populations and (b) to understand the difference between acculturation and QOL of first and second-generation Bangladeshis living in the U.S.

Based on previous studies, the current research question is "Will first-generation Bengali immigrants report lower acculturation and QOL than their adult children?"

The first hypothesis of this study is: first- generation Bengali immigrants will struggle more with acculturation than their adult children.

The second hypothesis is: second-generation adult children will have a lower QOL score compared to the first generation.

Based on previous studies, the second-generation has reported lower psychological well-being compared to first-generation (Shapiro et al., 1999). This finding

has been consistent throughout studies which is why it is hypothesized the second generation will have a lower overall QOL than the first generation.

Conclusion

Currently, there is a gap in the literature measuring these factors among Bangladeshis living in the U.S. The Bangladeshi population is continuously increasing in the U.S. and previous research has shown that immigrants who come to the U.S. have challenges acculturating to a new country, which affects their overall QOL (Shapiro et al., 1999; Titzmann & Lee, 2018; Yang, 2004). Additionally, literature has shown that their children have also been affected by the acculturation process as well which may also affect their QOL (Khaleque et al., 2008; Rumbaut 2004; Yang, 2004). The present study will focus on measuring acculturation levels and QOL between first-generation Bangladeshi immigrants and second-generation U.S. born Bengalis. These measures will be analyzed through Berry's Acculturation Model and the World Health Organization QOL measure. The present study will be used to fill in the gap within Bengali literature and increase awareness within professional communities regarding acculturation and QOL for Bengali communities in the U.S. The results will increase awareness and help improve psychological and general health practices for the Bengali community.

Chapter 2

Quantitative Methodology

The present study focused on comparing acculturation levels and QOL between Bangladeshi immigrants and their adult children in the U.S. To investigate the acculturation and QOL between Bangladeshi immigrants and their adult children, a quantitative method comparison study and a cross-sectional-design were used to investigate Bangladeshi generational differences. The current study utilized two questionnaires: (a) South Asian identity Acculturation Scale (SL-ASIA) and (b) The World Health Organization Quality of Life – Abbreviated (WHOQOL-BREF).

Participants

Participants for this study were Bangladeshi immigrants aged 18 and up living in the U.S. For the present study, first generation refers to individuals born in Bangladesh who migrated to the U.S. Second generation refers to U.S. born Bengalis with one parent or both parents born in Bangladesh. The participants were recruited from Facebook, Bangladeshi non-profit organizations and community groups by word of mouth and sending flyers within the Bangladeshi community. Most of the participants were recruited from California or the East Coast and many of them had lived for longer than 10 years in the U.S. An informational handout was passed out describing the study prior to their participation and providing the link to the surveys on Qualtrics. The desired power analysis for the study was a minimum of 62 participants (31 first-generation and 31-second generation).

Measures and Instrumentation

Participants completed a demographic questionnaire and two rating scales.

Demographic Questionnaire

A demographic questionnaire was administered at the beginning of the survey. The demographic questionnaire consisted of 10 questions regarding, age, sex, place of birth, year immigrated to the U.S., socioeconomic status, marital status, single-household, race/ethnic origin, education status and employment status (see Appendix A).

Suinn-Lew Asian Self-Identity Acculturation Scale

The Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) was developed by Suinn, Ahuna, and Khoo in 1992. The SL-ASIA allows for an analysis of acculturation of Asian-American individuals (Suinn et al., 1992). The SL-ASIA scale is a self-report measure that is comprised of 21 questions that focus on collecting information about an individual's historical background as well as more recent behaviors which that may be related to their cultural identity (see Appendix B). In scoring the 21 items, each item is added up for each question on the scale and the total value is obtained by summing the answers for all 21 items. The final acculturation scores are calculated by then dividing the total value by 21. A score can range from 1.00 (low acculturation) to 5.00 (high acculturation) for the SL-ASIA (Cohen & Williamson, 1988; see Appendix A).

The measure assesses acculturation as a multidimensional construct, with questions about language (4 items), identity (4 items), friendship (4 items), behaviors (5 items), generation and geography (3 items), and attitudes (1 item). Respondents rate the items on a 5-point scale, with low scores reflecting high Asian identification and low acculturation to Western culture, and high scores indicating low Asian identification and high acculturation to Western culture, and scores in the middle reflecting biculturalism.

Example questions include "What is your food preference in restaurants?" "Whom do you now associate with in the community?" and "What language do you speak?" A response of 1 is intended to reflect a low level of acculturation (more identification with one's Asian subgroup), while a response of 5 indicates a high level of acculturation (more Western identification).

The outcomes of the SL-ASIA provide insight into the nature, meaning, and impact of acculturation on the resiliency, psychological health, and overall well-being of Asian Americans. The average time of completion for the SL-ASIA is between 10 to 15 minutes (Cohen & Williamson, 1988). Suinn et al. (1987) reported SL-ASIA psychometric properties have internal consistency, reliability and validity. A reliability study was conducted on studies that reported the use of the SL-ASIA. Data from 83 Cronbach's alpha coefficients representing 12,992 participants were analyzed; only 67 out of 193 published studies (43.52%) reported reliability scores for their sample. The reliability scores produced by the SL-ASIA ranged from .62 to .96 with an average of .91 (SD = 0.07); therefore, all the reported reliability scores for this instrument were within an acceptable to excellent range. These results demonstrate that SL-ASIA continues to be an instrument with strong psychometric properties when used with diverse populations, and it is therefore, appropriate for continued use with studies on acculturation (Phillips et al., 2016).

Using the generation/geographic history and attitude items for validation criteria and the remaining items to score the instrument, Suinn et al. (1987) found direct relations between scores on the SL-ASIA and (a) generation since the immigration of respondent, (b) length of residence in the U.S. of the respondent, and (c) self-ratings of cultural

identity which confirms the measure's validity. The SL-ASIA is reliable to be used in the general population and can be used for the Bangladeshi population (Suinn et al., 1987).

The World Health Organization Quality of Life - Abbreviated

The WHOQOL- BREF was initiated in 1991 by the WHO (World Health Organization, 2018). The assessment was developed cross-culturally in measuring QOL. This instrument assesses an individual's perceptions of their personal goals, standards, and concerns (Power, 1998; see Appendix C).

The WHOQOL-BREF produces a QOL profile and is based on the four-domain structure derived from the World Health Organization Quality of Life-100 (WHOQOL-100), which is a 100-item scale. (Power, 1998; Skevington et al., 2004). The WHOQOL-BREF is a 26-item version of the WHOQOL-100 assessment. Domain scores produced by the WHOQOL-BREF have been shown to correlate at around 0.9 with the WHOQOL-100 domain scores. The WHOQOL-BREF is a self-report measure that focuses on the domains of physical health, psychological health, social relationships, and the environment. For instance, the assessment asks "How satisfied are you with your health?" and "How would you rate your overall quality of life?" The average time of completion for the WHOQL-BREF is between 10 to 15 minutes (WHO, 1998). The WHOQOL-BREF has been shown to be effective in assessing variations in QOL across different cultures (Power, 1998).

The items in the WHOQL-BREF are summarized by producing four domain scores. Question one and question two are examined differently. Question one asks about an individual's overall perception of QOL and question two asks about an individual's overall perception of his or her health. Higher scores in the WHOQL-BREF indicate a higher QOL. The mean score of the items within each domain is used to calculate the domain score.

Mean scores are then multiplied by four to make domain scores comparable with the scores used in the WHOQOL-100 (Power, 1998; see Appendix B).

Ohaeri and Awadalla (2009) reported that the WHOQOL-100 domain scores have demonstrated acceptable validity (Skevington et al., 2004). The WHOQOL-100 was based on six theoretical domains rather than the four domains during the development of the WHOQOL-BREF. In a study using WHOQOL- BREF in cross-sectional data obtained from a survey of adults carried out in 23 countries, researchers found that the mean domain scores for the total sample and for each country were calculated and found to be relatively similar, meaning they ranged from 13.5 to 16.2 (SD = 2.6–3.2). Summary Pearson correlations (one t-tailed test) between domains for the total sample were strong, positive, and highly significant ($p < 0.0001$), ranging from 0.46 (physical vs. social) to 0.67 (physical vs. psychological). Across samples, the WHOQOL-BREF generated the following alpha coefficients: physical health (.90), psychological health (.83), social relationships (.73), and environment (.84). The WHOQL-BREF is reliable to be used in the general population and not targeted for a specific population (Ohaeri & Awadalla, 2009). The WHOQOL-100 domain scores have demonstrated acceptable validity (Skevington et al., 2004).

Study Procedures

Informed consent forms were provided before the survey containing information about procedures, benefits and risks of participating, an explanation on how to acquire the results of the research, timing, confidentiality, voluntary participation, a crisis line and contact information of the researchers (see Appendix C). After participants read the consent form, they had the option to click "I agree" to continue the study or "I disagree"

if they wished to not participate. Next, the participants filled out demographic information consisting of 15 questions. Then, they were asked to complete the SL-ASIA scale followed by the WHOQ-BREF scale. At the end of the 15 to 30-minute survey, they were thanked for their time and offered a reminder of resources in case they had experienced any distress while taking the survey. Confidentiality was ensured by the anonymity of the survey and by aggregating the data. Data collection and survey administration was conducted through the use of Qualtrics, an online data collection platform. An incentive was used in this study that gave allowed the participants to join a raffle and win a $25 Amazon gift card (see Appendix B).

Conclusion

The present study compared generational differences between first-generation Bangladeshi immigrants and their adult children based on acculturation levels and their QOL. To investigate these comparisons, the present study used two questionnaires, the SL-ASIA to measure acculturation and the WHOQOL-BREF to measure QOL. The participants were recruited from various Bengali non-profit organizations and community groups across the U.S. This study will be used to increase awareness within professional communities regarding acculturation and QOL within Bengali communities in the U.S.

Chapter 3

Results

The current study aimed to (a) to describe the acculturation and QOL evaluated in the Bengali immigrant populations and (b) assess any differences between acculturation and QOL between first and second-generation Bangladeshis living in the U.S. Second generation Bengalis were hypothesized to report greater acculturation than first-generation individuals. In addition, it was hypothesized that the second-generation would report a higher QOL. In particular, QOL was measured through four different domains: physical health, psychological health, social relationships, and the environment.

Analytic Strategy

To prepare the data for analysis, acculturation was quantified by summing the 21 items in the SL-ASIA scale. Additionally, the responses for QOL were calculated by obtaining the mean score of each of the items within each domain (physical health, psychological health, social relationships, and environment). Moreover, overall QOL was measured by the first question on the WHOQOL scale which asked, "What is your overall quality of life?"

Separate analyses were used to test the hypotheses related to acculturation and QOL using gender as a covariate. An Analysis of Covariance (ANCOVA) was used to test the acculturation hypothesis with the Acculturation summary score as the dependent variable and Generation (first vs. second) as the independent variable. In addition, a Multivariate Analysis of Covariance (MANCOVA) was used to test the generation effect on QOL for the four domains, specifically physical, social, environment, and

psychological. An ANCOVA was also used to test the effect of generation on the overall QOL.

Results

Reported Acculturation and Quality of Life

Out of 102 participants in the study, 51 were first-generation Bengalis and 51 were second generation. Of the total sample, 37% of the female participants were first-generation and the remaining were second-generation Bengalis (*n*s = 24, 41, respectively). Out of the 37 male participants, 72% were first-generation and 37% were second-generation. Not all of the participants completed all the measures in entirety. Out of 102 participants, 96 completed the acculturation measure and 91 completed the QOL measure.

The overall mean score for acculturation fell within the moderate level (*M*=2.84, *SD*=.601). The single-item overall score for QOL fell at the moderate level (*M*=3.89, *SD*=1.15). Moreover, the physical (*M*=3.86, *SD*=.841), environmental (*M*=3.86, *SD*=.995), and social (*M*=3.76, *SD*=1.13) domain scores were towards the higher end of the moderate level whereas psychological QOL (*M*=3.59, *SD*=.895) ranked as the lowest domain across the sample. Table 1 shows the means for acculturation, and QOL and its domains overall, as well as by generation and gender.

Relationships Among Acculturation and Quality of Life

A correlational matrix with correlations among acculturation and quality of life is shown in Table 2. The correlation between acculturation and the overall quality of life score was not found to be statistically significant. The psychological domain showed the

highest correlation with the environmental domain. Additionally, the physical domain had the least amount of correlation with overall quality of life.

Table 1

Overall Means Across 1st and 2nd Generations

	Overall		1st Generation	95% CI		2nd Generation
	M	*n*	M	LL	UL	M
Acculturation	2.84	96	2.51	2.36	2.66	3.24
Male			2.52			3.38
Female			2.50			3.10
Quality of Life	3.89	91	3.65	-	-	3.98
Male			3.36			3.77
Female			3.95			4.19
Physical	3.86	91	3.83	3.51	4.14	3.96
Male			3.83			3.80
Female			3.91			4.04
Social	3.76	89	3.73	3.29	4.18	3.79
Male			3.60			3.40
Female			3.77			3.58
Environmental	3.86	91	3.89	3.52	4.27	3.93
Male			3.55			3.77
Female			3.97			4.01
Psychological	3.59	91	3.67	3.32	4.02	3.57
Male			3.50			3.53
Female			3.69			3.58

** *n*s for male and female subsamples for each of the measures

Test of Generational Differences

Acculturation.

A one-way ANCOVA was used to analyze acculturation among first and second generations. The ANCOVA testing for generational differences yielded a significant effect for generation as shown in Table 2 ($p < .01$). First-generation participants reported to having lower acculturation levels as compared to the second generation. No significant gender differences were found between the two generations.

Quality of Life.

An ANCOVA was used to analyze the effect of generation on overall QOL. The single-item measure of QOL had a significant gender effect ($p <$. 05 level). These results indicate that females reported higher QOL than males. Neither the main effect for generation nor its interaction with gender was significant in their association with overall QOL (see Table 4).

The MANCOVA results in Table 5 assessed the effect of generation on the four subdomains of QOL, with gender as a covariate. Despite the significant effect for the single-item measure, generation was not found to be significant for the omnibus test of QOL subdomains (p = .374). Gender was also not significantly associated with the QOL subdomains overall (p = .287). The effect of generation on each of the four QOL domains was further examined using ANOVA and the results revealed no significant differences of generation for each subdomain of QOL. First- and second-generation Bengalis tended to report similar levels of QOL. Specifically, a comparison of the scores among physical first generation (M = 3.86, SD= .122) and second-generation participants (M= 3.96, SD = .121) showed minimal differences as shown in Table 1. The least amount of difference was found within the environmental domain in which first-generation (M = 3.86, SD = .122) reported similar QOL than second-generation (M = 3.93, SD = .143). Although the differences were not statistically significant, second generation reported an overall higher QOL than the first generation in physical, social, and environmental factors, but reported lower QOL in the psychological domain compared to the first generation.

Table 2

Correlational Matrix

Variables	Acculturation	Quality of Life	Physical	Social	Environmental	Psychological
Quality of Life	.181					

Physical	.193	.651**			
Social	.101	.660**	.679**		
Environmental	.105	.782**	.810*	.714**	
Psychological	.027	.723**	.791**	.773**	.798**

**Significant at the 0.01 level

Table 3

Effect of Generation on Acculturation

	ANOVA			95% CI	
	F ratio	*p*	Eta squared	First Generation	Second Generation
Generation	37.8	1	9.88	[2.36, 2.66]	[3.05, 3.43]
Gender	1.14	1	0.28**		
Generation x Gender	19.4	2	5.07		

Note: Results based on n of 96.
* $p < .05$. ** $p < .01$.

Table 4

Effect of Generation on Overall Quality of Life

	ANOVA			95% CI	
	F ratio	*df*	Eta squared	First Generation	Second Generation
Generation	.242	1	1.75	[.914, .913]	[.049, .038]
Gender	.046**	1	5.16		
Generation x Gender	.027	2	4.75		

Note: Results based on n of 91.
* $p < .05$. ** $p < .01$.

Table 5

Effect of Generation on Quality of Life domains

	ANCOVA			95% CI	
Variables	*F* ratio	*df*	*η2*	First Generation	Second Generation

		Physical			
Generation	.558	1	.006	[3.51, 4.14]	[3.65, 4.27]
Gender	1.76	1	.020		
Generation x Gender	1.54	2	.035		
		Social			
Generation	.043	1	.003	[3.29, 4.18]	[3.35, 4.23]
Gender	1.14	1	.016		
Generation x Gender	.858	2	.020		
		Environmental			
Generation	.033	1	.001	[3.52, 4.27]	[3.93, 4.30]
Gender	1.17	1	.013		
Generation x Gender	.709	2	.016		
		Psychological			
Generation	.269	1	.003	[3.32, 4.02]	[3.22, 3.91]
Gender	0.89	1	.001		
Generation x Gender	.146	2	.003		

Note: Results based on n of 91.
* $p < .05$. ** $p < .01$.

Summary

The results of the study demonstrated that level of acculturation differed by generation and these results supported the hypothesis that first-generation Bangladeshi immigrants reported lower acculturation levels than the second generation. Although the effect of generation on the overall quality of life and its domain scores did not reach significance, the single-item overall quality of life measure appeared higher for second-generation Bengalis but was not significantly different compared to the first generation. In regards to the quality of life, the subdomains of quality of life did not differ by generation.

Chapter 4

Discussion

Previous research on acculturation and QOL has increased in the empirical literature (Shen, 2001). Various studies have found that acculturation is strongly related to an individual's overall QOL. This suggests that individuals who are more acculturated can have better overall well-being due to feeling less stress from the demands of adjustment (Shen, 2001; Song et al., 2004). The present study focused specifically on Bengali immigrants and their acculturation and QOL in the U.S. Due to the lack of previous Bengali research, the current study aimed to explore levels of acculturation and QOL across first- and second-generation Bengalis.

As part of Berry's Acculturation Model (Berry, 2003), first-generation Bengalis are more likely to adopt the separation strategy where they maintain their heritage culture and reject the new culture. In contrast, the second-generation is more likely to adapt to the integration strategy where they integrate more of the host culture and struggle to maintain their heritage culture (Berry, 2003). Regarding QOL, previous research has shown mixed results regarding whether first-generation or second-generation immigrants have a higher or lower QOL. Due to the implicated acculturation research that the first-generation struggles more with acculturation than other generations, the current study included the hypothesis that first-generation may also have a lower QOL. Based on the lack of Bengali research and mixed QOL findings among immigrant generations, the present study aimed to examine these ideas and add to the gap in the literature regarding Bengalis in the U.S.

The results of the investigation demonstrated that first-generation Bengalis struggle more with acculturation than the second generation. However, first-generation

and second-generation Bengalis reported similar QOL. Taken together, these results demonstrated that both generations reported similar QOL in all four QOL domains: psychological, social, environment and physical domains. Regarding acculturation, the current results confirm that adjusting to a new culture is more difficult for the first generation than for second generations. These results suggest first-generation individuals adhered to more of the Bengali culture than to the American culture into their lives. In contrast, second-generation individuals reported implementing more of the American culture than their heritage culture. Moreover, although both of the generations differed in their acculturation stages, their QOL maintained the same.

Acculturation

The findings from the present study showed that first-generation individuals preferred to speak in both Bengali and English equally well, whereas second-generation preferred to speak more English than Bengali. Additionally, more second-generation participants identified themselves as "Bengali American" than first-generation who preferred to be identified as "Bengali." Both the first and second generation reported that they both equally associate with Asian groups and Anglo groups. These findings fill an important gap in research regarding the type of groups with whom they associate in the community and how each generation identifies themselves.

Previous research on acculturation found that first-generation immigrants who are monolingual tend to maintain their cultural beliefs and values. In contrast, their adult children have shown to adjust better to the U.S. based on their English proficiency skills and increased adjustment to the American culture. Additionally, Abouguendia and Noels (2001) found that Southeast Asian immigrants in Canada differ between generations in that the second generation experienced more stressors from not feeling accepted by other

members from their ethnic group, compared to first-generation immigrants. The present findings confirmed the results from previous studies by first-generation individuals falling more into the separation category and second-generation identifying more with the integration strategy. However, the present finding showed that although the generations had their differences in their acculturation, both generations appeared to value their Bengali heritage. For instance, second-generation preferred to associate themselves with the Bengali community more but reported that they only associate with other community groups such as Caucasians, Hispanics, African Americans, and other Asian groups. These findings are consistent with previous studies for Italian, Egyptian, Chinese, Japanese, Indian, and Pakistani second generations growing up in a different culture (Giuliani, et al., 2018). Additionally, Madood et. al. (1994) found that second generations had a higher preference for the assimilation strategy where they would like to be able to integrate both their heritage culture and the host culture.

In contrast, previous findings have shown that first-generation individuals prefer to maintain their heritage culture more than adapting to the new culture. For instance, more recent studies have shown that among South Asians first-generation immigrants in Britain showed a higher preference for the separation strategy (Robinson, 2005). The present study is consistent with this finding due to first-generation immigrants preferring to maintain more of their Bengali culture by eating more Bengali food and associating themselves with the Bengali community more than other communities. This may be due to the first generations having the opportunity to be exposed to their heritage culture by living in Bangladesh. In contrast, second-generation Bengalis were born and raised in the

U.S. which gives them less exposure to the Bengali culture than first-generation (Rumbaut. 2004).

Further acculturation results implicated that both generations preferred to have Asian or Bengali food at home and are both extremely proud of their identity. These indicated how both generations value their heritage culture although they were both born and raised in different countries. Based on the results, both generations valued social gatherings and preferred similar foods, which are both highly valued in the Bengali culture. Both generations reported being proud of their identity, which provided a sense of belonging. First generations may have taught their children, who grew up in the U.S., about the Bengali culture and how valuable it is to identify with that part of themselves. Additionally, first-generation Bengalis may take trips to Bangladesh which helps their second-generation adult children to immerse themselves in the culture and ensure culture values stay ingrained.

Quality of Life

The present study analyzed the four QOL domains: (a) physical health, (b) psychological, (c) social relationships, and (d) environment. The results of the current study did not indicate any significant differences between these four domains within firs- and second-generation Bengalis. This suggests that first and second-generation Bengalis had similar responses to physical distress and psychological stress; how they perceive social relationships; and how they reported similar environmental factors. Many factors may have contributed to these results such as the number of years first-generation participants have lived in the U.S. Previous studies suggest that the longer immigrants live in their host country, their QOL increases (Yang, 2004). This finding shows that

although the first and second generations had varied in acculturation, their QOL was not substantially different. Most of the first-generation Bengali immigrants in the present study migrated to the U.S. between 1980 and 1995, which may indicate that first generations had enough time to adjust to the host country and have managed a sustainable QOL as their adult children. Moreover, the results show that both generations are content with their health, social life, environmental conditions, and have more positive feelings than negative.

Additionally, the results for QOL may not have shown much of a difference between generations due to first-generation Bengali immigrants settling within immigrant communities, where they could find the support they needed. Most first-generation participants from the present study had lived in the U.S. for over 10 years which may have led to a moderate level of QOL. Previous findings showed that immigrants who had moved within the last five years' experience lower self-esteem and less competence in sociocultural adaptation, causing a lower QOL (Tonsing, 2014).

Moreover, second-generation immigrants may not have lived very differently than their parents; thus, their QOL did not improve within one generation. For instance, both generations reported similar qualities regarding their physical health, psychological health, social relationships, and their environment. The results showed that both generations had satisfactory health and a moderate level of psychological health. Additionally, both generations reported that they felt safe in their environment and had supportive social relationships. These findings are inconstant with previous findings. For instance, one study found that second-generation experiences higher psychological distress (Giuliani et al., 2018), though the same results were not seen in the present study.

Another study found that first-generation had higher psychological distress and lower self-esteem than the second generation (Tonsing, 2014). The differences between the present study and previous studies may be due to the first-generation immigrants in the current study residing in the U.S. longer than in previous studies.

Additionally, the second generation reported similar values as the first generation. Previous studies have shown that first and second-generation immigrants face obstacles regarding a difference in their values (Anwar, 1998; Farver et al., 2002). For instance, education is an important value in the Asian culture, and this has been shown to cause psychological distress for second generations. However, in the present study, second-generation individuals reported valuing education along with their culture as much as first-generation participants. The results from the present study did not show high psychological distress levels about one's own beliefs and values.

Another reason the QOL may have been similar was that most of the participants in the study were living above the poverty line. Most of the participants in the present study reported to either make $40,000 to $60,000 a year or reported to make more than more than $80,000 a year. According to the Migration Policy Institute (2014), this is congruent with findings in previous research estimating that Bengalis in the U.S. make an average of $48,000 a year. These results indicate that they reported having more physical security and safety as well as being able to have access to financial resources easier than those living below the poverty line. Previous QOL studies have shown that living below the poverty line impacts QOL, including health, the physical environment, and psychological well-being (Parks, 2002).

Although the present study did not find significant differences in QOL, these results indicate that there is not a large difference in QOL among first and second generation Bengalis in the U.S. This helps better understand the QOL for Bengalis in the U.S. and provides more insight for future studies for the Bengali community in the U.S. For example, future studies can explore if there are benefits first-generation immigrants experience that second generations may not. For instance, first-generation may have closer Bangladeshi communities, which may lead to a clearer sense of clear belonging within a community, compared to second generations who may face challenges of identifying themselves with a specific community. Furthermore, future studies can examine if first generations have less psychological distress compared to second generations due to having social relationships within their community. The more specific sources of support and distress were not comprehensively explored in this study but provide avenues for future areas of research.

Gender and Generations

In addition to exploring acculturation and QOL, the present study also examined whether gender was an influential factor. Both genders were found to report similar levels of acculturation. In contrast, gender differences were found within QOL. The results indicated that females showed a higher overall QOL than males. Previous studies have shown that there are gender differences between gender and QOL. For instance, Campos et al. (2014) found that physical and psychosocial health were more correlated with QOL for females as males. Moreover, QOL was best associated with socioeconomic status, physical and psychosocial health (Campos et al., 2014). However, the present study showed fewer male participants than female participants with nearly twice as many

females than males within the second generation. Only 9 second-generation males completed the study whereas 36 second-generation females completed the study. In contrast, there were 24 first-generation males and 27 first-generation females who completed the study. One of the reasons fewer second-generation men completed the study may be due to sensitive information being asked about their social life. For instance, Blake et al. (2017) found that men find cultural differences in their social life, specifically in the workplace to be more challenging.

Implications for Practice

From a therapeutic perspective**,** previous research has shown that the level of acculturation can have an effect on acculturative stress, depression, and anxiety in immigrants (Schoppelrey, 2004). The present study showed moderate levels of psychological distress about one's personal beliefs, self-esteem, and negative and positive feelings. Immigrants encounter various factors that contribute to acculturative stress and have shown to affect the psychological well-being of immigrants (Schoppelrey, 2004). However, mental health is distinct from acculturation. The results indicate that both generations have challenges with mental health, but did not show significant results between generations in high psychological distress. The stigma around mental health is often one of the largest barriers for many South Asian immigrants (Lai & Shireen, 2013). The results in the current study showed that, overall, first and second-generation scored in the average range in terms of their psychological well-being. This suggests there may be less of a stigma in seeking psychological services within the Bengali population than other Asian immigrants.

Various implications can be drawn to inform mental health professionals on how to approach the mental health needs of the Bengali immigrant population in the U.S.

First, due to stigma associated with mental health care in the South Asian community (Lai & Shireen, 2013), providing psychoeducation with a Bengali client may be necessary because they may not understand the benefits of mental health care. Additionally, mental illness is not well understood within this community, and providing psychoeducation can include details on presenting problems, causes, treatments, how therapy works, and expectations of the client and the therapist. Psychoeducation should start from the beginning of the first session and should continue throughout therapy. These factors described are by Sue and Zane (2009) to be effective when working with ethnic minorities.

Secondly, establishing a strong therapeutic connection with a Bengali client supported will be beneficial. Social interactions are highly valued within the Bengali community; therefore, establishing a non-judgmental, strong connection and making sure that the therapist respects the client's strengths, values, and cultural and religious views will help build trust and a human connection that will be beneficial for the client. Kleinman (1980) found that when health professionals incorporate the patient's culture in their care, they provide more effective treatment for the patient. Additionally, Wang and Kim (2010) found that therapists who showed multicultural competencies during session received higher ratings from Asian American clients than the session without the therapist showing multicultural competence.

Thirdly, providing culture-centered psychotherapy is more beneficial for Southeast Asian groups in the U.S (Laungani, 2019). Laungani (2019) shared that Southeast Asian societies operate in a more emotional mode, whereas western society functions more in a more cognitive mode meaning that Southeast Asians tend to be more

relation-centered rather than work-and-activity centered. Southeast Asians find it more difficult to work with impersonal contractual arrangements and would rather have a greater emotional connectedness with their therapists (Laungani, 2019).

Nevertheless, gaining an understanding of the Bengali cultural background would be an asset to adequately conducting culturally sensitive treatment with them. Mental health professionals can improve their knowledge of the Bengali culture by being open-minded, respecting the client's perspective, doing more research on the community, and learning more about the client's background. Moreover, mental health professionals can also be more involved in the Bengali community in the U.S., which will help them have a better connection with their Bengali clients and build better rapport. Additionally, being more involved in the community will expand their knowledge in working with other Asian populations and in understanding not only the Bengali culture but also other cultures that may be similar yet different, such as Indian and Pakistani cultures.

Mental health professionals may also attempt to expand outreach among Bengali immigrant communities. The sense of community is highly important to Bengali immigrant populations; therefore, outreach and education on mental distress and psychotherapy among various Bengali immigrant communities should be promoted. Education and outreach can help mental health professionals with their training and also help their community in understanding the importance of mental health and support local advocacy. Lastly, mental health professionals can incorporate mental health discussions during cultural conferences and community gatherings.

In closing, the results from the current study yielded that first-generation Bengalis find it more challenging to acculturate and adjust to a new country than second-

generation Bengalis. This finding suggests that mental health professionals may need to explore more about adjusting to a new country with first-generation Bengalis. Additionally, understanding the obstacles first-generation Bengalis may have faced can help mental health professionals better understand their culture, and how they are maintaining both their culture as well as the new culture.

Limitations

The present study identified limitations to the approach of using the terms Bengali in the survey instead of using the term "Asian" as it was originally incorporated in the measure. This may have altered how the study may have been interpreted (Suinn et al., 1987). Specifically, it is unclear if the SL-ASIA measure is consistent with other Asian populations since it was not particularly designed for the Bengali population. The participants of the present study represented a specific ethnic background. However, the only measured characteristic related to ethnicity or race in the present study was the selection of Chinese or English versions of the survey.

Another limitation of the study was that 65% of the participants were female. This impacts the results in which there may have been gender differences which may have impacted the results of the study. As mentioned previously, Blake et al. (2017) indicated that gender differences impact immigrants and their social interactions when they are acculturating to a new country. Thus, given the acculturation level of first-generation individuals, it would be important to further understand the effects on males by evaluating a larger male sample size.

Lastly, the SL-ASIA measure used in the present study was limited to measuring different parts of acculturation such as their language, identity, and social relationships from an acculturation standpoint. Future acculturation studies should effectively measure

which participants struggle more with language, identity, friendship, behaviors, and attitudes. For instance, a study completed for British residents in Hong Kong measured these factors along with their acculturative stress and cross-cultural adaptations (Ward & Kennedy, 1993). Understanding these differences would help further illuminate those areas and would explore additional differences that may be found between first and second-generation Bengali immigrants.

Future Directions

Future directions can replicate the present study and identify a larger sample size of more evenly distributed genders to determine if the results of the present study translate across languages and/or cultures. Secondly, the present study focuses on the overall score for acculturation and does not explore the effect of the various areas within the acculturation measure. Measuring acculturation and identifying what specific areas contributed to low or high levels of acculturation would help identify how the acculturation process is changing across the generations.

The results of this study are focused on comparing how first and second generation are impacted by QOL along with its four domains and acculturation. To further understand the effect of how QOL and acculturation among the Bangladeshi population, a study could additionally do a qualitative study and interview both first- and second-generation Bengalis to specifically identify what in the various QOL domains, has been a challenge for each of the generations. Additionally, future studies can ask interview questions about what the acculturation process was like for first- generation and examine the challenges of integrating heritage culture and growing up in the host culture for second-generation Bengali immigrants. Furthermore, an area of potential

investigation is understanding the cumulative effect of QOL and acculturation among South Asian immigrants, as a whole, in the U.S. Due to the lack of South Asian studies in the U.S. in regards to QOL and acculturation, this may be an important tool to learn to help with future therapeutic interventions.

Conclusion

The immigrant population in the U.S. is increasingly becoming a substantial subset of the U.S. population. Among the immigrant population, the Bangladeshi population has been increasing in the U.S. every year. With the rise in the numbers of Bangladeshis in the U.S, Bangladeshi immigrants need to learn how to adjust to a new culture while having their values and perceptions of life challenged. Additionally, once they start families in the U.S., their beliefs and values are also challenged as their children grow up between the two cultures. The cultural adjustments and challenges for both first and second-generation Bengalis in the U.S. have been examined through acculturation and their QOL.

Previous studies have found that acculturation is strongly related to an individual's overall QOL, suggesting that more acculturated individuals feel less stress from the demands of adjustment and exhibit better overall well-being (Shen. 2001; Song et al., 2004). Approaching interventions through Berry's model of acculturation (Berry, 2003) provides an opportunity to examine the different levels of acculturation. As individuals migrate to new countries and have children, there is a difference in how they hold on to their heritage and also incorporate the new culture. Additionally, measuring QOL in immigrants has helped identify what needs need to be met for them and how to

be culturally sensitive to their needs. Finding meaning in what challenges and struggles Bengali immigrants face can help lower psychological distress for both generations.

The present study aimed to examine acculturation and QOL among first and second-generation Bangladeshi immigrants in the U.S. Previous studies have demonstrated that second-generation South Asian immigrants have lower levels of acculturation compared to the first generation. Additionally, there have been contrasting results in regard to measuring QOL among first and second-generation immigrants in the U.S. Therefore, the goal of this study was to measure acculturation specifically among the Bangladeshi population in the U.S. and measure their QOL. Study findings show that second-generation Bengali immigrants have lower levels of acculturation compared to the first generation. However, there were no significant differences found between QOL between the first and second-generation populations.

First- and second-generation Bengali immigrants have been shown to have differences in language preferences, how they identify themselves, and social relationships. However, first and second generation have shown similar coping mechanisms including their sense of community, spirituality or faith, engaging in activities they enjoy, and utilizing cognitive strategies that all contribute to their QOL. Future studies can further explore how their views were influenced by their cultural background or by the new culture based on their responses. It is also important for mental health professionals to provide an environment in which Bengali immigrants are comfortable so they can collaborate with their therapist based on their values and cultural challenges. Additionally, there is a need for education about mental health among the Bengali immigrant population. Cultural background has a significant influence on

people's conceptualization of mental and emotional distress and how they cope. Consequently, it can be concluded that to effectively treat the Bengali population in the U.S., it is highly important to seek to understand and respect their background, beliefs, and values. This study seems to better explore and understand the perception, experiences, and challenges of first and second-generation Bengali immigrants.

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Appendix A

Acculturation and Quality of Life

Informational Handout

Dissertation, Northwest University

Raisa Felts

You are invited to participate in a research study conducted by a psychology student in a doctorate program at Northwest University. As a participant of this survey, you will have a chance to enter a raffle for a $25 Amazon gift card as an incentive for participating in the survey. The purpose of this study is to examine the acculturation and quality of life among first and second generation Bangladeshi's living in the U.S. If you agree to participate in the study you will be asked to respond to an online survey divided into five sections. The survey will take approximately 15 to 30 minutes to complete.

If you have any questions about this study, contact Raisa Felts at raisa.ahmed15@northwestu.edu. If you have further questions, please contact my/our faculty advisor Dr. Nikki Johnson at nikki.johnson@northwestu.edu. You may also contact the Chair of the Northwest University IRB, Dr. Molly Quick, at molly.quick@northwestu.edu or 425-889-5327.

Below is the link to the Survey:

Qualitrics.com

Thank you for your consideration of this request.

Raisa Felts, Doctoral Student
Dr. Nikki Johnson, Psy.D

Appendix B

Acculturation and Quality of Life

Consent Form

Dissertation, Northwest University

Raisa Felts

You are invited to participate in a research study conducted by a psychology student in a doctorate program at Northwest University. As a participant of this survey, you will have a chance to enter a raffle for a $25 Amazon gift card as an incentive for participating in the survey. The study is being conducted for a dissertation research project. The purpose of this study is to examine the acculturation and quality of life among first and second generation Bangladeshi's living in the U.S.

If you agree to participate in the study you will be asked to respond to an online survey divided into five sections. The survey will take approximately 15 to 30 minutes to complete. The first screen presented in the survey will provide you the opportunity to complete the survey by clicking the "agree" button, or choose not to participate in the survey by clicking the "disagree" button. For each question in this survey, you will have the option to choose not to respond by clicking "I prefer not to respond". At the end of the survey, you will be given the option to submit your response by clicking "submit" or to withdraw from the study by clicking "withdraw".

Participation in this study is voluntary. You may choose not to participate in this study at any time and for any reason. There will not be any negative consequences for you if you refuse to participate. You may refuse to answer any questions asked. All responses are designed to be anonymous; therefore it is important that you DO NOT put your name on the survey. You may keep this consent form for your records. By turning in this survey, you are giving permission to use your responses in this research study. In case of adverse response to the study, you may contact the crisis hotline at 1-800-273-8255.

The results from this study will be presented at Northwest University. All data forms will be destroyed May 1st, 2020.

If you have any questions about this study, contact Raisa Felts at raisa.ahmed15@northwestu.edu. If you have further questions, please contact my dissertation chair, Dr. Nikki Johnson at nikki.johnson@northwestu.edu. You may also contact the Chair of the Northwest University IRB, Dr. Molly Quick, at molly.quick@northwestu.edu or 425-889-5327.

Thank you for your consideration of this request.

Raisa Felts,
Doctoral Student in Counseling Psychology
College of Social and Behavioral Sciences

Dr. Nikki Johnson, Psy.D
Assistant Professor
College of Social and Behavioral Sciences

Please print a copy of this consent form for future reference

If you are 18 years of age or older, understand the statements above, and freely consent to participate in the study, click on the "I Agree" button to begin the survey.

I Agree | I Do Not Agree

Appendix C

Acculturation and Quality of Life

Questionnaire Part 1: Demographic Questionnaire

Dissertation, Northwest University

Raisa Felts

1) Gender (male/female)
2) Age in years
3) Place of birth (Bangladesh, United States, other)
4) Year immigrated to the United States
5) Household status (single vs two parents)
6) Socioeconomic status (Less than 10,000, 10,000- 20,000, 31,000- 40,000, 41,000- 50,000, 51,000- 60,000, 61,000- 70,000, more than 80,000)
7) Relationship Status (married, divorced, single, widow, other)
8) Employment Status (employed, unemployed, other)
9) Race (Bengali, Asian, other)
10) Education (high school, bachelor, graduate, other)

Appendix D

Acculturation and Quality of Life

Suinn-Lew Asian Self-Identity Acculturation Scale
(SL-ASIA)

Dissertation, Northwest University

Raisa Felts

INSTRUCTIONS: The questions which follow are for the purpose of collecting information about your historical background as well as more recent behaviors which may be related to your cultural identity. Choose the one answer which best describes you.

1. What language can you speak?
   1. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
   2. Mostly Asian, some English
   3. Asian and English about equally well (bilingual)
   4. Mostly English, some Asian
   5. Only English
2. What language do you prefer?
   1. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
   2. Mostly Asian, some English
   3. Asian and English about equally well (bilingual)
   4. Mostly English, some Asian
5. Only English
3. How do you identify yourself?
   1. Oriental
   2. Asian
   3. Asian-American
   4. Chinese-American, Japanese-American, Korean-American, etc.
   5. American
4. Which identification does (did) your mother use?
   1. Oriental
   2. Asian
   3. Asian-American
   4. Chinese-American, Japanese-American, Korean-American, etc.
   5. American
5. Which identification does (did) your father use?
   1. Oriental
   2. Asian

3. Asian-American
4. Chinese-American, Japanese-American, Korean-American, etc.
5. American

6. What was the ethnic origin of the friends and peers you had, as a child up to age 6?
   1. Almost exclusively Asians, Asian-Americans, Orientals
   2. Mostly Asians, Asian-Americans, Orientals
   3. About equally Asian groups and Anglo groups
   4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

7. What was the ethnic origin of the friends and peers you had, as a child from 6 to 18?
   1. Almost exclusively Asians, Asian-Americans, Orientals
   2. Mostly Asians, Asian-Americans, Orientals
   3. About equally Asian groups and Anglo groups
   4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

8. Whom do you now associate with in the community?
   1. Almost exclusively Asians, Asian-Americans, Orientals
   2. Mostly Asians, Asian-Americans, Orientals
   3. About equally Asian groups and Anglo groups
   4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

9. If you could pick, whom would you prefer to associate with in the community?
   1. Almost exclusively Asians, Asian-Americans, Orientals
   2. Mostly Asians, Asian-Americans, Orientals
   3. About equally Asian groups and Anglo groups
   4. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
   5. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups

10. What is your music preference?
    1. Only Asian music (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
    2. Mostly Asian
    3. Equally Asian and English
    4. Mostly English
    5. English only

11. What is your movie preference?
    1. Asian-language movies only

2. Asian-language movies mostly
3. Equally Asian/English-language movies
4. Mostly English-language movies only
5. English-language movies only

12. What generation are you? (circle the generation that best applies to you:
    1. 1st Generation = I was born in Asia or country other than U.S.
    2. 2nd Generation = I was born in U.S., either parent was born in Asia or country other than U.S.
    3. 3rd Generation = I was born in U.S., both parents were born in U.S, and all grandparents born in Asia or country other than U.S.
    4. 4th Generation = I was born in U.S., both parents were born in U.S, and at least one
    grandparent born in Asia or country other than U.S. and one grandparent born in U.S.
    5. 5th Generation = I was born in U.S., both parents were born in U.S., and all grandparents also born in U.S.
    6. Don't know what generation best fits since I lack some information.

13. Where were you raised?
    1. In Asia only
    2. Mostly in Asia, some in U.S.
    3. Equally in Asia and U.S.
    4. Mostly in U.S., some in Asia
    5. In U.S. only

14. What contact have you had with Asia?
    1. Raised one year or more in Asia
    2. Lived for less than one year in Asia
    3. Occasional visits to Asia
    4. Occasional communications (letters, phone calls, etc.) with people in Asia
    5. No exposure or communications with people in Asia

15. What is your food preference at home?
    1. Exclusively Asian food
    2. Mostly Asian food, some American
    3. About equally Asian and American
    4. Mostly American food
    5. Exclusively American food

16. What is your food preference in restaurants?
    1. Exclusively Asian food
    2. Mostly Asian food, some American

3. About equally Asian and American
4. Mostly American food
5. Exclusively American food

17. Do you
1. read only an Asian language
2. read an Asian language better than English
3. read both Asian and English equally well
4. read English better than an Asian language
5. read only English

18. Do you
1. write only an Asian language
2. write an Asian language better than English
3. write both Asian and English equally well
4. write English better than an Asian language
5. write only English

19. If you consider yourself a member of the Asian group (Oriental, Asian, Asian-American,
Chinese-American, etc., whatever term you prefer), how much pride do you have in this group?
1. Extremely proud
2. Moderately proud
3. Little pride
4. No pride but do not feel negative toward group
5. No pride but do feel negative toward group

20. How would you rate yourself?
1. Very Asian
2. Mostly Asian
3. Bicultural
4. Mostly Westernized
5. Very Westernized

21. Do you participate in Asian occasions, holidays, traditions, etc.?
1. Nearly all
2. Most of them
3. Some of them
4. A few of them
5. None at all

22. Rate yourself on how much you believe in Asian values (e.g., about marriage,

families, education, work):

1 2 3 4 5

(do not believe) (strongly believe in Asian values)

23. Rate your self on how much you believe in American (Western) values:

1 2 3 4 5

(do not believe) (strongly believe in Asian values)

24. Rate yourself on how well you fit when with other Asians of the same ethnicity:

1 2 3 4 5

(do not believe) (strongly believe in Asian values)

25. Rate yourself on how well you fit when with other Americans who are non-Asian (Westerners):

1 2 3 4 5

(do not believe) (strongly believe in Asian values)

26. There are many different ways in which people think of themselves. Which ONE of the following most closely describes how you view yourself?
1. I consider myself basically an Asian person (e.g., Chinese, Japanese, Korean, Vietnamese, etc.). Even though I live and work in America, I still view myself basically as an Asian person.
2. I consider myself basically as an American. Even though I have an Asian background and characteristics, I still view myself basically as an American.
3. I consider myself as an Asian-American, although deep down I always know I am an Asian.
4. I consider myself as an Asian-American, although deep down, I view myself as an American first.
5. I consider myself as an Asian-American. I have both Asian and American characteristics, and I view myself as a blend of both.

Appendix E

Acculturation and Quality of Life

The World Health Organization Quality of Life - Abbreviated

(WHOQL-BREF)

Dissertation, Northwest University

Raisa Felts

Instructions: This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks.

Please read each question, assess your feelings, and select the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1(G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4(F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5(F4.1)	How much do you enjoy life?	1	2	3	4	5
6(F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7(F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither	Good	Very good
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18(F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20(F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21(F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22(F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23(F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24(F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25(F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Section III: Verification.

I certify that the above information is true and that I will follow the research procedures and method for obtaining consent as approved by the Institutional Review Board during the duration of this study. I will also submit any further changes to the IRB for review. If at any time, an ethical/data breach occurs, I will alert the IRB at the earliest time possible.

Principal Investigator _____ Date _____

*Faculty Advisor Signature _____ Date _____

I certify that the above information is true and that I will follow the research procedures and method for obtaining consent as approved by the Human Subjects Review Board during the duration of this study. I will also submit any further changes to the Board for review.

_____ _____

Principal Investigator Date Faculty Advisor Date