Pathways to Depression Among

Vietnamese Australian Adolescents

by

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CANDIDATE DECLARATION

I certify that the thesis entitled:

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is the result of my own research, except where otherwise acknowledged and

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Abstract

Previous research has found relatively high rates of depressive symptoms in immigrant Vietnamese adolescents. Two quantitative and one qualitative studies were conducted to examine pathways to depressive symptoms in a sample of 110 Vietnamese Australian adolescents. Study One examined the influence of family functionality, acculturative stress and ethnic identity on the participants' depressive symptoms and whether acculturative stress and ethnic identity contribute to additional variance beyond familial factors. Twenty percent of the sample reported clinical levels of depressive symptoms (compared to 12 % in the normative population). Family cohesion and parental psychological control were significantly associated with depressive symptoms; however, family conflict was not. After accounting for family variables, acculturative stress contributed an additional 10% of the variance in depressive symptoms.   The qualitative data also indicated that many Vietnamese Australian adolescents reported having problems with their parents regarding cultural issues. The qualitative data also indicated that many participants reported experiencing discrimination, especially at their school.

In a new sample of 106 Vietnamese Australian adolescents, Study Two examined two pathways to depressive symptoms to understand the precursors of family cohesion and acculturative stress respectively with broader contextual factors from the migration experience. Similar to Study One, 20% of participants in Study Two also reported clinical levels of depressive symptoms. The results of

Study Two also confirmed two independent pathways to depression among Vietnamese Australian adolescents: (1) family interactions contributed to low levels of family cohesion which in turn contributed to Vietnamese Australian adolescent depression, and (2) perceived discrimination led to increased acculturative stress and to decreased school connectedness, which in turn affected adolescent depression. The result of the integrated pathway suggested that the interconnection between adolescents' home environment, the school and broader social context simultaneously influence their mental health.

The findings of both studies indicate that Vietnamese Australian adolescents are at greater risk for depression. Clearly there is a need for an ecological approach for interventions to prevent depression in Vietnamese Australian adolescents.

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CHAPTER 1: INTRODUCTION

1.1 Overview of the Thesis

Adolescence is a period marked by rapid physical, cognitive, social and psychological change. The changing appearance of the body affects internal self-image as well as external appearance to others. Similarly, the move to secondary school influences teacher and peer-relationships (Cicchetti &Toth, 1998). Social roles also become more complex during this period, which exposes adolescents to a widening range of stressors. However, most adolescents negotiate this transition period without developing major psychological disorders. The majority are able to develop a strong sense of personal identity and manage to form adaptive relationships with peers, while continuing to maintain close relationships with family members. Conversely, some adolescents develop various psychological problems during this demanding period of time (Peterson, Compas, Brooks-Gunn, Stemmler, Ey & Grant, 1993). Due to the challenges adolescents have to confront, it has been suggested that psychological difficulty is more likely to occur during this transition than during other age periods (Arnett, 1999).

Depressive disorders have been recognised as the most common psychological disorder of adolescence (Steinberg, 1999). Depression has been operationalised in three ways: 1) depressed mood, 2) depressive syndromes and 3) depressive disorder (Cicchetti & Toth, 1998). Depressed mood is delimited by a group of symptoms that involve dysphoric affect. Depressive syndrome includes affective, cognitive and somatic symptoms that have been empirically shown to co-occur. Depressive disorders are reflected by the diagnostic criteria in

the Diagnostic and Statistical Manual of Mental Disorders IV or in the International Classification of Diseases (Cicchetti & Toth).

The estimated lifetime prevalence rate of major depressive disorder (MDD) in adolescents ranges from 15% to 20% and estimated point prevalence rates of MDD range from 0.4% to 8.3% (Birmaher, Ryan, Williamson, Brent, Kaufman, Dahl, Perel & Nelson, 1996). In Australia, the National Health and Medical Research Council (NHMRC) (1997) reported that at any given point in time, 1-3 percent of adolescents suffer from a major depressive disorder and up to 24% of young people will have suffered at least one episode of major depression by the time they are 18 years old. Moreover, an Australian study examined the frequency of depressive disorder in a large community sample of adolescents aged 15 to 18 years. This study found that 3.5% of the participants had experienced a confirmed episode of depression over the 30-month time frame of the study (Patton, Coffey, Posterio, Carlin & Wolfe, 2000). Another study of 1,518 high school students in Western Australia found that 8.3% of participants reported severe depressive symptoms (Macleod, 1995).

The reported prevalence rates of adolescent depression vary because of design and sampling issues, differences in age of participants and different measures used (e.g. interview versus self-report questionnaires). Prevalence rates also vary according to whether criteria for depressed mood, depressive syndrome and depressive disorders were used (Kovacs & Gatsonis, 1994).

With regard to ethnic minority adolescents, the risk of developing depressive symptoms during adolescence is more elevated among young people with Asian

background (Chang, 1996; Greenberger & Chen, 1996; Okazaki, 1997; Sam & Berry 1995). Okazaki (1997) compared responses of Asian and White college students on three measures of depression. The results revealed that Asian Americans reported higher levels of emotional distress than White Americans on all three measures (the mean of the Beck Depression Inventory for White Americans was 7.89, and Asian Americans was 10.67).

Similarly, Aldwin and Greenberger (1987) examined a number of psychological factors suggested to contribute to depression among Korean American and White American students and found that Korean American students were significantly more depressed than White American students. Perceived parental traditionalism was a powerful predictor of depression among Korean American students whereas this variable was not as strong a predictor for White American student. Greenberger and Chen (1996) examined perceived parent-adolescent relationships and depressed mood among a sample of adolescents of European and Asian American backgrounds and found that Asian American students reported more depressive symptoms than their counterparts. Similar results were also found in Europe. Approximately 11-14% of immigrant adolescents from the third world (Vietnamese adolescents were predominant in this sample) were found to have severe depressive symptoms compared with less than 6% of Norwegian children (Sam & Berry 1995). Recent cross-cultural research in Australia also found that Asian Australian high school students have higher levels of depression and lower self-esteem than their Anglo Australian counterparts (Heaven & Goldstein, 2001).

Although a large number of people with Vietnamese background have resettled in Australia since 1975, knowledge derived from empirical research regarding their psychological functioning and adjustment in Australia is limited. Previous research found that refugees reported higher rates of mental health disorders such as depression, anxiety, posttraumatic stress disorder and psychosomatic illness than the general population (Williams & Berry, 1991). The severity and frequency of the refugees' mental health problems have been found to steadily reduce over time once they become established in Australia (Steel, Silove, Phan & Bauman, 2002). However, most of these previous studies focused on the impact of the refugees' traumatic experiences in escaping from their country and their early adjustment to the host country. Not much is known about the frequency of depressive symptoms and factors that lead to the development of depressive symptoms in Vietnamese Australian adolescents who migrated to Australia when they were young or those who were born in Australia.

Vietnamese Australians have a unique cultural background and they struggle to adapt to Australian culture. Issues often include high unemployment, language barriers, experiences of racism and social and economic difficulties (Reid, Higgs, Beyer & Crofts, 2002). Therefore, there may be unique pathways of risk and protective factors for mental health outcomes in Vietnamese Australian adolescents. Research focusing on this development process is rarely found in the literature. As Vietnamese Australian adolescents are believed to be at greater risk for depressive disorders, it is important to identify the unique ethno-cultural influences on developmental processes, and other social factors that may contribute to mental

health problems in this population. Also, depressive symptoms in adolescents are associated with serious and negative consequences for many young people and their families (NHMRC, 1997). Identification of these factors is a necessary step in the development of early intervention programs to prevent depression and improve the quality of life for these adolescents.

The possibility that Vietnamese Australian adolescents experience more depressive symptoms than adolescents in the mainstream calls for attempts to understand this phenomenon. This research investigated factors hypothesised to account for unique pathways to depressive symptoms in a sample of Vietnamese Australian adolescents. This research consists of two studies which were conducted over two consecutive years.

Study One

The aim of study one was to explore the difficulties that Vietnamese Australian adolescents face and factors that might uniquely contribute to their elevated rates of depression. The study included a qualitative study (Part A) and a quantitative study (Part B). The qualitative study was designed to assess the difficulties facing Vietnamese Australian adolescents in various areas of their lives as expressed in their own words. The quantitative study examined the influence of family functionality (conflict, cohesion, and parental over-control), acculturative stress, and ethnic identity on depression symptoms. Study One is described in chapters 1-5. Chapter 1 will review the risk and protective factors associated with adolescent depression in the general population. Family cohesion, family conflict and parental control will be the focus of the literature review as previous research

has shown that family factors are the most consistent predictors of adolescent depression in the general population as well as in ethnic minority adolescents. Chapter 1 also will present the literature on risk factors that may account for the elevated levels of depression in ethnic adolescents. Chapter 2 presents the methodology and results of the qualitative study. Chapter 3 and 4 present the methodology and results of the quantitative study. Chapter 5 presents the discussion of both qualitative and quantitative study.

Study Two

The second study involved a quantitative study which aimed to investigate precursors of family cohesion and acculturative stress as a follow-up on the factors found to be most predictive in the first study. This study also aimed to investigate the influence of discrimination on acculturative stress and sense of school connectedness as the focus interviews revealed that these factors contribute to the mental health of Vietnamese Australian adolescents. Two theoretical pathways to depression among Vietnamese Australians were proposed and tested in this study. Chapter 6 presents further literature on familial factors that account for low levels of family cohesion among ethnic adolescents which in turn contributes to their elevated levels of depression. Chapters 7, 8 and 9 present the methodology, results and discussion of Study Two.

1.2 Consequences of Adolescent Depression

Adolescent depression is recognised as a major mental health problem with huge social and economic costs for individual adolescents and their families. Depression in young people can lead to serious short- and long-term problems including severe psychological distress, social withdrawal, poor academic and work performance, and reduced functioning in family and social relationships (NHMRC, 1997).

Furthermore, late adolescence is a major transition point, a crucial time when biological and psychological maturational processes become consolidated and critical life choices relating to educational and career plans, and intimate relationships are made. Developing depression at this crucial time could compromise these maturational processes and affect the long-term adjustment of the individual beyond adolescence (Rao, Hammen, & Daley, 1999). Rao et al. conducted a longitudinal study of 155 women aged 17 to 18 years for a 5-year period and found that 46.9% of participants who had depression prior to the study, experienced one or more episodes during the study. Women with depression have more negative experiences regarding school performance and intimate relationships, than women without depression. People who suffer a depressive episode during their adolescence are at considerable risk of experiencing a recurrence. Rao, Ryan, Birmaher et al. (1995) found that adolescents who were diagnosed with a major depressive disorder were more likely than the control group to develop another depressive episode in adulthood.

1.3 Co-morbidity with Other Psychiatric Disorders

Not only is depression itself a major health problem for adolescents, it also contributes to a wide range of other difficulties. Adolescent depression commonly co-occurs with other psychiatric problems (Birmaher et al., 1996). Clinical as well as epidemiological investigations have shown that 40-70% of depressed children and adolescents are also diagnosed with other psychiatric disorders (Birmaher et al.; Rohde, Lewinshon & Seeley, 1991). The most frequent co-morbid diagnoses are dysthymia, anxiety, disruptive disorders, substance abuse and eating disorders (Birmaher et al.).

More devastatingly, depression is shown to be a major risk factor associated with adolescent suicidal behaviour (Reynolds & Mazza, 1994). In Australia, the suicide rates among males and females aged 15-24 years increased from 4.3 per 100,000 to 16 per 100,000 between 1964 and 1995 (Victorian Suicide Prevention Task Force Report, 1997). In 1999, 22.3% of young male deaths were attributed to suicide (Australian Bureau of Statistic, 1999). Suicide attempts are more prevalent among depressed young people than among those who have other psychiatric disorders. In a study by Kovacs, Goldston and Gatsonic (1993), 28% of participants with major depressive disorder had attempted suicide in the period since the onset of their depression compared with only 8% of the psychiatric comparison group. The majority of suicide attempts occurred during a depressive episode (Kovacs et al.). Clearly, the long-term consequences of adolescent depression represent a significant personal,

economical and social loss for individuals, their families and the broader

community (Sawyer, Kosky, Graetz, Arney, Zubrick & Baghurst, 2000).

1.4 Familial Risk Factors and Adolescents Depression in the General Population

As the causes of adolescent depression are complicated, the identification

of risk factors, and the mechanisms through which they operate, is important in

reducing the incidence and prevalence of adolescent depression as well as

management of depression and prevention of further cases (NHMRC, 1997). This

section provides an overview of research investigating familial risks factors

correlated with adolescent depression in the general population. Risk factors can

be defined as variables that increase the likelihood that an individual will develop

a disorder. Risk factors are correlated with the disorder and do not necessarily

imply a causal role. However, risk factors commonly exist before the onset of the

disorder (NHMRC).

A large number of factors have been found to increase risk for adolescent

depression. Risk factors can be biological or psychological and can be manifested

within the individual or the family, community or institutions (Peterson et al.,

1993). It has been found that the increased risk for adolescent depression is due to

a combination of a number of factors including genetic vulnerability, biochemical

disturbances, cognitive attributions, difficulty in forming relationships with peers,

exposure to stressful life events, family history of depression, school factors,

perceived family environment, parenting practices, quality of parent-child

relationships, and high levels of family conflict (Peterson et al.).

Although a number of risk factors for adolescent depression have been suggested, lower quality of parent-child relationships and extreme family conflict have been consistently identified in the literature as correlates of adolescent depression (Reinherz, Giaconia, Pakiz, Silverman, Frost & Lefkowitz, 1993). Furthermore, research has generally found that depressive symptoms were inversely related to levels of support and attachment adolescents experience in their families. In contrast, depression has been found to be positively associated with extreme parent-adolescent conflicts (Sheeber, Hops, Alpert, Davis & Andrews, 1997). The following section will focus on reviewing the research investigating the association between family relationships, parenting practices and adolescent depression as these variables have been consistently identified as risk and protective factors in the development of adolescent depression in the general population as well as in ethnic minority groups.

1.4.1 Family Cohesion and Adolescent Depression

Cohesion is an important aspect of family relationships that has been consistently found to directly impact on adolescents' depressive symptoms (Kashani, Allan, Dahlmeier, Rezvani & Reid, 1995). Family cohesion is defined as the extent to which family members are concerned and committed to the family and the degree to which family members are helpful and supportive to each other (Moos, 1974).

Family cohesion can be measured in a range from low to high, with higher levels of family cohesion associated with better adolescent well-being (Barber & Buehler, 1996). Evidence that family cohesion affects adolescent

depression has been found in both clinical and community samples using both cross-sectional and longitudinal study designs.

Stark, Humphrey, Crook and Lewis (1990) examined the relationship between family cohesion and depression in a sample of fifty-one children diagnosed as depressed and anxious by the Beck Depression Inventory and semistructured interviews. Results showed that depressed children and their mothers perceived low levels of family cohesion and high levels of family conflict (Stark et al.). Parallel to the findings of this study, the association between adolescent depressive symptoms and family environment was examined in a sample of 93 families attending an outpatient marital and family therapy clinic (Cumsille & Epstein, 1994). An inverted relationship between family cohesion and adolescent depressive symptoms was found in this study. Furthermore, a cohesive and supportive family environment protected these adolescents from developing depression even during the time their parents experienced marital and family problems (Cumsille & Epstein).

In a retrospective study by Lizardi et al. (1995), 142 outpatients with depressive disorders reported having poorer relationships with their parents, citing less parental care and more parental overprotection as children, than the normal controls. Asarnow (1992) used the Family Environment Scale to assess the perception of family environment in a psychiatrically disturbed sample of fifty-five preadolescents. The attempted suicide group had higher levels of depression than the nonsuicidal psychiatrically disturbed control group. These children described their family as less cohesive, less expressive and higher in

conflict than the control group. Similar to Asarnow's findings, Campbell,

Milling, Laughlin and Bush (1993) found that greater pre-adolescent suicidality

was associated with lower levels of family cohesion coupled with higher levels of

family conflict.

Community samples also revealed similar results. Family cohesion,

adaptability, structure, friendship support and depression were assessed in a

community survey of 103 preadolescents (Feldman, Rubenstein & Rubin, 1988).

Cohesion and friendship support were significantly associated with depression.

Family structure was also significantly associated with depression, however, at a

modest level. Family cohesion was strongly correlated with depression (-.64).

The stepwise regression showed that more than 50% of the variance in depression

was predicted by level of family cohesion and friendship support. Clearly, results

of this study indicate a cohesive and supportive family is an important factor in

protecting preadolescents against depression (Feldman et al.). This linear

relationship between family cohesion and youth depression was also found in two

community surveys, in which cohesion was found to be negatively associated

with depression (Barber & Buehler, 1996; Farrell & Barnes, 1993).

Family cohesion assessed at the dyadic level also yielded similar results.

Garber, Robinson and Valentiner (1997) and Eccles, Early, Fraser, Belansky and

McCarthy (1997) found that mothers who were described both by themselves and

their children, as less caring, less accepting, and less responsive, had children

with higher levels of depressive symptoms than children of caring, nurturing

mothers. Their children also had a lower sense of self-worth. Family cohesion is

also a mediator of the influence of family drinking problems, stressful life events, and other multiple risk factors (e.g. unemployment, imprisonment and mental health problems etc.) on children's mental health (Roosa, Dumka & Tein, 1996).

Garrison, Jackson, Marsteller, McKeown and Addy (1990) examined the risk factors of major depressive disorder in a sample of 247 adolescents in a one year longitudinal study. They found that undesirable life events and family structure were not associated with depression at Time 1 or Time 2. In contrast, the baseline family cohesion score was correlated with depression at both Times 1 and 2 (Garrison et al.,). The link between risk and protective factors and psychological distress has been investigated in cross-sectional and longitudinal studies. Four hundred parents and their children participated in a study by Holahan and Moos (1987). Protective factors for the children were parental self-confidence and an easy-going disposition, and family support (measured by the Family Cohesion, Adaptability and reversed Family Conflict subscales of the Family Environment Scale). Risk factors were parental negative life events, coping styles and parental distress. It was found that parental risk and protective factors and parental distress contributed significantly to children's psychological distress at Time 1. At Time 2, when the children's level of psychological distress at Time 1 was controlled, maternal risk factors and maternal distress were predictive of the children's psychological distress. Similar to other findings, the results of this study indicate that family support was the strongest factor linked to children's psychological distress at the time of assessment and one year later.

Studies in Australia that investigated the link between family environment and adolescent psychological well-being also found similar results. Heaven and Goldstein (2001) investigated the influence of family climate and mental health of 202 Anglo Australian adolescents. Their results confirmed that adolescents who experienced low parental care were more likely to suffer from low self-esteem, which in turn predicted their elevated depression levels. Members of cohesive families may be more sensitive to each other's needs and their problems, and more ready to share with other family members, than families with low levels of cohesiveness. Thus, family cohesiveness may strengthen adolescents' resilience in times of difficulty (Aydin & Oztuuncu, 2001).

Although the above mentioned studies have provided evidence of a link between family cohesion and adolescent depression, most of these studies only used single-informant design. Some researchers (e.g., Greenberger & Chen, 1996; Ross, Marrinan, Schattner & Gullone, 1999) suggest that the relationship between elevated levels of depression and unsupportive family environments may be due to the depressed adolescent's biased perceptions. Ross et al. used a multi-informant design to gather data from 45 adolescents and their biological parents to overcome the bias of single-informant design. Similar to other studies, adolescent self-reports of depression were inversely associated with family cohesion. The results of this study also demonstrated that the adolescents' perceptions of their family environment were significantly associated with those of their parents. This suggests that the relationship between adolescents' heightened levels of depression and self-reported family environment is not

entirely due to their individual perception of their family environment (Ross et al.).

1.4.2 Family Conflict and Adolescent Depression

Similarly to family cohesion, a conflictual family environment also has been found to be a predictor of adolescent depression and externalising problems (Lewinshon, Rohde, Klein & Seeley, 1999). As adolescence is a time when the task of individuating from parents becomes central, many theorists argue that parents and adolescents inevitably experience conflict. Conflict between parents and adolescents increases with the onset of puberty, peaks during early adolescence to mid-adolescence and gradually decreases as adolescents enter adulthood (Conger & Ge, 1999; Laursen & Collin, 1994; Smetana & Gaines, 1999). The desire for independence and autonomy that typically emerges in adolescence elicits more conflict in families than in previous developmental stages. Normally, conflict occurs when adolescents' attempt to assert their autonomy against their parents' goals of regulating the family, and other conventional standards (Smetana, 1988). The typical conflicts that occur in families relate to everyday issues such as doing chores, getting along with others, regulating activities, and doing homework (Smetana, Yau, Restrepo & Braeges, 1991).

Conflict by itself is not necessarily destructive, and sometimes it is necessary for normal development (Laursen & Collin, 1994). Conflict with other family members contributes to adolescents' individuation because when conflict occurs, it highlights their differences from one another (Cox, Brooks-Gunn &

Paley, 1999). However, excessive family conflict has been found to correlate with adolescent depressive symptoms. Greenberger and Chen (1996) reported that conflict with parents contributed substantially to depressive symptoms in a sample of early adolescents. Similarly, another study found that conflictual and negative parental behaviour toward adolescents accounted for 37% of the variance in depressive symptoms (Reiss, Howe, Simmens & Bussell, 1995).

In a longitudinal study over a one-year period, Sheeber et al. (1997) also found a significant correlation between family conflict and adolescents' depressive symptoms in a community sample. Family conflict was stable over the course of one year. Family conflict at Time 1 prospectively predicted depression at Time 2. Inversely, depression at Time 1 did not contribute to family conflict levels at Time 2. The results of this study suggest that family characteristics impact on the psychological functioning of young people rather than family relationships being reactive to the depressive behaviour of adolescents (Sheeber et al., 1997).

Similarly to parent-adolescent conflict, general family conflict and marital conflict have also been found to be detrimental to children's mental health (Asarnow, 1992). David, Steele, Forhand and Armistead (1996) examined the association between marital conflicts and psychological problems in a sample of adolescents. They found that higher levels of marital conflict were significantly associated with higher levels of internalising problems in adolescents. Formoso, Gonzales and Leona (2000) investigated whether the association between family conflict and adolescent depression and conduct problems is attenuated by

parental and peer attachment. The results indicated that family conflict was significantly associated with depression regardless of the levels of parental attachment. Parental attachment attenuated conduct problems in adolescent girls only; parental attachment did not reduce adolescent boy's conduct problems. Parent-adolescent conflict was also found to be related to antisocial behaviour in a longitudinal study (Shek & Ma, 2001). The results of this study support the notion that parent-adolescent conflict influences adolescent social behaviour.

Clearly, previous research has established a link between family environment and adolescent depression. Furthermore, family environment influences the mental health of adolescents rather than adolescent depressive behaviours having a deleterious effect on family relationships. Research also suggests that a perceived negative family environment is not exaggerated by adolescents' depressive mood. Rather, a negative family environment may present before the onset of an adolescent's depressive episode.

1.5 Parenting Style and Adolescent Depression

In addition to family environment, specific parenting practice is also an important factor that predicts adolescent psychological outcomes (Garber et al., 1997; Grotevant, 1997; Sheeber et al., 1997). Baumrind (1991) proposed four parenting typologies that she believed affect children and adolescent's psychological outcomes: authoritative, authoritarian, permissive and neglecting. Authoritative parenting is defined by the combinations of both high demandingness and responsiveness. Authoritative parents monitor and impose a clear standard for their children's conduct, but they are not intrusive, or punitive.

Authoritarian parents are demanding but not responsive. They expect their children to obey them without explanation. Permissive parents are responsive to their children's needs but do not require mature behaviour and avoid confrontation. Neglecting parents are neither responsive nor demanding.

Several researchers have investigated the influence of these parenting typologies on adolescent outcomes. Baumrind (1991) reported that authoritative parents were successful in protecting their adolescents from drug use. High levels of academic achievement and a healthy sense of psychological autonomy were found among adolescents of authoritative parents, whereas authoritarian and permissive parenting styles were negatively associated with children's academic performance (Steinberg, Lamborn, Dornbusch & Darling, 1992). Radziszewska, Richarson, Dent and Flay (1996) also found that adolescents of authoritative parents reported the lowest levels of depressive symptoms compared to the youngsters of other parenting styles. From this line of research, authoritative parenting has been recognized as the most optimal parenting style (Barber, 1997).

Although the parenting typological framework has been helpful in understanding child development, Barber (1997) asserted that the family socialisation literature indicated that at least three central dimensions of family socialisation are critical for healthy child development. These dimensions of socialisation are behaviour regulation, emotional connection and psychological autonomy. Behaviour regulation was measured in terms of supervision, monitoring and rule setting. Psychological autonomy is the socialisation process that facilitates a child's development of an independent sense of identity.

Emotional connection refers to the positive emotional bond that a child/adolescent has developed with significant others such as parents, or other family members. Emotional connection has been conceptualised and measured in various ways, however the central aspect of emotional connection is bonding between a care-giver and a child/adolescent (Barber). Ainsworth, Blehar, Water and Wall (1978) discussed the connections in terms of attachment experiences between children/adolescents and their parents. Emotional connections measured in terms of an accepting, supportive, warm, nurturing, loving, responsive and involved relationship between children and their parents have been investigated by several researchers (Herman, Dornbusch, Herron & Herting 1997; Barber & Olsen, 1997; Garber et al., 1997).

The approach that guided Baumrind (1991) and other researchers (e.g., Dornbusch et al., 1987; Radzisewska et al.,1996) to investigate the impact of these parenting typologies on the development of children, aggregated some, or all of the dimensions of each typology into composite scores. For example, authoritative parenting included three aspects of socialisation: loving, warm nurturance (connection), behaviour regulation, and psychological autonomy. Psychological autonomy included behaviours that encourage open communication between parents and children and encouragement of independence and individuality. Authoritarian parenting style has been operationalised in previous studies including restriction of both behaviour autonomy and psychological autonomy. Barber (1997) suggested that the effects of these two types of control could be different and may not be detectable if

measures of both types of control are aggregated (Barber; Barber & Olsen, 1997).

Barber argued that whilst these aspects of parenting naturally occur together to

some degree, this should not negate the validity of investigating the influence of

each parental behaviour on children's outcomes separately (Barber). Barber and

colleagues (1996; 1997) attempted to disaggregate specific parental behaviours

that make up the parenting typologies so the unique effects of each parenting

dimension on adolescent outcomes could be examined. Barber and colleagues

and Herman et al. (1997) found that each dimension of regulation, psychological

control and emotional connection contributed distinctively to different aspects of

adolescent adjustment. Emotional connection was associated with educational

outcomes. Behavioural regulation was associated with deviant behaviour.

Psychological control was associated with educational outcomes, deviant

behaviour and psychological distress.

1.6 Psychological Control

An important aspect of parental behaviour that influences adolescents'

psychological well-being is psychological control. Psychological autonomy refers

to the socialisation processes which facilitate the child's development of an

independent sense of identity, self-efficacy and self-worth (Barber, 1997). In

contrast, psychological control is defined as a pattern of family interactions that

intrude into the psychological and emotional development of a child (Barber,

Olsen & Shagle, 1994). According to Barber (1996), the construct of

psychological control emerged in the 1960. It was recognised as a method of

discipline that parents use to shape their children's behaviour by inducing guilt

and manipulating the love relationship between the child and their parents. These are parental behaviours that appeal to the child's pride, guilt, and shame. Parents express excessive disappointment and criticism, discourage their child's expression of opinions, minimise open parent-child communication, restrict autonomous expression of the child's individuality, and threaten to withdraw their love if the child does not comply with parental requests.

Barber (1996) argued that parental psychological control impedes the child's individuation process which may lead to emotional difficulties. Individuation is a term Mahler (cited in Grotevan & Cooper, 1986) used to describe the process during the toddler period in which the child successfully asserts their individuality from their parents. Following Mahler, Blos (1979) proposed that adolescence is a second phase of individuation during which the adolescent needs to disengage from parents to successfully become a separate person. Individuation in the family is generated by the quality of the parent-adolescent relationship, and is seen as the interaction between the individuality and connectedness of parents and their children. Achieving a balance between individuality and connectedness in family relations is an important facilitator of adolescents' identity development (Grotevan & Cooper, 1986) and adaptive psychological functioning (Barber).

1.6.1 Operationalisation of Psychological Control

A measure of psychological control was first developed by Schaefer (cited in Barber, 1996). In Schaefer's study, factor analyses of child and parent reports on the Child Report of Parent Behaviour Inventory (CRPBI) revealed

three factors: Acceptance/Rejection (emotional connection), Firm Control/Lax Control (behaviour regulation), and Psychological Autonomy/Psychological Control. The Parental Behaviour subscales defined as Intrusiveness, Parental Direction and Control Through Guilt loaded onto the Psychological Autonomy/Control factor. The items loaded on this factor captured the degree of manipulation of the parent-child bond, negative expression, criticism and excessive personal control. Schludermann and Schludermann (cited in Barber, 1996) modified this version and only 10 items were included in the Psychological Autonomy/Control subscale.

Barber (1996) asserted that some of the items included in the modified CRPBI version such as "is always telling me how I should behave" and "only keeps rules when it suits her/him" appear to measure behavioural control rather than psychological control. Moreover, although there are sound reasons to believe that self-reports from children may be the most valid way to measure psychological control, as these controlling feelings are a subjective experience, it is also important to determine if such controlling behaviours could be observed.

In a study by Barber (1996), interaction between parents and adolescents were observed during a family problem-solving task, and were coded according to the characteristics of psychological control (i.e., constraining verbal expression, invalidation of feelings, personal attack, guilt induction, love withdrawal, and erratic emotional behaviour). It was found that parental psychological control was associated with adolescent depressive symptoms. Using the results of this study, Barber refined the Psychological Autonomy

/Control subscale of the CRPBI and included eight additional items. The final version of this scale consists of 16 items and is named: Psychological Control Scale - Youth Self-Report. Items 1-3 measure constraining verbal expression, items 4-6 measure invalidating feelings, items 7-9 measure personal attack, items 10-11 measure guilt induction, items 12-14 measure love withdrawal, and items 15-16 measure erratic emotional behaviour.

1.6.2 Psychological Control and Adolescent Depression

Support for the relationship between psychological control and depression comes from several studies. Barber and Olsen (1997) investigated this relationship in a sample of 227 mothers and their adolescents. The CRPBI and the Child Behavioral Checklist were used to measure the degree of parental psychological and behavioural control, adolescent outcomes, and how much parents knew about their adolescent's activities. Barber et al. found that a high score on the psychological control measure was associated with depressive symptoms.

Similarly, Barber (1996) found that adolescent perception of parental psychological control is consistently predictive of depression in both cross-sectional and one-year longitudinal analyses. In order to reduce the limitation of subjectively perceived parental behaviours by children, Garber et al. (1997) gathered data from multiple informants. Two hundred and forty mothers and their children completed the CRPBI, and the Children's Depression Inventory separately. In addition to self-reported symptoms, both the mothers and children were interviewed about the children's depressive symptoms during the last 2

weeks. Composite scores were created by combining data from these sources. It was found that maternal psychological control was significantly related to depressive symptoms of their children in this sample. This relationship was also mediated by the child's perceived self-worth. Excessive intrusions and control over children's decisions was found to diminish a positive sense of self and self-efficacy. Thus, maternal psychological control was both directly and indirectly related to adolescent depression (Garber et al.).

Comparable results were also found in a longitudinal study conducted by Conger, Conger and Scaramella (1997). Conger et al. assessed the association between parents' and siblings' psychological control and adolescent depressive symptoms and self-confidence over a three-year period. Conger et al. found that parental psychological control contributed to adolescent adjustment problems and diminished self-confidence.

Barber (1996) argued that psychological autonomy is important during adolescence given the need for young people to develop both connectedness and separation from their parents. Adolescents who consistently perceive that their parents criticise their opinions and try to change them will be more likely to distrust their own ideas and have difficulty recognising their uniqueness (Barber, 1997), and may lack confidence dealing with the external world (Barber, 1992). Also, adolescents who experience manipulative parental behaviour that threatens to discontinue the parent-adolescent emotional bond would be unlikely to develop individuality for fear of losing this bond (Barber & Olsen, 1997). In such an environment, an adolescent's independent expression and autonomy is

inhibited. Such an environment discourages interaction with others and interferes with self-exploration and self-discovery which is necessary to establish a sense of identity (Barber, 1992; Barber, 1996).

Consistent with Barber's (1996) argument, Conger et al. (1997) also asserted that a controlling family environment may impede the development of personal autonomy, self-confidence, self-control and self-regulation necessary for normal and healthy adolescent development to take place. As a result, adolescents who live in highly controlling environments may be at risk for adjustment problems.

In summary, the present review indicates that depression occurs in adolescents with relatively high prevalence rates in Australia as well as abroad. Adolescent depression is a serious illness, which impacts on the individual and society and is a cause of mortality. Adolescent depression is commonly comorbid with other psychiatric disorders and may precede substance abuse. Adolescent depression can also recur in later years and throughout adult life. An understanding of risk factors that are associated with depression is important in prevention and treatment. A number of risk factors have been identified in previous studies. Familial factors such as quality of family relationship and parenting practices have been found to relate to adolescent depression in the general population. While a negative family environment and inappropriate parenting practices are detrimental to the mental health of all adolescents, ethnic minority adolescents may have additional risk factors pertaining to their

immigrant status. The following section will present literature regarding

immigrant issues.

1.7 Challenges of Immigrant Vietnamese Australian Adolescents

Similarly to adolescents in the general population, a negative family

environment (characterised by lack of family cohesion, and high levels of family

conflict and parental psychological control), is detrimental to the mental health of

Vietnamese Australian adolescents. However, beyond these familial factors,

Vietnamese Australian adolescents may also face additional risk factors that

specifically pertain to their immigrant status.

Given research suggestive of higher rates of depression in ethnic

adolescents compared with the general population, Vietnamese Australian

adolescents should be considered an at-risk population suitable for public health

intervention. An understanding of immigrant specific risks is important as it may

indicate a need to develop a different approach for treatment and prevention. This

section will review literature regarding specific issues of immigrants.

1.7.1 Vietnamese Culture and Parenting Practices

The first challenge for immigrant Vietnamese Australian adolescents is

the differences between Australian and Vietnamese cultures. Traditionally, the

Vietnamese culture is collectivist. A collectivist culture has the family, rather

than the individual as the basic unit of society (Nguyen, 1990). Family interest

and harmony often take precedence over individual concerns such as personal

achievement, independence and competitiveness. Filial piety is the strong ethic

within Vietnamese families. In addition to filial piety, hierarchical relationships

are also strongly emphasised (Nguyen & William, 1988). Family roles and their associated obligations and responsibilities are well defined. Respect for the elderly, teachers and authorities are socially expected behaviours. Younger members are expected to display respect, deference and obedience to their parents, older family members and older siblings (Leung & Boehnlein, 1996).

Harmony in interpersonal relationships, especially with family members is strongly emphasised. Self-control and avoidance of direct expression of emotions (especially negative emotions), are highly valued (Huang, 1998; Nguyen & Williams, 1988). Vietnamese children are not encouraged to express affection, negative emotions, and personal grievances. Aggressive language or behaviours (especially sibling-directed) should be suppressed. Children are expected to inhibit strong feelings and exercise self-control in order to maintain family harmony. Direct discussion of issues such as sexuality, or personal affairs seldom occurs in Vietnamese families.

Cultures determine the skills and behaviours that parents think their children need in order to be a successful member of a society (Uba, 1994). As such, child-rearing practices that parents consider to be effective, appropriate and acceptable are also different in each culture. Since filial piety dictates that Vietnamese children must obey their parents, verbal communication in Vietnamese families is usually one way: when parents speak, the child is expected to listen. Children are forbidden to express disagreeing opinions, or to confront their parents (Nguyen & William, 1988). Vietnamese parents are more controlling, restrictive and protective of their children than American parents

(Nguyen & Williams). According to Herz and Gullone (1999), Vietnamese parents are more likely to use affectionless-control parenting style than Anglo-Australian parents. In order to control or shape their children's desired behaviour, parents appeal to the child's sense of obligation to parents or to others. Also, shaming, scolding, or techniques of guilt induction will often be used to shape a child's behaviours (Morrow, 1989).

Furthermore, Vietnamese children are commonly taught to think of their parents and family first. Family members are expected to place priority on family interests over individual members' desires. Children are expected to fulfill their responsibilities within the family and must develop a sense of obligation and loyalty to the family. Children's behaviours, either positive or negative reflect on the entire family. Thus, a child's academic and occupational achievements bring pride to parents and the family. Applying the same principle, undesired behaviours such as academic failure or wrongdoing bring shame to the family (Morrow, 1988). Sometimes Vietnamese children have to pursue careers that give social status to the family, even if this means they have to give up their personal dream (Leung & Boehnlein, 1996).

The literature reviewed above demonstrates that the practice of parenting in collectivistic cultures is different from individualistic cultures. The family or group's goal takes priority over individual goals. There is little room for individual assertion. Vietnamese Australian adolescents who migrated to Australia when they were young or those who were born in this country constantly need to adapt to both cultures. The pressure of adapting to two distinct

cultures simultaneously is stressful for Vietnamese Australian adolescents. These adolescents may experience conflict and stress as they realise that their cultural values and beliefs are not recognised among peers or at school; and cultural expectations of mainstream society may conflict with the cultural values and expectations of their families. They may be torn between wanting to fit in with their peers from the mainstream and wanting to please their parents by abiding to parental values and traditions. This pressure places many Vietnamese immigrant adolescents at-risk for developing psychological difficulties.

1.7.2 Acculturation and Acculturative Stress

The second challenge pertaining to immigrant adolescents is the impact of acculturation. When immigrants migrate to a foreign country with an unfamiliar culture and social networks, significant adjustment and adaptation is required. Immigrants sometimes need to change their behaviours, thinking patterns, values and self-identification as a result of contact with another culture. This process of changing is called acculturation (Berry, 1980; Berry & Kim, 1988). Acculturation is an adaptive process that requires immigrants to negotiate the changes so that their life conditions are congruous with their new environment (Mena, Padilla & Maldonado, 1987). Acculturation has two different but related dimensions: behavioural and psychological (Berry, 1998). Behavioural acculturation relates to learning and adopting the observable and external aspects of the host culture such as language, social skills, and the ability to fit in to the new social context. Psychological acculturation reflects the ability to adopt the host culture's values, beliefs and attitudes etc. (Berry).

Not every immigrant experiences acculturation at the same rate, or at the same intensity. Variables such as language proficiency, education, previous contact, age, family structure, attitudes of people in the host society, and cultural similarity influence acculturation (Berry & Kim, 1988). Acculturation is also not an "all-or-none" phenomenon. Immigrants must understand the new social norms and customs and must acquire appropriate verbal and non-verbal skills. They must change their self-identification to allow the incorporation of new social roles and values that provide a sense of belonging to the host country. While acculturation results in positive adaptations, negative consequences of this process are also paramount (Berry & Kim). The experience of being stressed by such changes has been recognised. Acculturative stress refers to one kind of stress which has its sources in the process of acculturation. This stress leads to the development of a set of particular psychological problems such as anxiety, depression, feelings of marginality and alienation, heightened psychosomatic symptoms, and identity confusion. Accordingly, acculturative stress may be a factor that underlies a reduction in the physical and psychological health status of immigrants (Berry & Kim; Williams & Berry, 1991).

Berry (1980) and Berry and Kim (1988) suggest that mental health problems often arise during acculturation. However, these problems are not inevitable. There are several cultural, social and psychological factors that affect acculturative stress. The more discrepancy between the two cultures, the more immigrants experience acculturative stress (Berry). The longer immigrants stay in the host country, the better their mental status (Beiser, 1988). Padilla, Wagatsuma

and Lindhold (1985) found that first and second-generation Japanese immigrants in the USA experienced more stress than the third and later generations. The first generation may have difficulty acquiring the language, and be unfamiliar with the social customs and behaviours of the host country while second-generation immigrants may be caught between the cultural values and behaviours of their parents and those of the dominant society. Mena et al. (1987) found similar results from a sample of seven different ethnic groups.

The acculturation strategies that immigrants adopt also mediate acculturative stress. Assimilation occurs when an immigrant relinquishes their cultural identity and seeks to become part of the dominant society. This mode of acculturation is not possible for immigrants who have physical characteristics that are distinctively different from the mainstream people, for example Asian immigrants. Separation describes the response when immigrants exclusively maintain their ethnic identity and traditions, and withdraw from contact with the main society. Immigrants who cannot speak the mainstream language often adopt this mode of acculturation. They tend to reside in ethnically segregated communities. Integration is evident when immigrants simultaneously maintain their ethnic culture and practice, as well as adapt to the main society by learning the necessary skills and behaviours. Marginalisation occurs when immigrants perceive their own culture negatively, become estranged from their own culture and fail to adapt to the mainstream culture (Williams & Berry, 1991).

Immigrants who are marginalised tend to be highly stressed, and those who are separated, are almost as stressed. In contrast, integrated immigrants have

been found to have minimal stress and higher self-esteem, while assimilated immigrants have been found to suffer from intermediate stress levels (Berry & Kim, 1988;). Sam (1995) found that Third World (Vietnamese, Pakistan, South American, African and Turkish) immigrant youths in Norway considered integration as the most desired acculturation mode, with separation the next. The results of Sam's study suggest that while most young immigrants are interested in becoming integrated into the host country, maintenance of their cultural norms and values are equally important.

The nature of the dominant society presents another mediating factor. The degree of tolerance and acceptance of cultural diversity, or the level of discrimination within the larger society mediates the relationship between acculturation and stress (Berry & Kim, 1988). Mehta (1998) found that the greater perception of acceptance by Americans, related to better mental health of Indian immigrants, independent of age, gender, educational level, family income, and years in the United States. In addition, premigration traumatic experiences had less impact on the psychological well-being of Vietnamese immigrants in Finland than their experiences of prejudice and discrimination (Liebkind, 1996). Perceived prejudice and discrimination systematically increased stress and behaviour symptoms and decreased self-esteem and life-satisfaction among the group of adolescents studied (Liebkind & Jasinskaja-Lahti, 2000). These results suggest that what happens to immigrants after they settle in the host country has greater effect on their psychological well-being than what happened to them before (Liebkind).

Beyond social factors, a number of psychological variables such as age, prior contact, socioeconomic status, social support network and stress coping style also influence the mental health status of those experiencing acculturation (Berry, 1998; Williams & Berry, 1991). Acculturative stress may also be a result of the conflicting messages that adolescents receive from the two socialising agents: parents and society. For immigrant adolescents, their parents may not like the mainstream cultural norms and values, while society may reject the immigrant parents' cultural values. Acculturative stress is more intensified for children who live in predominantly ethnically segregated areas and whose parents do not understand the new social norms and customs well (Kopala, Esquivel & Batise, 1994).

Consistent with the cognitive-development model (Laursen & Collin, 1994), by adolescence, individuals are strongly aware of the attributes that distinguish different groups, and can behave appropriately according to ethnically linked social expectations and behavioural patterns (Rotheram-Borus, 1993). The pressure of adapting to two distinct cultures simultaneously is stressful for immigrant adolescents, or for those whose parents were immigrants. These adolescents may experience conflict and stress as they realise that their cultural values and beliefs are not recognised among peers or at school. Furthermore, the cultural expectations of mainstream society may conflict with and challenge the cultural values and expectations of their families (Uba, 1994).

1.7.3 The Measure of Acculturative Stress

The relationship between acculturative stress and mental health outcomes in adult immigrants has been examined by several researchers (Gil, Vega & Dimas, 1994; Mehta, 1998; Shin, 1994). In general, these studies report a positive association between acculturative stress and depressive symptoms. Although these studies aimed to assess the relationship between acculturative stress and depression, the operationalisation of acculturative stress was not uniform in these studies.

Padilla et al. (1985) have developed and validated a measure for acculturative stress. This scale was called "Societal, Attitudinal, Familial, Environmental, Acculturative Stress (SAFE) Scale". This 60-item scale measures the acculturative stress that may be perceived in societal, attitudinal, familial, and environmental contexts. The SAFE scale includes items that aim to assess acculturative stressors rather than general stress. The SAFE scale was found to discriminate between immigrants of the first, second and third generation. Immigrants of the second or third generation perceived less acculturative stress than first generation immigrants. Based on the results of this study, Mena et al. (1987) selected 17 items of the original 60-item SAFE scale which best discriminated between first-generation and later-generation immigrants. To be consistent with the theoretical framework of Berry (1980), seven additional items pertaining to perceived discrimination toward one's ethnic group were included. These seven items were included because acculturative stress may not only be due to perceived conflict between one's ethnic culture and the mainstream

culture, feelings of alienation, and conflict between parental values and those of the mainstream, but it may also result from perceived discrimination (Berry, 1998). The internal consistency reliability of this 22-items SAFE scale was α =.89 (Mena et al., 1987).

The language used in the SAFE scale was also modified so that it can be used with younger children. Similarly, this modified version of SAFE also discriminated well between European and Latino American children. Latino American children scored significantly higher than European Americans children on the SAFE scale (Chavez, Moran, Reid & Lopez, 1997). This modified version of the SAFE scale was also found to have adequate internal consistency (α.= .86). The results of these studies suggest that the SAFE is a reliable and valid measurement tool that operationalised acculturative stress as conceptualized by Berry (Chavez et al.).

1.7.4 Acculturative Stress and Mental Health

The SAFE scale has been used previously to examine the link between acculturative stress and mental health outcomes. One previous study (Hovey & King, 1996) used the SAFE scale to examine the relationship between acculturative stress, suicidal ideation and depressive symptoms. The Reynolds Adolescent Depression Scale (Reynolds, 1986) was used to measure depressive symptoms in a sample of 70 first-generation and second-generation Latino American adolescents. The results showed that 20% of participants reported high levels of depression and suicidal ideation. Depression and suicidal ideation were significantly correlated with acculturative stress. Acculturative stress accounted

for 9% of the total variance in their model. Hovey (1998) replicated this study by using a Mexican American sample. Comparable to their earlier study, results also showed a positive relationship between acculturative stress, depressive symptoms and suicidal ideation. Recently, Hovey (2000) also found that Central American immigrants experiencing elevated levels of acculturative stress also reported high levels of depression. Lack of family support was the core factor associated with high levels of acculturative stress and depression among this sample (Hovey).

Similarly, Romeo and Roberts (2003) also found a direct relationship between depression and acculturative stress among adolescents of Mexican descent. Acculturative stress was significantly positively associated with depressive symptoms in both U.S.-born and foreign-born Mexican American adolescents even after demographics and self-esteem were controlled. The findings of these studies indicate that immigrant adolescents who report high levels of acculturative stress may be at risk for experiencing depression and suicidal ideation.

In summary, from these theoretical perspectives and data supporting them, it seems clear that acculturation is an inevitable process of adapting to a new culture when people migrate to another country. Depression is more likely to occur during acculturation (Hovey & King, 1996). Ethnic adolescents who have the ability to learn the new language, resolve cultural differences and integrate into mainstream culture have better mental health outcomes. However, those who cannot do so, may become marginalised which places them at risk for developing psychological problems. As Vietnamese Australian adolescents are at risk of

developing depression, an understanding of the impact of acculturation on their mental health is important.

1.7.5 Ethnic Identity

The third issue that pertains to adolescents who belong to ethnic minorities is the development of a healthy sense of ethnic identity. While identity development is a complex task for all young people, it may be more complicated for adolescents belonging to ethnic groups that have different facial features, skin colour, language, and cultural behaviours that distinguish their group from the mainstream group (Phinney, 1990; Spencer & Markstrom-Adams, 1990). Minority adolescents are exposed to two different sets of norms and values which have varying degrees of impact on their lives (Phinney, 1990). They confront not only the normal developmental tasks within each culture, but also have to integrate the sometimes conflicting values of these cultures (Huang, 1994). These adolescents must sometimes negotiate different expectations between family members, peers and society to resolve the question, Who am I? (Huang).

In order to achieve a positive and stable sense of self-identity in a multicultural society, minority adolescents must be able to integrate a positive ethnic identity within their sense of self-identity (Phinney & Rosenthal, 1992). Ethnic identity is conceptualised as an enduring, fundamental aspect of the self that includes the person's thoughts, feelings, perceptions, and behaviours that are due to being a member of an ethnic group as well as having positive attitudes, and a sense of belonging to that group (Phinney, 1990; Phinney, 1996). Ethnic identity indicates the level of knowledge about cultural values, beliefs and

expectations that a person has about their ethnic group. Ethnic identity implies an individual's level of pride and acceptance of one's own heritage (Phinney, 1992). Ethnic identity also influences the way one interprets objects, events, and regulates one's behaviour (Uba, 1994).

Phinney (1990) asserted that ethnic identity, which becomes more salient during adolescence, is an important component of identity development. An achieved ethnic identity is central to an achieved individual identity for minority adolescents (Phinney, 1993). As such, a strong sense of ethnic identity is therefore crucial to the development of a healthy self-concept and the psychological functioning of a minority individual who belongs to a group where ethnicity is salient (Phinney & Rosenthal, 1992). Minority adolescents who do not develop a secure ethnic identity in an ethnically heterogeneous society, may be at risk for poor self-concept or identity confusion (Phinney, Lochner & Murphy, 1992).

The importance of developing a strong sense of ethnic identity varies among ethnic group members; some people have a clear sense of commitment and strong positive emotional ties to their group, whereas others feel confused and conflicted about their ethnicity. While some people are highly involved in their cultural heritage and its customs, others show little interest in it (Phinney, 1995). Research has shown that two-thirds of African American, Mexican American and Asian American students consider ethnicity as 'quite important' or 'very important' to their identity. Compared with other minority groups, Asian Americans had a lower sense of ethnic identity (Phinney & Alipuria, 1990).

Phinney (1989) proposed three stages of ethnic identity formation among American born ethnic minority adolescents. The Unexamined Ethnic Identity stage was characterised by lack of exploration of ethnic identity. Individuals in this stage have little concern about ethnic identity. Their attitudes toward their own group memberships could be negative or positive, but these views appeared to reflect their parents' and other's views in the society. Their relationship to other groups also could be negative, positive or neutral depending on socialisation in the family and in the social context. At the Ethnic Identity Search stage, young people show concern and involvement in exploration of their ethnic identity. Adolescents move into a large world, encounter people from different backgrounds, and probably are exposed more to racism and discrimination. These experiences might trigger their desire to learn more about their own history, cultural customs and behaviours and the situation of their group in the dominant society (Phinney, 1995). At the Ethnic Identity Achievement stage, young people have resolved their ethnic identity conflict. They feel secure in their own ethnicity and tend to accept and have positive but realistic views about their group. Phinney's stages of ethnic identity formation have been substantiated by several studies (Phinney, 1989; Phinney & Alipuria, 1990; Phinney & Tarver, 1988).

1.7.6 Ethnic Identity and Psychological and Behavioural Outcomes.

Numerous studies have found a positive relationship between level of ethnic identity and psychological adjustment (Martinez & Duke, 1997; Phinney, 1989, Phinney & Chavira, 1990, Phinney, Cantu & Kurtz, 1997; Phinney,

Ferguson & Tate, 1997). In a longitudinal study, Phinney and Chavira (1992) found that higher ethnic identity scores were correlated with higher levels of self-esteem at both Time 1 and Time 2 across a three-year time span. Similarly, Phinney et al. (1997) studied the relationship between ethnic identity and self-esteem among 669 American-born high school students. In this study, ethnic identity was assessed as a broad construct including sense of belonging, positive attitudes, commitment, and involvement with one's own ethnic group. Ethnic identity was found to be a strong predictor of self-esteem for minority adolescents. Consistent with this finding, analyses of data collected from 12,386 adolescents (Martinez & Dukes, 1997) also revealed that the higher the ethnic identity score, the higher the individual's global self-esteem, academic confidence and purpose in life. For Vietnamese immigrants in Norway, ethnic identity was found to be the most important factor in determining their life satisfaction (Sam, 1998).

Ethnic identity was also found to be related to other aspects of minority adolescents' functioning. When negative stereotypes of Hispanics were presented (i.e., threatening), the Hispanic participants who had a strong ethnic identity were more likely than the ones who had weak ethnic identity, to maintain a positive view of themselves as a member of their ethnic group. This finding suggests that adolescents who are more secure about themselves, as well as about being a member of their ethnic group, are more able to resist the group's negative stereotypes than those who are insecure (Phinney et al., 1997). Minority adolescents with high ethnic identity and high sense of self-esteem may be more

able to use active strategies in dealing with threats such as discrimination and negative stereotyping than those with low ethnic identity (Phinney et al.).

Ethnic identity also related to attitudes towards people from other groups. According to social identity theory (Tajfel & Turner, 1986), as part of an individual's self esteem, social identity is derived from social categorisation. Social identity is based on an individual's sense of belonging to a group and the individual's perception of, and attitudes toward the group the individual belongs to. The more positively the group is perceived, the greater the positive self esteem individuals can draw from their membership of the group. Social identity theory also posits that such categorisation is a precursor of in-group bias and the development of negative beliefs about members of out-groups. However, social identity theory (Tajfel & Turner) was only partially supported by a study of Romero and Roberts (1998). Romero and Roberts found that only individuals who are in the stage of exploring their ethnic identity showed negative attitudes toward out-groups. Whereas, individuals with high ethic affirmation, that is, who have a strong sense of belonging to their own ethnic group, reported more positive attitudes toward out-groups which in turn, lessened perceived discrimination. Similarly, results of a survey completed by 547 adolescents from three ethnic groups (African, Latino and Asian American), suggested that a secure and positive sense of one's ethnic identity predicts positive in-group attitudes and these positive attitudes then contribute to positive out-group attitudes (Phinney et al., 1997).

Some researchers have also investigated the relationship between ethnic identity and behavioural outcomes. Ting-Toomey (1981) and Uba (1994) argue that each culture provides a framework of values and appropriate behaviours. Ethnic identity is a cultural self that indicates an individual's level of commitment to certain shared patterns of communication, beliefs, and philosophy of life which regulate the individual's behaviours. Ethnic minority adolescents who fail to develop a consistent inner pattern of behaviours and values which is provided by their own cultural framework, may not adequately internalise social directives which facilitate the development of social maturity. They may also be unable to relate their behaviour to any stable set of standards (Uba).

Brook, Whiteman, Baka, Win and Gursen's (1998) study of Latino Americans, found that cultural knowledge, involvement with cultural activities, and a strong sense of ethnic group attachment and identification acted as protective factors against drug use. Another study found that adherence to Chinese cultural values was negatively associated with delinquent behaviours among Chinese Canadian youths (Wong, 1998). Most of the studies on ethnic identity were based on one of three broad theoretical perspectives: identity formation, social identity or acculturation (Phinney, 1990).

In summary, it appears that a healthy sense of ethnic identity is important for the psychological well-being of ethnic adolescents. Although personal identity development takes place throughout the life course, it is particularly important during adolescence (Erikson, 1968). The central task of adolescent development is achieving a personal identity. Personal identity assumes a

prominent role in shaping behaviour, attitudes, and future possibilities. During this period, adolescents are actively restructuring and shaping their sense of self. The consolidation of identity provides a sense of meaning and personal continuity through time, and guides an adolescent in making choices in life such as career path, future partner, religious affiliation etc. Failure to develop a coherent and stable identity can lead to confusion and psychological distress (Erikson). As such, Vietnamese Australians who do not have a healthy sense of ethnic identity may also be at risk for developing psychological problems. The relationship between ethnic identity and depressive symptoms in Vietnamese Australian adolescents has never been empirically examined. This study attempts to address this issue.

1.8 The Aims and Rationale of Study One-Part A and B

From the present review, it appears that ethnic adolescents have higher rates of depression than adolescents in the general population. Family cohesion, family conflict, and parental psychological control have been found to relate to depressive symptoms in adolescents in the general population as well as those who have an Asian background. Although depression appears to be more prevalent in ethnic adolescents, empirical evidence regarding the frequency of depressive symptoms in Vietnamese Australian adolescents is not known. More importantly, the unique risk factors associated with their depressive symptoms have not been identified by Australian practitioners and researchers. Acculturative stress and ethnic identity may account for the elevated rates of depression found in ethnic adolescents.

As mentioned in the thesis overview section, Study One included a qualitative study (Part A) and a quantitative study (Part B). A focus group interview was used to gather qualitative data for Study One-Part A. A focus group is a discussion among people similar to the studied population and it is used frequently in research to obtain in-depth information about a particular topic (Vaughn, Schumm & Sinagub, 1996). Participants in the focus group were asked to discuss difficult experiences that they had faced in various areas of their lives. Specifically, the participants were asked to discuss their experiences at home, their attitudes toward maintaining their ethnic identity and their perceived discrimination. The method and results of Study One-Part A will be presented in Chapter 2. Following this chapter, the method and the results of Study One-Part B will be presented. The discussion section will integrate and discuss the findings of both Part A and B.

The aims of the Study One-Part A and B were:

(1) to explore the difficulties facing Vietnamese Australian adolescents.

(2) to identify the frequency of depressive symptoms among Vietnamese Australian adolescents;

(3) to investigate the relationship between familial factors, acculturative stress, ethnic identity, and depressive symptoms; and

(4) to examine whether acculturative stress and ethnic identity contribute to additional variance beyond familial factors.

1.9 Hypotheses of Study One-Part B

It is hypothesised that:

1) High levels of family cohesion will be negatively associated with depressive symptoms;

2) High levels of family conflict and parental psychological control will be positively associated with depressive symptoms; and

3) High levels of acculturative stress and low levels of ethnic identity will add unique variance above that of family functionality in predicting depressive symptoms in this sample.

1.10 Study Design and Data Collection of the Current Studies

1.10.1 Sampling Procedure

Initially, ethical approval was obtained from Queensland Educational Department and permission to recruit Vietnamese Australian participants was sought at several public high schools in Brisbane. However, these schools advised that they did not wish their students to participate in the research because they did not want to cause their Vietnamese Australian students to feel different from other student groups. As a result, the plan to recruit participants from school could not be accomplished. Moreover, previous researchers (Sam, 1995; Sam & Berry, 1995) who investigated ethnic minority adolescents, particularly Vietnamese immigrants, often faced recruiting problems. This may be because Vietnamese immigrants are not familiar with the Western concept of psychological research, therefore they hesitate to take part in research. As permission was not approved to recruit participants at schools, Vietnamese

churches, community organizations, and Australian White Page were used as convenience mediums to recruit Vietnamese Australian adolescents. Thus, this sampling procedure did not permit a representative sample of the population under study and could limit interpretation of the results. However, because the population under study is difficulty to access, these procedures were used in order to recruit adequate numbers of participants. The limitations of these sampling procedures are acknowledged.

1.10.2 Control Group

This study did not employ control groups because many previous studies had already established evidence that ethnic adolescents reported higher levels of depressive symptoms than their Anglo-counterparts. Moreover, previous research (Herz & Gullone, 1999) also demonstrated that Vietnamese Australian adolescents reported higher incidence of the affectionless-control parenting style and lower bonding parenting style than their Anglo-counterparts. Herz and Gullone's study showed evidence of cultural differences in parenting style and family functioning between Vietnamese Australian and Anglo Australian families. Furthermore, ethnic comparison studies do not elucidate the specific factors that predict psychological distress in each group. According to Roosa and Gonzales (2000), ethnic differences are due to variations in culture-specific values, histories and experiences, and in the case of ethnic minorities, their struggles to deal with language difficulties, cultural differences and discrimination from the mainstream group. The unique cultural background and experiences of each ethnic minority group produce fundamental differences in the

development of risk and protective factors which predict their mental health outcomes. This development process is not necessarily shared by the mainstream group and, therefore, should not be compared (Roosa & Gonzales). Hence, the present study was only interested in understanding the risk and protective factors that are associated with the mental health of Vietnamese Australian adolescents, although it is acknowledged that this lack of a control group could also limit interpretation and generalization of the findings.

STUDY ONE: Part A

CHAPTER 2: FOCUS GROUP INTERVIEW

2.1 Rationale of the Focus Group Interview

Focus group interview methodology was selected as the data collection technique for Study One-Part A as the purpose of the research was to gain a rich, in-depth perceptions and opinions of Vietnamese Australian adolescents regarding the topic of enquiry. The SAFE scale (Mena et al., 1987) consists of only two items designed to measure stress resulting from cultural conflicts in immigrant families. There was no valid measure that captured the range of parent-adolescent issues in Asian immigrant families (at the time this study was conducted). Since the SAFE was only designed to measure stress stemming from experiencing discrimination, the types of discrimination and places where Vietnamese Australian adolescents commonly encounter racial discrimination could not be captured by the SAFE. This methodology therefore, was intended to elicit participants' perspectives of the challenges and difficulties that they experienced in various areas of their life.

Thus, the focus group interview was designed to obtain a wide range of information about their family environment, parenting practices, parent-adolescent problems, attitudes toward maintaining their ethnic identity, and perceived discrimination that can not be obtained from the questionnaires. It was hoped that the focus group interview will generate in-depth information about the difficulties facing Vietnamese Australian adolescents that may impede their successful integration into the mainstream society. Furthermore, the qualitative

results, then, can provide information to assist in interpreting the results of the quantitative data in Part B. Finally, all the questionnaires used for Study One-Part B have never been used to study Vietnamese Australian adolescents; hence the result of the focus group interviews can provide alternative interpretation of findings that might not be clear by the quantitative method (Part B) (Vaughn, Schumm & Sinagub, 1996).

2.2 *Participants*

The participants were 21 Vietnamese Australian adolescents. Their age range was 14 to 18 years, with a mean of 15.5 years. Seventeen participants were born in Australia, and four were born in Vietnam. These participants were recruited by a snowballing method. Initially, Vietnamese Australian adolescents who were known to the researcher were contacted. Then, after explaining the purpose of the research to them, they were asked to introduce their Vietnamese Australian friends and acquaintances to the researcher. After a list of 24 names had been compiled the researcher contacted these adolescents, and invited them to participate. All participants initially accepted; however, three adolescents did not attend the group discussion due to family matters. Although this sampling method was one of convenience, participants resided in a number of different suburbs and attended 12 different educational institutions. Three participants were first year tertiary students, and the remaining eighteen were attending nine different high schools (four catholic high schools and five public high schools). A small monetary reward was exchanged for the participants' time.

2.3 Materials

A whiteboard, large sheets of paper, notebooks, pens, and audio recording equipment were used to gather information. The first two introductory questions were designed to introduce participants to the topics of inquiry, and to provide them with an opportunity to reflect on the experiences of being an adolescent, and specifically being an adolescent of Vietnamese ethnic origin. These questions were designed to establish rapport with participants and encourage candid participation, therefore they were not analysed (Vaughn et al., 1996). The transitional and key questions were chosen for their direct relationship with the topic of interest and to elicit the range of issues that ethnic minority adolescents encounter, as mentioned in the literature review.

2.3.1 Introductory Questions

1) When you think about teenagers, what things come to your mind?

2) When you think about Vietnamese teenagers, what things come to your mind?

2.3.2 Transitional Question

3) What sort of issues and difficulties do Vietnamese Australian teenagers experience, that European Australian teenagers might not?

2.3.3 Key Questions

4) In what situations have you felt as if you were being treated unfairly because you are Vietnamese Australian, or in what situations have you felt as if you were being put down because you are Vietnamese Australian?

5) In what types of issues and values do you and your parents differ?

6) Is it useful for Vietnamese Australian teenagers to learn and adopt
   Vietnamese cultural values and behaviour?

7) What made you feel that learning and adopting Vietnamese cultural values
   and behaviour was helpful?

8) What types of issues hinder or prevent Vietnamese Australian teenagers from
   taking pride in being Vietnamese?

2.4 Procedure

There were three focus groups: two groups consisted of eight participants and the third group had five. Participants arrived at the location approximately 20 to 30 minutes before the group commenced, so that they could get to know each other. During this 'getting to know each other' time, they were provided with food and drinks (tea, orange juice, or soft-drink). Before the discussion commenced, a parental consent form was obtained from each participant. Each participant was then given a notebook and a pen. Following this, discussion began with a welcome statement and introduction during which the purpose and confidentiality of the group were clearly stated. The group guidelines and questions were written on large sheets of paper. Questions were presented one at a time and the same procedure was used for each question. After checking that each question was clearly understood, participants were instructed to write down their ideas and experiences relating to that question, so that they would not be influenced by the opinions of others. With the exception of the two introductory questions, the participants were then asked to form small groups of two or three

to further discuss the topic. However, participants who wanted to work individually were allowed to do so.

The principal researcher and her assistant facilitated small group discussion through the use of probes, encouragement and clarifying questions. After each small group discussion, one participant in each group reported the content to the whole group. Their ideas were clarified and summarised and were then written on the white board. Each focus group discussion lasted approximately 1.5 hours and was audio taped for later transcription and analysis. Information written in individual notebooks and field notes was also collected for analysis.

2.5 Data Analysis

Specific hypotheses for Part A data collection were not made; however, the questions used to elicit participants' opinions and perceptions were guided by the present literature review. As the data contained qualitative comments, analysis of the transcripts involved an inductive process, and was carried out in several steps. The transcripts were first read, and margin notes were made to identify main themes. Each theme was then categorised by different colour highlighters, and this process was repeated to categorise subordinate themes (Morse & Field, 1995). Because of the nature of the qualitative data collection methods, no attempt was made to quantify themes that appeared individually. However, specific quotes were abstracted from the transcripts to substantiate themes.

Results of Study One– Part A

Analysis identified several themes that arose consistently across the focus groups. These themes addressed the difficulties that Vietnamese Australian adolescents were facing. When participants were asked to discuss the difficulties that Vietnamese Australian adolescents faced that European Australian adolescents might not face, they identified three broad challenges: discrimination; ethnic identity; and parent-child relationship issues. Under three broad themes, sub-themes were identified.

2.6 Discrimination

2.6.1 Feeling Unaccepted by Teachers and Peers

Acculturative stress is made up of multiple facets, and part of the experience may include feelings of being discriminated against (Berry, 1998). Additionally, adolescents from other cultures are more likely to experience discrimination in school settings, where they have their most direct encounters with mainstream culture. Also, a lack of acceptance and understanding from teachers and peers may foster a sense of being different and alienated. Furthermore, the more ethnically distinct by culture, and physically different by appearance (e.g. eye shape, skin colour, & hair colour) adolescents are, the more intensely different they could feel (Kopala et al., 1994). Extracts of responses to questions 3 and 4 that illustrate the feeling of being discriminated against are given below.

> *When teachers read names and they come to Asian names, if they find it is difficult, they* [seem to] *exaggerate how difficult it is.*

Other students make fun of us because our names are different.

Other students refer to us by our skin colour instead of calling our name.

They tease us and swear at us. People tease you about being Vietnamese.

They [European students and teachers] *don't see us as equal.*

Other students put us down, saying that we are not good enough [as a student].

They [teachers and students] *think you are dumb. When we are in a group discussion, if we have a good idea and you say it out loud, the other students don't write it down, even though that was part of the group. Sometimes teachers think that we don't understand English, and they put us in special courses* [unnecessarily].

2.6.2 A Sense of Being Rejected

The majority of participants experienced discrimination in numerous situations. Besides their general feeling of being disliked by many mainstream people, some participants felt that people from the mainstream often rejected them and prevented them from becoming members of the broader society. Some felt that European Australians excluded them from joining their activities, or their circle of friends. Text shown in italics consists of responses to questions 3 and 4 that illustrate the experience of feeling rejected.

I think people [European Australians] *do not let us adapt to their environment. I feel like there are barriers and I try to break the barriers.*

It is difficult for Vietnamese people to make friends with [European]

Australians – they make it hard for Vietnamese. White people make it easy

to dislike us [Vietnamese Australians].

When I talk to them [European Australians] *they ignore me, pretending*

that they are not hearing. They don't want to be friends [with Vietnamese

Australians]. *They act like we don't exist.*

In the class teachers want students to work in groups, but they [European

Australian students] don't want us in their group.

At sport, we are treated differently. We are not picked first for any sport

team. In the sport team, as well as always being picked last, they don't

like us. They don't let us play with them. If we are in a game and if our

team loses, they blame it on the Asian kids.

Hence, considering these extracts, many participants expressed feelings of rejection due to behaviours shown by mainstream European Australians. Further, these feelings of rejection could contribute to acculturative stress by making it difficult for Vietnamese Australian adolescents to develop a sense of Australian cultural identity.

2.6.3 Feeling Isolated

Rejection by European Australians, who are in the majority within Vietnamese Australian adolescent peer groups, could also be associated with feelings of isolation. As illustrated by the following extracts from responses to question 3 and 4, feelings of isolation were a concern for several participants.

I feel left out from the mainstream group.

I feel outcast from Westerners.

It is difficult to fit in with Australians. We are not used to the ways that White people live – because of cultural differences, it is difficult for Vietnamese teenagers to fit in.

The community we live in is mainly White Australian, and we feel alone because we don't have an understanding of the community.

I try to fit into the White Australian community, but the difference is that I am a Vietnamese person, and I do not have the types of attitudes, thoughts and feelings.

Thus, regardless of how psychologically well these Vietnamese Australian adolescents may have been in other areas of their life, for example within their families, their expressed feelings of rejection could lead to negative psychological outcomes, such as feelings of worthlessness, helplessness, and isolation. Additionally, feelings of isolation may be heightened for adolescents who have poorly developed social skills. For example, Kopala et al. (1994) found that adolescents with poorly developed social skills might not be able to make friends with or relate to others. Further, a lack of general knowledge about mainstream culture, particularly with regard to Western communication and interpersonal styles, combined with poorly articulated English language, may exacerbate such feelings of isolation.

2.6.4 The Experience of Being Negatively Stereotyped

Sub-themes that were expressed by several participants suggested that these feelings of discrimination could be exacerbated when the ethnic group to

which adolescents belonged was negatively perceived and stereotyped by mainstream society.

> *Sometimes teachers want to kick Asian students out* [of the school] *because of their school reports, even though the reports are not that bad. They* [teachers] *think that Asian students ruin the school's reputation. Teachers treat us unfairly because of other Vietnamese students' reputations.*

> *We sometimes get into trouble at school even if we haven't done anything.*

> *Teachers pick on us more often, and if we mix with a big group of other Asian students, teachers pick on us even more.*

Thus, participants in this group of Vietnamese adolescents experienced being negatively stereotyped. For example, the social status of the Vietnamese community in Australia has been relatively low in many areas (Reid, Higgs, Beyer & Crofts, 2002). Further, the Vietnamese community in Australia has been portrayed by mainstream media as a group of migrants who have many social problems, such as a high incidence of illicit drug trafficking and use, gang activities, and high unemployment rates (Reid et al.,). The attitudes of mainstream society toward ethnic minority members are important for their mental health (Berry, 1998) and such experiences could contribute to acculturative stress. Furthermore, as illustrated by the following extracts, some participants expressed their frustration about not being treated as an individual member of the society.

When people know you are Vietnamese they think you are bad. When I went to the city two weeks ago, a policeman asked me if I was Vietnamese or Chinese. I said I was Vietnamese, and then he asked me for my ID card, as he thought I had skipped school. However, if I say I am Chinese, then police do not ask for my ID.

Everyone thinks that Vietnamese people deal with heroin.

People think that Asians take drugs, and they think we influence Australian young people to do the same.

We are seen as either intelligent, or as a rebel who is dumb — but we are not seen anywhere in between. Even in the street we are not treated as individuals.

Vietnamese people have a bad reputation in [Australian] *society.*

They [European Australians] *categorise us. Because we might be different from them, they think about us in a negative way.*

2.7 Ethnic Identity

2.7.1 Problems of Maintaining a Positive Sense of Ethnic Identity

The experience of stereotyped treatment illustrated above could also have contributed to these participants finding it difficult to develop a healthy sense of ethnic identity with their Vietnamese cultural background. Most participants were aware of and concerned about negative stereotypes that Australian society imposed upon people of their ethnic group.

Some participants also internalized and accepted negative stereotypes. For example, instead of expressing their disagreement toward people who treated

them unfairly, some participants seemed to think that their ethnic group deserved negative stereotypes, and some even disliked being a member of their group.

> *Maybe some Vietnamese have done wrong things which have caused people* [European Australians] *to categorise Vietnamese people. For example, issues such as drugs, gangs and fighting in the media.*

> *What we hear about Vietnamese teenagers are mostly bad things. At our State High School, Vietnamese teenagers have the worst reputation for 'fighting'.*

> *Because people think Vietnamese are bad, some Vietnamese people feel ashamed to be a Vietnamese.*

> *I am ashamed of being Asian.*

> *It is very hard to feel proud of yourself as a Vietnamese person when you hear so many bad things — we hear things like Vietnamese people do this and that* [bad things]*, and Vietnamese are violent — these type of things put us down.*

> *Inside, I feel proud of myself, but I am not proud of what other Asians are doing.*

2.7.2 Advantages of Learning and Maintaining Vietnamese Culture and Language

Although some participants said that they did not like being Vietnamese, or that they did not like other Vietnamese, many agreed that it is helpful to learn and maintain Vietnamese culture and language. Some participants articulated that

adherence to their ethnic culture could provide them with a sense of self-identity and framework for ways of behaving.

There is a framework that we can follow; there is a framework for us to lean on.

We are allowed to do certain things and it is a direction for our life — for us to develop our own family.

It gives us individuality, and some forms of self-identity.

It gives me who I am and I am not denying it.

[Learning about Vietnamese culture] makes me know who I am; I know where I came from — that makes me become who I am — my identity.

Moreover, for some of these Vietnamese adolescents, accepting their ethnic culture appeared to mean that they could maintain a good relationship with their parents and other people in their ethnic community.

Denial of who I am may cause suffering to the family.

Knowing our culture means that we won't disappoint our parents. We will make our parents feel happy.

I am [want to be] a Vietnamese person, otherwise my family will probably deny me as a part of their community.

Other elderly members of the family respect and recognise us when we speak Vietnamese.

If we know our own culture, it is easier for us to get along with other

[Vietnamese] people.

If we can speak Vietnamese, we have more chance to get jobs in cross-

cultural work environment.

As illustrated above, most participants agreed that having the ability to speak Vietnamese was an advantage, as they could then communicate well with their parents and other Vietnamese. Some participants also said that they liked Vietnamese cultural festivals, such as New Year and Full Moon. Furthermore, they said that Vietnamese foods are healthy and contain less fat than foods of European countries. Further, having a second language also enhanced their chances of being employed in cross-cultural work environments.

2.8 Parent-Child Relationship Issues

When compared to their Western peers, all participants in this study perceived the relationships between themselves and their parents as somehow different. They believed that they respected and obeyed their parents more than European Australian adolescents. The manner in which they related to each other in their family was also different. For example, they did not want to say anything against their parents. Further, there were different expectations about how girls and boys should behave. For example, girls should be quiet and should do the housework, whereas boys could have more freedom. In general, they perceived that their parents were more restrictive about their personal freedom and independence, and were emotionally distant.

2.8.1 Personal Freedom

All participants expressed that their parents overly restricted their personal

freedom and their right to have privacy.

When we ask our parents' permission to go out, they will ask where we are

going, what time we will be home, who we are going out with etc. They make

sure that we are not going.

They restrict us every time we want to do something, they always make

barriers, and if we turn in another direction, then they make other barriers

until we turn to their direction.

If we want to watch television, they want us to study. If we want to go out

they make us to help them; they make us do something that they think is

useful.

Sometimes we want privacy, but they don't let us have that privacy.

    Thus, these participants indicated that their parents not only restricted

their personal freedom, but also dictated what activities adolescents should

participate in, the types of clothes they should wear, and how to spend money etc.

Some participants also expressed that their parents dictated the types of friends

they should have. For example, they were not allowed to have friends that looked

or sounded too trendy, or who smoked. Further, some Vietnamese parents of

these participants did not support activities such as participation in sport.

2.8.2 Pressure of Academic Achievement

In terms of education, the participants all agreed that their parents put a lot of emphasis on academic achievement. For example:

Our parents, like most Vietnamese parents, push us to study hard and do better at school.

They make us study all the time. There is not much chance for us to go out. They make us study 24 hours a day, 7 days a week.

They make sure we don't have boy friend, and they say that we should put our minds to study.

They don't let us hang out with our friends. They want us to use that time to study even on the weekend and during holidays. They don't want us to have a social life, but to study all the time.

It seems that Vietnamese parents of these participants not only demanded their children study hard, but they also had high expectations of academic achievement. The majority these adolescents said their parents expected them to do very well, and to be perfect at school.

2.8.3 Parents Dictate Career Choice

Some participants voiced that their parents did not allow them to choose their own career. Their parents wanted them to choose careers that would earn good money and give the family social status. For example:

In high school, it does not matter what we are learning as long as we have high marks, but when we get to the career stage, then they want us to take a career that gives them status. For example, by being a doctor.

We have to choose careers according to what our parents wish rather

than what we want.

Our parents want us to follow in their footsteps. For example, if your

father is a lawyer or something else, then they have too much expectation

on you — they expect you to be one — there is a lot of pressure.

2.8.4 Emotional Distance

When describing the relationships with their parents, most participants

expressed that their parents were less likely to attend to their emotional needs in

comparison to European Australian parents. For example, they said that their

parents did not understand what they would like to do in the future, or how they

felt about career choices. Further, their parents avoided talking about issues such

as sexuality. In general, these participants said that their parents were not very

communicative, and were emotionally closed to them.

The relationship between the child and the parents is completely different.

Vietnamese parents have less emotional contact with their children, and

believe that as long as we study we are fine.

I think there is a lack of communication with parents on emotional issues. My

dad has never sat down and talked about sex and other things with me. If I

have problems at school they never sit down and talk about it – I have to sort

it out by myself.

It started when we were small, there was no emotional contact; when you

grow up, they start to talk to you, but then it is difficult because you feel there

is a gap to do that.

Parents don't understand you very well in terms of what you want to do in the future.

I know they (parents) want the best for us but they don't know how we feel e.g. they expect us to stay home most of the time, but they don't know how bored we feel.

Thus, although problems that could be due to authoritarian style parenting, such as strong discipline and emotional detachment mentioned above, may also occur in some European Australian families, these participants appeared to believe that for them the experience was greater than that of their Australian peers.

2.8.5 Conflict About Cultural Values

Participants thought that their parents were more traditional, and adhered more to cultural values than were in place at the time of departure from Vietnam. For example, their parents expected them to learn Vietnamese culture, and to follow traditional values, such as restricted dating behaviours. However, these adolescents said that they would like to adopt the values of mainstream Australian culture. Further, they also believed that they had more experience and understanding about mainstream culture than their parents.

They teach us the old ways. When they came here they brought with them the old stuff and they raise us like that, even over there [in Vietnam] people have already changed the way they raise kids, but here they still raise us with the old ways.

They are cultural and religious. For example, they expect you to remain a

virgin until you marry.

They expect us to become religious, and go to the church or the temple.

My parents want to arrange my marriage — they want me to marry a

traditional Vietnamese girl — the same way my parents met. Their

marriage was arranged.

As stated above, some of these Vietnamese Australian adolescents believed that their parents had not kept up with cultural changes in Vietnam. Further, these participants appeared to believe that if their parents had changed in similar ways to Vietnamese people who remained in Vietnam, they would be more liberal in their views of dating and marriage. Furthermore, participants wanted their parents to be more similar to Australian cultural norms for marriage and dating.

Summary of the Key Findings of Study One-Part A

In summary, many participants reported the experiences of being rejected, unaccepted, teased, discriminated against, and being treated as if they belonged to a negatively stereotyped group. Beyond the perceived discrimination, the difficulty in acquiring knowledge of mainstream social customs, behaviours and interpersonal communication styles also are challenges for Vietnamese Australian adolescents. Some participants revealed that it is difficult to integrate into the mainstream community as they do not have the skills, and they do not understand the customs of European Australians well. Lack of ability to integrate into the large society could possibly predispose these adolescents to the feelings of isolation from the mainstream and being an outcast.

When participants were asked about their parent-child relationship, all participants agreed that their parents were stricter and more demanding than the parents of their European Australian peers. Their parents controlled their personal freedom, dictated their choice of friends and careers and had high expectations of their academic achievement. Their parents do not understand them. The participants of this study also had some conflicting cultural values such as dating behaviours and religiosity with their parents. Participants of this study also indicated the issue of lacking closeness with their parents. As a comparison to their European Australian peers, participants of this study perceived that there was a lack of emotional closeness between them and their parents. Their parents did not like to talk about personal issues such as problems at schools or sexual issues.

With regard to ethnic identity, all participants perceived that their ethnic group was negatively portrayed by the mainstream society. The interview revealed that some of the participants of this study were not proud of their ethnic group, and did not like to be a member of their ethnic group; one participant even felt ashamed of being Asian. Although some participants perceived their ethnic group negatively, some expressed their desire to maintain some aspects of Vietnamese culture and their ethnic identity. They said that Vietnamese culture gave them a sense of identity and directions for behaviours. Also, adherence to cultural values would please their parents, and denial of their ethnic identity could cause suffering to their parents.

STUDY ONE—Part B

CHAPTER 3: METHODOLOGY

3.1 Participants

Data for this study were obtained from 110 Vietnamese Australian secondary school students who had lived in Australia for at least two years, lived with at least one biological parent, and were able to read English. Approximately 315 questionnaires were distributed with a 35% return rate. The sample consisted of 34 males and 75 females (one participant failed to indicate their gender). Age ranged from 12 to 19 years old (mean = 15 years old, $SD = 2.57$). Sixty-one participants resided in Brisbane and 49 lived in Sydney. Sixty-seven participants were born in Australia (61%), forty-one were born in Vietnam (37.4%). Of those who were born in Vietnam, the average time they lived in Australia was 9.60 years (SD = 3.80), ranging from 2.5 to 14. Two participants did not indicate place of birth. Participants were offered a small amount of money for participating.

3.2 Procedure

Two sampling techniques were used to recruit subjects for this study. Brisbane participants were recruited by snowballing. A few participants who were known to the researchers were invited to participate in the study and asked to distribute questionnaire packets to other Vietnamese Australian students in their schools. Participants who resided in Sydney were recruited though the Catholic Churches. Questionnaires were anonymous and took approximately 35 minutes to complete. Approximately 35% adolescents returned the questionnaires and all returned questionnaires were complete and reliable for data analysis.

Participation in the study was voluntary and written consent was obtained from both participants and their parents in accordance with University Ethnics Committee requirements.

3.3 Measures

The assessment protocol included: a) a consent form (written in Vietnamese for parents and English for participants); b) a demographic questionnaire designed to collect information on age, grade, gender, generational status, length of time living in Australia; and c) a battery of self-report questionnaires written in English.

3.3.1 Reynolds Adolescent Depression Scale

Adolescent depressive symptoms were measured by the Reynolds Adolescent Depression Scale (RADS) (Reynolds, 1986). The RADS is a self-report measure intended to assess the severity of depressive symptoms in adolescents aged 13-18. It consists of 30 items rated on a 4-point scale: "almost never"; "hardly ever"; "sometimes"; and "most of the time", yielding a total possible score of 120. In accordance with the Griffith University Ethics Committee agreement, one item ("I feel like hurting myself") was omitted, leaving a possible total score of 116. The RADS has high internal consistency reliability ($\alpha = 0.93$) and a split-half internal consistency coefficient of 0.91 (Reynolds, 1987). This study obtained an internal consistency alpha of .86.

3.3.2 Family Environment Scale

The Cohesion and Conflict subscales of the Family Environment Scale (FES) (Moos & Moos, 1981) were used to assess family cohesion and conflict.

Each subscale contains nine items that are rated true or false. The FES-Cohesion

subscale assesses the amount of commitment, assistance, and support family

members contribute to one another, and the FES-Conflict subscale measures the

extent to which family members engage in aggression, conflict and overt anger.

Internal consistency reliability for Cohesion is $\alpha = 0.78$ and Conflict is $\alpha = 0.76$.

Test-retest reliability of these subscales ranges between 0.76 and 0.89. The

Alpha levels of Cohesion and Conflict Subscales in this study were 0.73 and 0.70

respectively.

3.3.3 Psychological Control Scale – Youth Self-Report

The Psychological Control Scale – Youth Self-Report (PCS–YSR)

(Barber, 1996) was used to assess adolescents' perceptions of the extent to which

their parents constrain, invalidate and manipulate their psychological and

emotional experiences. The PCS–YSR scale contains 13 items, each providing

three response options (1 = Not like her (him), 2 = Somewhat like her (him), 3 =

A lot like her (him)). This scale originally was a subscale of the Child Report of

the Parental Behaviour Inventory developed by Schafer in 1965 (cited in Barber,

1996) and was refined by Barber to include more behaviourally specific items.

Internal consistency reliability for sub-samples range from $\alpha = 0.72$ to 0.85. To

validate the scale, youth depression was set as the criterion. In both cross-

sectional and longitudinal analyses, perceived parental psychological control

(measured by PCS – YSR) was consistently predictive of youth depression

(Barber, 1996). Internal consistency reliability of the PCS – YSR in this sample

was $\alpha = 81$.

3.3.4 Social Attitudinal Familial Environmental Acculturative Stress Scale

The Social Attitudinal Familial Environmental Acculturative Stress Scale (SAFE) (Mena et al., 1987) consists of 24 items which measure acculturative stress in social, attitudinal, familial, and environmental contexts as well as perceived discrimination. Participants rate each item on a 5-point likert scale (1 = not stressful, 5 = extremely stressful). The SAFE scale consists of two components: seventeen items relating to the process of acculturation, and seven items relating to perceptions of discrimination. Examples of items include: "I do not feel at home in Australia"; "It bothers me that my family members I am close to did not understand my new values"; and "Many people have stereotypes about my culture or ethnic group and treat me as if they are true". SAFE was originally developed to assess acculturative stress in a sample of college students, so four items not relevant to high-school students were omitted. The SAFE scale has been shown to effectively discriminate between immigrants (first generation) and US-born (second and third generation) individuals, with each successive generation experiencing less acculturative stress (Mena et al.,). Thus, the SAFE scale has good construct validity. The SAFE scale has good internal consistency reliability ($\alpha = 0.89$). In this sample, the 20-items SAFE scale yielded a internal consistency reliability of $\alpha = .88$.

3.3.5 Multigroup Ethnic Identity Measure

The Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992) consists of 12-items relating to the extent to which an individual identifies with,

feels they belong to, has pride in, and has knowledge of, their ethnic background. The MEIM assesses three aspects of ethnic identity: (1) a sense of belonging to, and attitudes toward one's ethnic group; (2) ethnic behaviours and customs; and (3) ethnic identity achievement, based on exploration and commitment. Example items include: "I have a strong sense of pride in my ethnic group and its accomplishment"; "I participate in the cultural practices of my own group; and "I have spend time trying to find out more about my own ethnic group, such as history, traditions and customs". Items are based on a 4-point Likert scale. Scores range from 12 to 48, with higher scores indicating greater ethnic identity. The reliability of the MEIM for high school sample was $\alpha = .81$ and $\alpha = .90$ for college sample (Phinney). In establishing the construct of the MEIM, Phinney expected that older subjects would have higher scores on ethnic identity achievement, and ethnic identity achievement should change with age. Also, a strong sense of identification with the members of one's own ethnic group is important to developing both positive personal identity and healthy self-esteem. Therefore, ethnic identity should be associated with a higher sense of self-esteem. As expected, ethnic identity achievement was found to be higher among college students than high school students, and self-esteem was found to be related to ethnic identity among all students. The internal consistency reliability of the MEIM in this sample was $\alpha = .86$.

STUDY ONE—Part B

CHAPTER 4: **RESULTS**

4.1 Cross-sectional Analysis

Hierarchical regression analyses are a set of statistical techniques that assess the relationship between one dependent variable and several independent variables. The product of a hierarchical regression analysis is an equation that estimates unique variance of each independent variable at its own point of entry (Tabachnick & Fidell, 2001). According to the study hypotheses, family cohesion, family environment, parental psychological control, ethnic identity and acculturative stress were designated as independent variables that predicted depression. Family cohesion, family environment and parental psychological control were entered in block one, acculturative stress and ethnic identity were entered in the equation in the second block to determine the unique variances that these variables added to the prediction over and above the variables in the first block.

4.2 Diagnostic

The fit between the data set and the assumptions of multivariate analysis was assessed. Results of the preliminary screening revealed no missing data, skew and/or extreme outliers. Each variable and all linear combinations of the variables were normally distributed. As other measures (family cohesion and conflict) assessed adolescents' perceptions of their family, the scales of mother psychological control and father psychological control were added together to make one score for both parents. The correlation between mother psychological

control and father psychological control was (r = .73). The correlations between

mother and parent psychological control were (r = .92), father psychological

control and parent psychological control (r = .93).

4.3 Descriptive Statistics

Means and standard deviations of all variables are presented in Table 1.

Twenty percent of participants scored ≥ 75 on the RADS, indicating they were

experiencing clinical levels of depressive symptoms. It is noted that the mean of

family cohesion obtained from this sample was lower than the standardized

sample. The mean of the FES in the standardized sample was 6.61 as compared

with 5.3 in this sample. Ross et al. (1999) also used the FES to investigate the

family environment of a non-clinical Australian sample and the mean of the FES

(6.38) in their study was also higher than the mean of the FES in this study.

Table 1

Mean Score and Standard Deviation of all Variables

Variables	Mean	Standard Deviation
Depression (RADS)	62.32	13.44
Family Environment: Cohesion (FES)	5.36	2.46
Family environment: Conflict (FES)	3.81	3.34
Parental Psychological Control (PCS)	23.05	5.06
Multi-group Ethnic Identity Measure (MEIM)	36.48	6.02
Acculturative Stress Scale (SAFE)	45.03	13.40

4.4 Correlation Analyses

Pearson's correlation coefficient is a basic correlation technique for describing the strength and direction of a relationship between two variables. In this study Pearson's correlation coefficient was used to estimate the strength and direction of relationships between depression, acculturative stress, family cohesion and conflict, parental psychological control and ethnic identity. Correlations between depression, acculturative stress, family cohesion, family conflict, parental psychological control and ethnic identity are presented in Table 2. Family cohesion demonstrated a negative relationship with depression symptoms. Family conflict demonstrated a significant positive correlation with depression scores and a negative relationship with family cohesion. Correlations between parental psychological control and depression were modest, but significant. Consistent with previous research, acculturative stress was moderately related to depressive symptoms. Ethnic identity was not associated with any measured variables so it was excluded from subsequent analyses.

Table 2

Intercorrelations Between Family Cohesion, Family Conflict, Parental

Psychological Control, Acculturative Stress, Multi-group Ethnic Identity

Measure and Depression

	RADS	Cohesion	Conflict	Parent-PCS	SAFE	MEIM
RADS	__	-.48**	.24*	.31**	.41**	-.04
Family Environment: Cohesion		__	-.47**	-.19*	-.13	.10
Family Environment: Conflict			__	.30**	.05	-.07
Parent-Psychological Control				__	.19*	.18
Acculturative Stress					__	.09
Multi-group Ethnic Identity Measure						__

Note: *N*=110. Pearson correlation coefficient. Significance levels are based on

two-tail test.

** correlation is significant at 0.01 level.

* correlation is significant at 0.05 level.

RADS = Reynolds Adolescent Depression Scale, Parent-PCS = Parent

Psychological Control Scale,   SAFE = Acculturative Stress Scale, MEIM =

Multi-group Ethnic Identity Measure.

4.5 Regression Analyses

A hierarchical regression analysis was conducted to examine the influence of perceived family relationships on depressive symptoms, and whether acculturative stress contributed additional variance in depression scores. In the first step, family cohesion, family conflict and parental psychological control were entered as predictors. Family conflict lost its significant association with depression when entered simultaneously with other family variables. Family cohesion and parental psychological control significantly predicted depression and accounted for 29% of total variance ($F(3,106) = 14.30$, p<.001). As the unique contribution of acculturative stress to depression was the main interest of this study, this variable was entered in the second step. Family variables (family cohesion, conflict and parental psychological control) and acculturative stress accounted for 39% of the total variance ($F(4,105) = 16.58$, p<.001). Both R^2 and *F* significantly increased ($p = <.001$). After accounting for family variables, acculturative stress contributed an additional 10% of the variance in depression scores.

Table 3

Hierarchical Analyses of Cohesion, Conflict, Parental Psychological Control,

Acculturative Stress and Ethnic Identity on Depression (N=110)

Predictors	β	R	R^2	F	Df	R^2 Change	F Change	p
Step one								
Cohesion	-.46***							
Conflict	-.04							
Parental PCS	.24**							
		.54	.29	14.30	3,106			
Step two								
Cohesion	-.42***							
Conflict	-.029							
Parental PCS	.18*							
Accul. Stress	.32***							
		.62	.39	16.58	4,105	.10	2.28	.001

*** = *p* <.001, **= *p* < .01, *=p < .05

In summary, family cohesion, family conflict, parental psychological control and acculturative stress were significantly correlated with depression. Family conflict lost its significance when family variables were entered into the regression model. Acculturative stress adds 10% of variances into the equation. Ethnic identity was not associated with any variables investigated in this study.

CHAPTER 5: DISCUSSION (Part A and B)

5.1 Methodological Issues

Before discussing the results, a comment about the sample should be noted. Only 35% of distributed questionnaires were returned. However, most researchers who have investigated ethnic minority adolescents have experienced similar recruitment problems. For example, 60% of parents in Sam and Berry's (1995) study refused to let their children participate in the study. Most of the refusals were due to the problem of unfamiliarity with the concept of psychological research in Western societies (Sam & Berry). In addition, most participants in this study were recruited from the Vietnamese Community Church and schools that have a large proportion of Vietnamese Australian students. Hence, there might be uncertainty about the representativeness of the sample.

These methodological caveats notwithstanding, the findings of this study are compelling as they revealed that a large percentage of adolescents reported clinical levels of depression. The findings also identified concurrent relationships between family functionality, acculturative stress and depression. Furthermore, the current study is unique in that both quantitative and qualitative results were obtained. The combination of both methodologies allowed interpretations of findings that may not be possible using a quantitative method alone.

5.2 Self-reported Rates of Depressive Symptoms

The present study revealed that 20% of Vietnamese Australian adolescents reported experiencing clinical levels of depressive symptoms. This percentage is high compared with only 12% of the RADS standardised sample reporting the same level of depressive symptoms (Reynolds, 1986), suggesting that acculturating Vietnamese Australian adolescents may be at increased risk for developing depressive disorders. This finding is consistent with a number of previous cross-cultural studies (e.g., Chang, 1996; Greenberger & Chen, 1996; Hovey & King, 1996; Okazaki, 1997; Sam & Berry, 1995), which also found higher levels of depressive symptoms among ethnic minority adolescents than their mainstream counterparts.

It should be mentioned that the current study used a self-report questionnaire to measure depression as a cluster of affective, cognitive and somatic symptoms. Therefore, specific clinical information about the onset, duration and severity of the depressive symptoms was not possible to obtain. However, the RADS was developed to assess the symptoms that are thought to reflect the central features of depressive disorders (Compas, Ey & Grant, 1993; Reynolds, 1986). Hence, the results of the present study have relevance for clinical application and future research on Vietnamese Australian adolescents.

5.3 General Family Conflict in Relation to Depression

Contrast to the hypothesis, family conflict was not significantly associated with depression in the standard regression model. In the zero order correlation, family conflict was modestly correlated with depression, however, family conflict lost its significance when family cohesion and parental psychological control were simultaneously entered into the regression model. This finding is inconsistent with previous research (e.g., Reiss et al., 1995; Sheeber et al., 1997).

Generally, previous research has shown a concurrent relationship between family conflict and depression in clinical as well as community samples (e.g. Reiss et al., 1995; Sheeber et al., 1997). This relationship would be expected to be even more prominent in migrant populations because family conflict is exacerbated by acculturation gaps among family members. However, significant concurrent relationship between family conflict and depression was not evident in this current study. Perhaps direct parent-child conflicts or conflicts that reflect cultural differences are more important in influencing Australian Vietnamese adolescents' mental health than the general family conflict measured in this study. Many participants in the focus group interview reported that their parents were too strict and over protective. Their parents determined their career paths and expected them to behave like a traditional Vietnamese boy or girl. The participants generally thought that their parents could not accept the fact that they (the participants) have been integrating new values and behaviours of the mainstream culture (European Australian). Therefore, the participants wanted more personal freedom and autonomy.

It is also possible that Vietnamese families may not voice disagreements overtly because in Vietnamese culture, expression of emotions such as anger or dissenting opinions is not encouraged. The mean family conflict score in this current study is relatively low compared with standardised scores. Thus, there may be differences in the way conflicts manifest in Vietnamese families and European Australian families.

5.3 Family Cohesion in Relation to Depression

As hypothesised, family cohesion was significantly associated with depressive symptoms. Participants who viewed their family as cohesive reported fewer depressive symptoms. These findings are consistent with the results of studies investigating the influence of family cohesion on mental health outcomes of adolescents in the general population (e.g., Harris & Molock, 2000; Sheeber et al., 1997). This result is also similar to the findings of studies of ethnic adolescents (Greenberger & Chen, 1996).

The results confirmed that adolescents who live in a family with high levels of support, understanding and acceptance have better mental health. In such families, members may be more sensitive to each other's emotional needs and readily share difficult times with each other. Adolescents in a cohesive family might be encouraged to communicate their personal problems and receive support from parents and siblings when personal problems or difficulties arise. Thus, family cohesiveness may strengthen adolescents' resilience in times of difficulty therefore protecting them from developing depression.

One important finding of this study is that the mean score for family cohesion reported was lower than the standardised norm and studies with adolescents in the general population (Ross et al., 1999). Therefore, the low level of reported family cohesion deserves further explanation.

Low levels of family cohesion may also be a result of the acculturation gap and cultural conflicts which are often seen in immigrant families. Many studies (e.g., Liebkind, 1996; Nguyen, 1988; Phinney, Madden & Ong, 2000; Rosenthal, Ranieri, & Klimidis, 1996) have found that Vietnamese parents are more likely to hold on to their traditional cultural values whereas young people are generally more open to embracing the new culture and relinquishing traditional values. The results of the qualitative data revealed that participants and their parents had many conflicting cultural values. The adolescent participants preferred more personal freedom on issues such as choice of career paths or choice of potential romantic partners.

Furthermore, as a cultural norm, Vietnamese parents are less likely to express their emotions, such as demonstrating positive emotions of affection to their children. They are also less likely to attend to their children's emotional needs. The results of the focus group interview supported this cultural practice. Most participants agreed that the relationships between themselves and their parents were emotionally distant. Their parents would not talk to them about personal issues such as sex and love, hobbies and entertainment. Rather, their parents liked to talk about their academic performance or asked them to study harder. Further, their parents would not attend to them even though they

apparently looked distress. Due to these parenting practices, the adolescents in this study might have felt their parents were not supportive and caring.

The communication style in Vietnamese families also represents another factor that may hinder the development of family cohesion. Because verbal communication in Vietnamese families is relatively restrained, younger people are not allowed to talk back to their parents or to assert their point of view. Participants in the focus group interview stated that they commonly did not have much say in their family; they had to listen to their parents even though frustration was always a result of this one-way communication.

Moreover, many participants in the focus group interview also revealed that they and their parents could not communicate well, especially participants who were born in Australia. Generally, adolescents who were born in Australia or migrated to this country before the age of five did not have good command of the Vietnamese language. Thus, many of them did not have the language ability to converse about emotional issues with their parents. On the other hand, many Vietnamese parents do not speak English well enough in order to discuss these issues with their children. Therefore, the language gap between parents and their adolescents might impede effective communication and may inhibit their interactions, therefore reducing the emotional bonding between parents and adolescents and intensifying the emotional distance between them.

Perceived low levels of family cohesion could also be a manifestation of unresolved conflicts. Vietnamese culture stipulates that adolescents defer to their parents' authority. They should not assert their rights, desires or opinions, or

argue with authority figures. Further, adolescents whose parents strongly embrace traditional Vietnamese values, may be more likely to repress their disagreements rather than express them. In this case, when differences between parents and adolescents occur, Vietnamese adolescents might not voice their needs, but rather walk away with resentment, and consequently, perceive their parents as unsupportive. This interaction style might eventually disengage the family members. One participant who scored very high in RADS symptoms wrote in the questionnaire that "I and my father no longer have conflicts because we no longer talk to each other." This participant and many other participants might have become depressed because they learned that the differences between them and their parents could not be resolved.

5.3 Parental Psychological Control in Relation to Depression

This study examined the relationship between perceived parental behaviour and adolescent depression. Rather than employing global parenting styles as a predictor, only parental psychological control was used. The results show that parental psychological control was significantly related to depression in the hypothesised direction. The results of the current study were in line with other previous findings (e.g., Barber, 1997; Barber & Olsen, 1994). The results also support the observation that Vietnamese parents are more likely to use disciplinary techniques such as shaming, scolding, guilt induction, and appealing to the child's sense of obligation as a method of shaping their children's desirable behaviour, than physical punishment (Morrow, 1989). This result was also in line with the findings of the focus group interview. Many participants in the focus

group interview stated that their parents induced guilt in order to shape their behaviours as well as to comply with their parents' wishes. Being compared with others was a common technique that their parents often used to motivate or to shame them.

The results of this study indicate that parental psychological control was related to poor adolescent functioning. This finding is consistent with Barber's (1996) argument that support for autonomy is key to healthy development. This is particularly important during adolescence because establishing independence and individuality is the central task of adolescence (Eccles, Wigfield, Midgley, Reuman, MacIver, & Feldlaufer, 1993). Parental over-control inhibits the development of individuality, self-identity and independence. Parental psychological control thus impedes the development of self-confidence, self-esteem and self-control which are necessary for cultivating well-adjusted children (Barber, 1996; Fieldman et al., 1988). Adolescents with high parental control tend to be more depressed. These adolescents may learn that their desire for psychological autonomy might not be acceptable, thus they may use withdrawal or giving up as defense strategies.

Further, families with high parental psychological control may not effectively assist adolescents in developing good social skills which facilitate the process of acculturation. Effective strategies to cope with stress (such as discrimination), also might not be taught in such families. Thus, adolescents of these families may be more likely to experience acculturative stress than adolescents whose parents are caring, supportive and responsive, and allow them

to develop individuality. The significant correlation between parental psychological control and acculturative stress provides support for this explanation.

It is clear that parenting practices that are characterised by high degrees of affectionless control and manipulation and that are preferred in collectivist cultures, may not be as adaptive in an individualistic culture like Australia. Because children acculturate at a faster rate than their parents, this type of parenting may no longer be perceived as functional by acculturating adolescents. Rather, this type of parenting practice impacts negatively on the psychological well-being of immigrant adolescents.

5.4 Acculturative Stress in Relation to Depression

The results of this study confirmed that higher levels of acculturative stress were positively related to higher levels of depressive symptoms. The hypothesis that acculturative stress would add unique variance above that of family functionality in predicting depressive symptoms was confirmed. The results indicate that acculturative stress plays an important role in the development of depressive symptoms among Vietnamese Australian adolescents. Acculturative stress accounted for an additional 10% of variance in depression scores after controlling for family variables. This finding is similar to the results of Hovey and King (1996) who also found that after controlling for family effects, acculturative stress accounted for 9% of variance in depression scores.

The results are consistent with William and Berry's (1991) model of acculturation. Berry (1986) suggested that acculturative stress is greater when

there is more cultural and behavioural disparity between the culture of an immigrant and those of the host country. Vietnamese culture has been described as differing significantly from Western cultures in terms of language, behaviours, family and social orientation, and role expectations (Nguyen & William, 1988).

Constant struggles in attaining English proficiency and the impact of language difficulties on their school work could be stressful for many Vietnamese Australian adolescents. Furthermore, language difficulty coupled with unfamiliar customs of the mainstream culture can place young immigrants in isolating situations and produce feelings of being outcasts. Some participants in the focus group interview revealed that they were not used to European Australians' behaviours and attitudes, therefore it was difficult for them to fit in. Also, some could not integrate into mainstream society because of their lack of understanding of European Australian interpersonal communication styles. Difficulty in integrating into the Australian mainstream seems to account for the psychological distress in many Vietnamese Australian adolescents.

Perceived discrimination is another stressor that influences the relatively high rates of reported depressive symptoms in this sample. Although Australia officially acknowledges multiculturalism, discrimination in this country is not totally absent. The qualitative data of this present study provided support for this contention. For example, the majority of participants in the focus group interview experienced racial discrimination. These participants reported that they have been the target of discrimination and stereotyping within their school and the larger community. They believed that some teachers deliberately pick on them, and that

European Australian students excluded them from joining their activities. It seems that Vietnamese Australian adolescents experienced paramount stress resulting from racial discrimination at their schools. The experience of racial discrimination combined with language difficulties, and perhaps, the difficulty in adjusting to the school has exposed many young immigrants in this study to chronic stressful conditions which diminished their self-confidence and self-esteem, and increased their mental health problems.

Another stressful aspect of the acculturation process is the sense of not belonging to mainstream society (Smart & Smart, 1995). Perceived discrimination also seems to contribute to social isolation among many Vietnamese Australian adolescents. Many participants reported feelings of being rejected by mainstream peers, which further hindered their ability to integrate into the mainstream culture. Not feeling accepted seems to lead to poorer psychological well-being, regardless of how well these young immigrants may be functioning in other areas of life (e.g., academically). Some young immigrants may be rejected because they do not have adequate language and social skills to form friendships with mainstream peers; however, being rejected also lessens their opportunities to develop necessitated social skills which further places them in situations that induce rejection. Rejection and discrimination can indirectly affect the mental health of young immigrants in many ways. For example, students' academic and sporting talents may be under recognised. Participants in the focus group interview stated that teachers and mainstream students sometimes disregarded their contributions to group discussions. Not being treated equally

can create emotional turmoil for many young immigrants and cause damage to their self-esteem, and further reinforces the feeling of being an incompetent, unworthy and undesirable person.

5.5 Ethnic Identity in Relation to Depression

In contrast to previous research (e.g., Mossakowski, 2003; Phinney et al., 1997), ethnic identity was not significantly related to depression. Perhaps the lack of relationship between ethnic identity and depression was due to sampling techniques used to recruit subjects for this study. Most participants were recruited from the Vietnamese community Church and the majority of them had a strong affiliation with their own ethnic group. These Vietnamese Australian participants may have a stronger sense of ethnic identity than those that do not have such affiliation. It is also possible that ethnic identity is only associated with measures of self-esteem (Phinney et al., 1997; Phinney & Chavira, 1992; Martinez & Duke, 1997) and life satisfaction (Sam, 1998). Thus, ethnic identity might not be an important individual attribute that influences depression in this sample.

Although there was no relationship between ethnic identity and depression, the results of the focus group interview revealed that some Vietnamese Australian adolescents had difficulty in developing a healthy sense of ethnic identity. Statements like "It is very hard to feel proud of yourself as a Vietnamese person when you hear so many bad things [about Vietnamese people]", "Because people [mainstream people] think Vietnamese are bad, some Vietnamese are ashamed to be Vietnamese", indicate that many Vietnamese

Australian adolescents do not have positive attitudes toward the Vietnamese ethnic group or a sense of belonging to that group.

Perhaps the development of ethnic identity is multidimensional and too complex for the MEIM scale (Phinney, 1992) to capture the important aspects of the construct. Although some participants in the focus group interview did not like being Vietnamese and/or they did not like other Vietnamese, they agreed that it is helpful to maintain Vietnamese culture and language, so they could gratify their parents and maintain a good relationship with other Vietnamese Australians. Further, the majority of participants said they liked Vietnamese foods and Vietnamese cultural festivals such as lunar New Year and Full Moon Autumn.

According to Uba (1994), ethnic identity behaviour reflects an individual's attitudes toward his/her ethnicity. An individual may have positive attitudes toward certain aspects of their ethnicity and negative attitudes toward other aspects. Vietnamese Australian adolescents in this sample certainly had both positive and negative attitudes toward their group. It is also possible that psychological well-being depends on whether ethnic identity is an important aspect of an adolescents' self-identity and whether self-concept is derived from ethnic membership. Many Vietnamese Australian adolescents in this sample seem to have a self-concept that is independent of their ethnic membership. However, in contradiction to Phinney's proposition, many adolescents in this study seemed to have a good sense of self-esteem even though they evaluated their group negatively. For instance, one adolescent said, "Inside, I feel proud of myself, but I am not proud of what other Asians are doing".

In summary, ethnic identity appears to have no effect on the mental health of adolescents in this sample. This result is inconsistent with previous findings. Vietnamese Australian adolescents have both negative and positive attitudes toward their ethnicity. Ethnic identity does not seem to be an important aspect of self-esteem in this group. This suggests that while acculturative stress is a significant risk factor, a strong sense of ethnic identity is not necessarily a significant protective factor for depressive symptoms.

5.6 Summary of the Results of Study One

The findings of this current study suggest an unacceptably large number of acculturating Australian Vietnamese adolescents experience clinical levels of depressive symptoms. Family functionality accounted for 29% of the total variance, and acculturative stress added another 10% of variance to the model. Acculturative stress uniquely contributed to depression above family functionality, suggesting that acculturating adolescents are at higher risk of developing depressive disorders. This study indicates that family cohesion and acculturative stress play an important role in the development of depressive symptoms. The results of the focus group interview also indicated that Vietnamese Australian adolescents have substantial amount of parent-adolescent conflicts which reflect cultural conflict. The participants also experience many racial discrimination instances, especially at their own school. The findings of this study highlight the need to address the issue of high incidence of depressive symptoms in Vietnamese Australian adolescents and factors that contribute to their elevated depressive symptoms.

Similarly to adolescents in the general population, family environment characterised by low levels of family cohesion and high levels of parental control are detrimental to Australian Vietnamese adolescents' well-being. Importantly, the results also showed that the level of family cohesiveness was lower than the standardised sample and other Australian samples (e.g., Moos & Moos, 1981; Ross et al., 1999). The mechanisms by which Vietnamese Australian family interactions that might decrease family cohesion, and thus, increase risks of developing depression are not clear from the results of the current quantitative study. However, the results of the focus group interview revealed that Vietnamese Australian adolescents have many conflicts with their parents regarding issues such as choice of friends and careers, emotional closeness, hierarchical communication, and difficulty in resolving parent-adolescent conflict.

Family cohesion is a result of an individual's perception about behaviours and interactions among family members. Thus, the way Vietnamese parents communicate with their children, their conflict resolution styles and specific family conflicts that reflect the gap of acculturation, may account for lower levels of family cohesion. In this current study, family cohesion accounted for a large percentage of variance and seems to play an important role in predicting Vietnamese Australian adolescents' depressive symptoms hence, it merits further investigation.

In addition, acculturative stress also played an important role in the development of depressive symptoms in this sample. Factors such as language

difficulty, being caught between two cultures, being discriminated against, and being rejected and isolated, significantly diminished the psychological well-being of many young Vietnamese Australians.

5.7 Conclusion

Several explanations were suggested to account for the relationship between family functionality, acculturative stress and depression in Vietnamese Australian adolescents. In cross-sectional studies such as this, it is not possible to infer whether family functionality and acculturative stress predicted adolescent depression as the reverse relationship is also possible. Adolescents who experience depressive symptoms may believe their parents do not accept their new values, may feel more alienated, and may be more likely to feel that people in the mainstream discriminate against them.

However, the former interpretation that family functionality and acculturative stress predict adolescent depression is more intuitive. It would be difficult to have a happy state of mind while living in a family environment where cultural conflicts between family members constantly occur. Accumulated disagreements between parents and adolescents can have a significant impact on an individual's mental health. Furthermore, living in a community that seems to reject you and portrays your ethnic group negatively would also decrease an individual's state of well-being.

As adolescent depression has significant costs for individuals, their families and society, reducing the rates of adolescent depression would clearly be beneficial. The elevated rate of depressive symptoms among Vietnamese

Australian adolescents underscores the need to identify specific pathways to depressive symptoms for this population. The results of the focus group interview highlight the difficulties that many Vietnamese Australian adolescents were experiencing. Particularly, issues regarding cultural differences between parent-adolescent. Thus, it would be fruitful to further investigate specific family interactions that contribute to low levels of family cohesion. Another important theme that emerged in the focus group discussion was perceived discrimination, especially at school. Successful school adjustment is often regarded as a form of cultural adaptation; however, discrimination at school may hinder acculturating adolescents to adapt to their school (Liebkind, Jasinskaja-Lahti & Solheim, 2004). Therefore, the impact of perceived discrimination at school on Vietnamese Australian adolescents' adjustment to school should be further investigated. An understanding of these risk factors could aid in developing an effective intervention program for this specific population. The second study will further illuminate the findings around family factors, acculturative stress, sense of school connectedness and discrimination which were suggested by both quantitative and qualitative studies.

STUDY TWO

CHAPTER 6: PRECUSORS OF FAMILY COHESION AND

ACCULTURATIVE STRESS

6.1 Objectives of Study Two

The findings of Study One suggest an unacceptably large number of Vietnamese Australian adolescents experience clinical levels of depressive symptoms. Family cohesion and acculturative stress each independently account for a large percentage of variance in the depressive symptoms, suggesting that these two variables play important roles in the development of Vietnamese Australian adolescents' depression. The findings of Study One highlight the need to further investigate factors around family cohesion and acculturative stress and the possible interactions of these variables.

Furthermore, previous research has overlooked the impact of factors that operate simultaneously within contexts such as families, schools, and wider society, on the mental health of ethnic minority adolescents. Consequently, the effect of non-family contexts on the mental health of ethnic minority adolescents within and across contexts, is not known. It is clear that parent-adolescent interaction is an important factor that influences adolescent well-being. However, children's development is not only a product of the parent-child relationship, but is also influenced by the broader context in which they function (Bronfenbrenner, 1979). As adolescents constantly grow through interactions with their families and other social systems such as school and neighbours (Bronfenbrenner), it is therefore, important to examine the relationships between adolescents'

interactions within their families and their larger social contexts. Hence, this study aimed to:

1. Investigate the specific family interactions that are thought to contribute to the low levels of family bonding observed in Vietnamese Australian families which consequently contribute to Vietnamese Australian adolescents' depressive symptoms (Pathway 1).

2. Investigate the influence of discrimination, acculturative stress and sense of school connectedness on the mental health of Vietnamese Australian adolescents (Pathway 2).

6.2 Pathway 1: Migration Contextual Factors That Affect Family Cohesion

In the first study, family cohesion played a key role in predicting depressive symptoms in a sample of Vietnamese Australian adolescents. Also, the average reported family cohesion score in Study One was relatively low as compared with the standardised norm and other research. Family cohesion is a result of the perception of behaviours and interactions among family members. As people are influenced by the social and cultural context in which they live (Bronfenbrenner, 1979), similar family interactions may be interpreted differently depending on the context. Perhaps the low levels of perceived family cohesion observed in Study One were due to traditional Vietnamese parenting practices that are not perceived as adaptive by acculturating adolescents. The following are considered as possible migration contextual factors and acculturation factors that contribute to the low family cohesion observed in Vietnamese Australian families.

6.2.1 Transcultural Parent-Adolescent Conflict

When people migrate to another cultural context, they usually change their behaviours and ways of living to adapt to their new milieu (Berry, 1980).Typically, individuals of a minority group acquire a set of ethnically linked values, attitudes and patterns of behaviour from childhood through adulthood (Uba, 1995). At the same time, the values and norms of the dominant culture also influence minority individuals through daily contact with that culture. The school system, peer groups and the media are pervasive socialisation forces and regulators of behaviours, attitudes and standards. They greatly shape and influence the values and behaviours of minority individuals (Matsuoka, 1990).

However, problems arise when members of a family acculturate to the dominant culture at different rates. In general, immigrant adolescents have more daily contact with the mainstream culture through school and extra curricular activities than their parents (Drachman, Kwon-Ahn & Paulino, 1996). They establish peer networks that include members of the dominant culture and are likely to become accustomed to the languages, behaviours, attitudes, habits and values of the dominant culture faster than their parents (Nguyen & William, 1988; Sluzki, 1979). Immigrant adolescents are more likely than their parents to abandon their traditional cultural values that are not seen to be adaptive in the host culture (Matsuoka, 1990).

Nguyen and William (1988) used the Traditional Vietnamese Family Value Scale to explore the differential acculturation of Vietnamese parents and

their adolescents in the USA. They found that Vietnamese parents scored significantly higher than Caucasian controls on Vietnamese values. This pattern of endorsement remained stable regardless of the time Vietnamese parents lived in the USA. In contrast, Vietnamese adolescents' scores on this scale decreased as a function of the length of their stay in the USA. The longer they stayed in the USA, the more the family values of Vietnamese adolescents resembled those of their Caucasian peers. With respect to gender, Vietnamese girls were less likely to endorse the traditional family values than boys, and this difference increased with the number of years they had lived in the USA. A similar result was also found in a sample of Vietnamese adolescents who live in Australia (Rosenthal, Ranieri & Klimidis, 1996). Rosenthal et al. used the Traditional Vietnamese Family Values Scale and the Adolescent Independence Values Scale to assess the value discrepancy between Vietnamese parents and their adolescents. Results showed that Vietnamese Australian adolescents perceived themselves as less traditional and more independent than their parents suggesting that they are more acculturated to the mainstream than their parents.

Dinh, Sarason and Sarason (1994) compared the perceived quality of parent-adolescent relationships measured by the Quality of Relationship Inventory and Parental Bonding Instrument between Vietnam-born immigrant and American-born college students. The Vietnam-born students reported less acceptance and support by their parents than non-Asian American-born students, with Asian American-born reporting a middle range. Similar results were found in a study conducted by Greenberger and Chen (1996). The quality of family

relationship was not different among a sample of early Asian American and European American adolescents. In contrast, late Asian American adolescents described their parents as less warm and accepting, and their overall family environment as less cohesive and more conflictual than their European American peers. The Asian American adolescents portrayed their mothers as understanding them less well, less expressive of affection toward them and more demanding of them to fulfill mothers' standards and expectations. This finding contradicted the assertion that Asian families are more cohesive than European families (Greenberger & Chen).

Furthermore, Pyke (2000) found that Vietnamese and Korean Americans used images of normal American families portrayed by media, and non-Asian friends' families as an interpretive framework, giving meaning to experiences with their parents. Generally, participants preferred the emphasis on independence, autonomy, open communication and emotional expression in American families. The participants used this family ideology as a standard for normal and good parents, leading them to view their immigrant parents as overly strict, unloving, emotionally distant and deficient. Some participants reported that their parents were not attending to their emotional needs even in situations in which their emotional distress was apparent. When asked if they would change anything about their parents, most participants wished their parents were emotionally closer, less strict and traditional, and more liberal, open-minded, communicative, expressive and affectionate (Pyke). A study conducted in Australia examined the effect of parenting practices of Vietnamese immigrant

and Australian parents on their adolescents and found that Vietnamese Australian participants reported higher levels of parental control and lower levels of family bonding than their Anglo Australian counterparts. This study also showed that Vietnamese Australian adolescents have a lower sense of self-esteem than their Anglo Australian peers (Herz & Gullone, 1999).

Different values between immigrant parents and their adolescents often results in greater miscommunication and intergenerational conflicts. This type of conflict reported in Asian immigrant families cannot be explained by the usual parent-adolescent conflict that is seen to reflect the intergenerational-conflict hypothesis that is used to understand parent-child conflict within Western cultures (Lee, Choe & Ngo, 2000; Lee & Liu, 2001). Rather, family conflicts within Asian immigrant families can be more adequately explained by the acculturation disparity between parents and their adolescents. Conflicts occurring within these families may reflect disagreements in values and behaviours between Australian-raised adolescents and their Vietnamese parents because parents tend to embrace traditional Vietnamese values and their adolescents are more likely to adopt Australian values. Previous research suggests that an acculturation gap among members of immigrant families exacerbates normal parent-adolescent conflict (William & Nguyen, 1988). Lee and Liu found that Vietnamese American college students reported more transcultural conflicts (measured by the AAFCS) than other Asian ethnic minority groups. This type of transcultural parent-adolescent conflict may directly impact on the mental health of Vietnamese Australian adolescents and may be more important in predicting

their levels of depression than general family conflict. This type of transcultural parent-adolescent conflict may also contribute to the low levels of cohesiveness observed in Vietnamese immigrant families.

6.2.2 Conflict Resolution Styles

As adolescence is a time when young people strive for independence and autonomy, parent-adolescent conflicts seem to be inevitable during this time (Laursen & Collin, 1994). How conflict is resolved or managed within the family may account for the well-being of family members. Previous research has suggested that culture influences how people resolve their conflicts (Dsilva & Whyte, 1997). People from individualistic cultures prefer a direct conflict resolution style whereas individuals from collectivistic cultures prefer an avoidant conflict resolution style. A study that investigated conflict resolution styles in a Vietnamese American sample found that Vietnamese adults tend to withdraw and avoid confrontation in conflict situations. When conflicts arise, they avoid the issue and remain quiet. Vietnamese in this sample stated that they do not want to question authority and they fear offending others. This conflict resolution style reflects the nature of Vietnamese culture (Dsilva & Whyte). Yau and Smetana (1993) found that Chinese American adolescents prioritised parental expectations over their own personal desires in conflict situations. The Chinese American adolescents' major justification for using an avoidant, non-confrontational conflict resolution style was to maintain harmonious family relationships. It was also found that when conflicts arise, although Taiwanese students experience negative emotions such as sadness, shame and regret, they

would still be considerate of their mothers' face in choosing ways to manage the conflict (Tsai, Yu & Maynard, 1999).

Similar to the Chinese culture, the Vietnamese cultural norms also require adolescents to defer to their parents' authority and restrain negative emotions. Thus, when differences arise, they are less likely to assert their rights, desires, or opinions, opting to give in to their parents' request in order to avoid conflict. This avoidant conflict resolution style may bring family harmony and parental acceptance, but may lead to a build up of resentment and sadness in acculturating adolescents. This type of conflict resolution may lead to the perception of low levels of perceived cohesion in Vietnamese families. Although there have been a few studies on parent-adolescent conflict in Vietnamese immigrant families, there is no empirical research on conflict resolution styles among Vietnamese adolescents who have been raised in Western countries. The influence of conflict avoidance on mental health and perceptions of family cohesion has not been investigated.

6.2.3. Communication Style

Communication styles in Vietnamese families may also reduce cohesion within the family. Communication among family members is considered a crucial facet of interpersonal relationships and is seen as a key to understanding the dynamics underlying family relationships (Clark & Shields, 1997). Communication is important for the development of family cohesion as poor communication can lead to feelings of isolation and disintegration within the family. Good communication between parents and their adolescents facilitates

development of family cohesion and adaptability (Olson, Mccubbin & Barnes, 1983). Also, good parent-adolescent communication leads to a closer family relationship, higher levels of family cohesion, and satisfaction (Barnes & Olson, 1985). Good communication enables family members to articulate their expectations and needs, and love and admiration for each other. Open communication creates an atmosphere that allows family members to express their differences as well as to resolve disagreements constructively. Good communication can mitigate the serious conflict between parents and adolescents (Jackson, Bijstra, Oostra, & Bosma, 1998). Open communication within families helps adolescents to develop a clearer sense of self (Barnes & Olson) and improves adolescents' social skills. These skills are correlated with a healthy sense of self-esteem (Bijstra, Bosma, & Jackson, 1994). Good communication at home enables adolescents to have a clear role within the family. It also facilitates the process of individualisation and at the same time facilitates an adolescent's development of a sense of connectedness to the family (Grotevan & Cooper, 1985).

A number of studies have suggested that family communication is related to adolescent psychological outcomes. For example, poor communication with parents was found to be related to self-harm in a sample of Australian adolescents (Tulloch, Blizzard & Pinkus, 1997). Also, poorer parent-adolescent communication was found to be associated with lower levels of family cohesion, internal locus of control, and depressive symptoms (Tulloch et al.,), as well as a lower sense of self-esteem (Kernis, Brown & Brody, 2000). Adolescents who

perceive their communication with their mother as open are more likely to agree with their mother about decisions on family matters such as finance, future choice of spouse, and personal decisions, than adolescents who perceive communication with their mother as less open or problematic (White, 1995). A negative correlation between parent-adolescent open communication and forms of delinquency has been found. Adolescents who have problems in communicating with parents have a significant tendency toward engaging in serious forms of delinquency. Good communication with parents on the other hand is significantly associated with less serious forms of delinquency (Clark & Shield, 1997).

While open family communication has been found to be related to better adjustment in adolescents in Western countries, patterns of communication within Vietnamese families seems to resemble the closed communication style proposed by Barnes and Olson (1985). In traditional Vietnamese culture, non-confrontational communication is emphasised and valued. Non-confrontational communication refers to the expression of one's thoughts and feelings in an implicit manner especially when people disagree. This pattern of communication aims to protect family harmony (Nguyen, 1990). Also, verbal communication in Vietnamese families is relatively restrained. For example, parents do not talk to their children as much as European parents may do and emotional issues and personal problems are often avoided in Vietnamese families (Nguyen). As Vietnamese Australian adolescents are acculturating into the mainstream culture, this pattern of communication may not be perceived as adaptive by these adolescents and therefore, may reduce levels of cohesion in Vietnamese families.

Rhee, Chang and Rhee (2003), examined levels of acculturation, openness in communication with parents, interaction with peers and self-esteem among Asian American high school students and their Caucasian peers and found that Asian American adolescents had greater difficulty communicating with their parents compared to their Caucasian peers. They reported that they are more cautious about what they say and in expressing their beliefs to their parents. They also indicated that their parents are not good listeners and sometimes said things that were better left unsaid. Generally, these Asian adolescents were significantly less open in communicating with their parents than their Caucasian counterparts. Also, it was found in this study that Asian students who communicated more openly with their parents had a higher sense of self-esteem than those who have difficulty in communicating with their parents (Rhee et al.).

In summary, clearly from the reviewed theoretical perspectives and empirical studies supporting them, general family conflict, transcultural conflict, conflict resolution styles and communication styles in Vietnamese culture might influence how acculturating adolescents perceive the interaction within their family. These factors might contribute to the low level of family cohesion observed in Vietnamese families.

Figure 1 depicts a conceptualisation of the influences of family functionality on Vietnamese Australian adolescents' depressive symptoms. The diagram was developed to illustrate theoretical links between family interactions (general conflict and transcultural conflict, communication styles, conflict resolution), family cohesion and adolescent depressive symptoms.
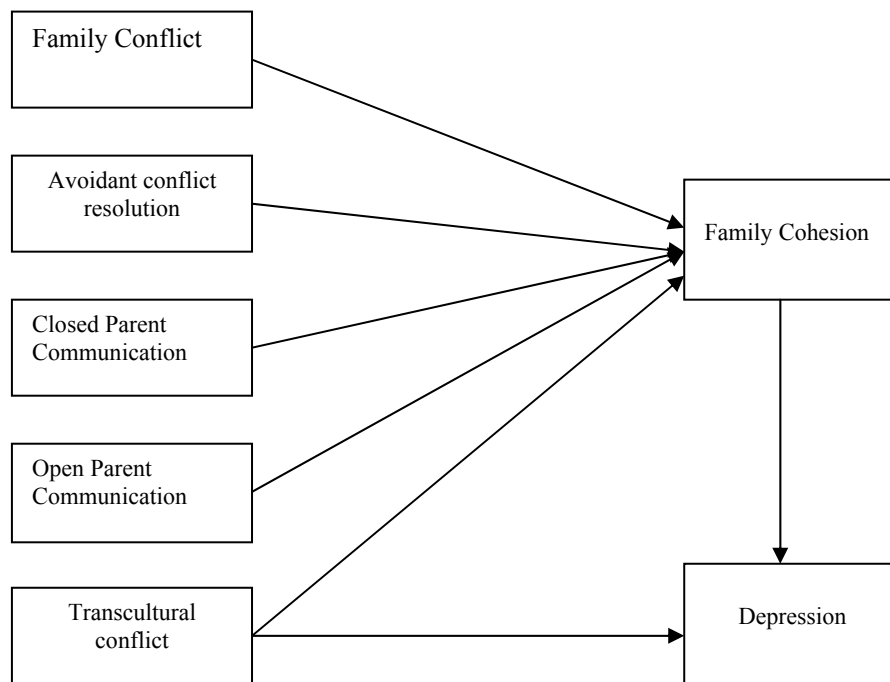
Figure 1: Hypothetical Relationships Between Family Variables and Depression

6.3 Hypotheses

It was hypothesised that:

1. Transcultural parent-adolescent conflict directly correlates to depression.

2. Family cohesion mediates the direct effects of transcultural conflict, general family conflict, avoidant conflict resolution, and closed and open parent communication, on depressive symptoms.

6.4 Pathway 2: The Impact of Discrimination on Acculturative Stress and School Connectedness

6.4.1 Overview

The results of Study One demonstrated a significant link between acculturative stress and depressive symptoms among Vietnamese Australian adolescents. The qualitative data also revealed that many Vietnamese Australian participants were a target for discrimination at school. As a result of being rejected by school peers, many participants felt alienated and socially isolated. According to the framework of acculturative stress (William & Berry, 1991), discrimination is a specific stressor that contributes to acculturative stress. Racial discrimination can traumatise, humiliate, and alienate individuals from society, and create a feeling of isolation from the school environment and ultimately prevent optimal growth and functioning of individuals (Adam, 1990). Therefore, the second pathway aims to examine the impact of discrimination on acculturative stress and school connectedness in an attempt to increase understanding of this pathway to depression for Vietnamese Australian adolescents.

6.4.2 Discrimination

It is well recognised that stress is the most common cause of ill health in our society (Posen, 1995). In addition to stressors that are common to all, ethnic minority groups may experience stress resulting from their ethnic status. These stressors include prejudice and discrimination (Berry, 1990). An increasing

amount of literature indicates that perceived discrimination is an acute and chronic stressor linked to mental and physical health problems (Fisher, Wallace & Fenton, 2000; Jackson, Brown, William, Torres, Sellers, & Brown, 1996; Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Szalacha, Erkut, Coll, Alarcon, Fields & Ceder, 2003). The relationship between discrimination and psychological and physical health has been investigated in many different ethnic groups, in different countries, and in adults as well as younger people. Methods for investigating this subject also varied. Some studies focused on physiological responses to racism and its health implications, others investigated the correlation between perceived discrimination and psychological distress in large community samples. Jackson, Brown, and Kirby (1998) defined discrimination as "intentional acts that draw unfair or injurious distinctions that are based solely on ethnic or racial basis and that have effects favorable to in-groups and negative to out-groups" (p.110).

Discriminatory acts may be expressed in direct forms of behaviour or in more subtle and elusive attitudes and behaviours (Noh et al., 1999). It has been proposed that personally experiencing discrimination and perceiving oneself to be a target of discrimination by a member of a mainstream group is a psychological stressor. Experiencing discrimination is stressful because it elicits cognitive appraisal of threat (Dion, Dion & Park, 1992). Chronic experiences of discrimination may damage one's self-esteem with the internalisation of negative self-images due to racist beliefs and may also elicit feelings of being worthless, helpless, powerless, looked down upon, sad and fearful (Noh et al.).

A laboratory study was designed to elicit affective and physiological responses to racism in 60 African American women (Jones, Harrell, Morris-Prather, Thomas & Omowale, 1996). Affective response was measured using a self-report questionnaire while a monitor of heart rate and blood flow, and facial electromyography were used to record physiological responses. Participants were randomly assigned to three groups and were presented two videos depicting different levels of blatant racist scenarios, and one neutral scenario. The results of this laboratory study indicated that both of the firm presentations of racially noxious material elicited significant changes in physiological responses. Participants' mood states in the neutral scene differed significantly from those experienced in racist scenarios. Participants rated themselves as feeling more angry, distressed and tense than the group who viewed the neutral presentation (Jones et al.).

Parallel results have been found in epidemiological and community research. Jackson et al. (1996) evaluated the effects of racist discrimination on the physical and mental health status of African Americans in a national sample followed from 1979 to 1992. Respondents who reported poor treatment due to race had lower levels of life satisfaction and happiness and a greater number of physical problems. Racism was still significantly related to health status after controlling for sociodemographic variables. Similar results were also found in samples of Asian Americans. Results from interviews with 647 Southeast Asian refugees (Chinese, Vietnamese and Laotian) provided empirical evidence for a relationship between perceived discrimination and depression (Noh et al., 1999).

The data for this study were derived from the study of the Refugee Resettlement Project (RRP), a decade-long study of the psychological, economic and social adaptation of Southeast Asian refugees in Canada. The baseline sample included 1,348 adult refugees who resettled in Canada between 1979 and 1981. Sixty-two and a half (62.5) percent of participants in the baseline sample were located for the second interview between 1991 and 1993. Discrimination, depression, ethnic identity and coping response were measured in the second study. Noh et al. found significant positive relationships between discrimination and depression. The effect of discrimination was not affected by sociodemographic factors.

Mossakowski (2003) studied the link between discrimination and depressive symptoms in a sample of 2,109 Filipino Americans. The result of this study indicated that chronic every day unfair treatments influenced on the mental health of the participants. A study of Vietnamese immigrants in Finland found experiences of prejudice and discrimination had more impact on psychological well-being than traumatic pre-migration experiences (Liebkind, 1996). A study in a sample of Mexican Americans also yielded similar results, finding that discrimination was directly related to depression as measured by the Center of Epidemiologic Studies Depression Scale (Finch, Kolody & Vega, 2000).

A few studies investigating the effects of racial discrimination on mental health of children and adolescents have also found comparable results. Szalacha et al. (2003) studied the link between discrimination and mental health in 289 grade 1 to 4 Puerto Rican students. Only 12% of these children reported having been a victim of discrimination. However, results showed that there were

negative differences in mental health for children who reported perceived discrimination. In contrast to this sample, 49% of the adolescent sample (13-14 years of age) experienced racial discrimination in at least one situation. Perceived discrimination was linked with a lower sense of self-esteem (Szalacha et al.). Liebkind and Jasinskaja-Lahti (2000) showed that perceived prejudice and discrimination systematically increase stress and behaviour problems, and decrease self-esteem and life-satisfaction in adolescents. Raubaut (1994) found a relationship between discrimination and depressive symptoms among young people of Asian American, Latin American and Caribbean American backgrounds. Fifty-five percent of the adolescents in Raubaut's study reported having experienced discrimination. These self-reports of discrimination were significantly related to depressive symptoms. Fisher et al. (2000) found more than 50% of African and Latino Americans in their sample perceived themselves to have been discriminated against in public places such as restaurants. Many of these adolescents also perceived themselves to have been discriminated against in school as they had been discouraged to take advanced classes and were disciplined wrongly by their teachers. The results of Fisher et al.'s study showed that perceived discrimination was associated with psychological distress and low self-esteem.

In summary, the above findings indicate that racial discrimination is stressful and adversely affects the mental and physical health of ethnic minorities. However, most of these studies have been conducted in North America, and therefore it is important to examine the effects of racism on the mental health of

ethnic young people in Australia. In the first study, many participants in the focus group interview verbally reported that they were treated unfairly in their schools as well as in public places. Some participants were not able to develop a good relationship with their teachers and peers because of their perceived rejection. Some participants described a lack of a sense of belonging to their local community due to the language difficulties and cultural differences.

6.4.3 Sense of School Connectedness

An important task for immigrant children is adapting to school in their host country. School adjustment is often regarded as a form of cultural adaptation (Liebkind, Jasinskaja-Lahti & Solheim, 2004). However, adjustment to school is a difficult experience for many ethnic immigrant children and they are often poorly adapted to school systems in the host country (Hyman, Vu & Beiser, 2000). School adaptation depends on the attitudes and characteristics of immigrant adolescents and the responses of mainstream people. Theoretically, perceiving one self to be the target of discrimination is likely to detrimentally affect an individual's identity formation, occupational goals, physical and psychological well-being, and school achievement. Further, it is likely to be detrimental to an immigrant adolescents' ability to develop peer relationships with mainstream adolescents (Brown & Bigler, 2005). Not feeling accepted by mainstream people could influence many aspects of immigrants' lives. For example, in the workplace, rejection can adversely affect hiring, promotion and salary levels, and in the social arena, rejection can make it difficult for immigrants to form interpersonal relationships (Mehta, 1998).

It has been suggested that an important part of the human experience is the ability to form and maintain meaningful relationships with others, objects, environments, self and society (Baumeister & Leary, 1995). A sense of social connectedness develops early in life and extends throughout the life span. In the early infant stage, parent-child attachment is an example of social connectedness that provides an initial sense of security and likeness with others. In adolescence, affiliation with peer groups, social groups and school membership allows individuals to identify with others. By adulthood, the experiences of past and present relationships are incorporated into a person's sense of self providing a stable sense of psychological connectedness (Lee & Robbins, 1998). Disruption to a person's ability to maintain connectedness and relatedness to others and their social settings may lead to biological, psychological and social disturbances (Sargent, Williams, Hagerty, Lynch-Sauer & Hoyle, 2002).

Sense of belonging has recently been described as one specific interpersonal process that affects psychological well-being (Hagerty, Williams, Coyne & Early, 1996). Anant (1966) defined sense of belonging as the experience of personal involvement in a system/s to the extent that a person feels themselves to be an integral part of that system/s. Hagerty, Lynch-Sauer, Patusky, Bouwsema and Collier (1992) later expanded Anant's concept of belonging to include two additional dimensions: (1) the experience of a person being valued, needed and accepted; and (2) the experience of fitting in or being congruent with other people, groups, and the environment through shared complementary attributes.

Previous research has generally found a relationship between a sense of belonging and psychological well-being (Hagerty, Lynch-Sauer, Patusky, & Bousena, 1993; Hagerty et al., 1996; Sargent et al., 2002). Lack of a sense of belonging to a person's social settings has been shown to be related to loneliness, distress and ill health (Sargent et al., 2002). One study examined the relationship between sense of belonging and social and psychological functioning in a sample of 379 college students (Hagerty et al.). A sense of belonging was related to both psychological and social functioning. Negative social support and interactions with peers and high levels of conflict were related to a lower sense of belonging. With regard to psychological functioning, a lower sense of belonging was positively related to depression, anxiety and loneliness (Hagerty et al.,). Similar results were also found in a more recent study that examined a group of depressed clients and college students. The results of this study indicated that a low sense of belonging was strongly associated with higher levels of depression. Sense of belonging plays a more important role in the experience of depression than social support, loneliness and conflict (Hagerty & Williams, 1999).

People belong to various psychological and social communities that fulfill their psychological needs and their social identities. Membership in one's communities may be attained (e.g., locality, profession) or ascribed (e.g., race) (Fisher & Sonn, 1999). In this sense, school is one specific community which students naturally belong to. If lack of a sense of belonging to a person's systems affects their psychological and social functioning, then theoretically, the school environment should exert a powerful influence on adolescents' mental health

because adolescents spend a substantial amount of time at school. Roeser, Eccles and Sameroff (2000) argued that school is an important social environment that affects adolescent development. If students' needs are met and if they feel respected and cared for by teachers and classmates alike, and if they have some choices in their classrooms, they are more likely to develop a sense of connectedness to school and less likely to connect with deviant peers. Students who experience school as a caring and supportive environment in which they have the opportunity to participate and exercise their influence, will feel connected to their school and will more readily accept school norms. Also, school bonding is positively associated with students' prosocial behaviours and potential academic achievement, and negatively associated with problematic behaviours such as vandalism, fighting, truancy, bullying and substance abuse (Roeser et al.).

Moreover, Roeser, Midgley and Urdan (1996) found that school environments that were perceived as supportive, with caring, positive teacher-student relationships, predicted adaptive patterns of cognition, affect and behaviour. When sense of community was created in the classroom, (that is, a caring and supportive environment was fostered), students liked their school better. Also, students with a strong sense of community are inclined to abide to the school norms and values (Solomon, Watson, Battishtich, Schaps & Delucchi, 1996). Thus, school climate has an important influence on student's sense of belonging.

The importance of developing and maintaining a sense of school membership is also noted by Wehlage, Rutter, Smith, Lesko and Fernadez

(1989). These researchers suggest that students need to develop a sense of school membership which includes attachment to teachers and peers, commitment to school norms, involvement in school activities, and belief in the legitimacy of school values. Indeed, an accumulating body of evidence supports the link between school connectedness and positive psychological, social and academic outcomes. Kuperminc, Leadbeater and Blatt (2001) conducted a cross-sectional and longitudinal study to examine the interaction of psychological functioning and perception of school climate in a sample of 460 grade six and seven students. Seven dimensions of school climate, namely achievement motivation, fairness, order and discipline, parent involvement, sharing of resources, student-peer relationships and student-teacher relationship were assessed. As the investigators' expected, students who perceived their school as an orderly place where they were treated fairly, and where relationships with teachers and peers were positive, had less internalising and externalising problems than students who perceived their school negatively.

Similarly, Simons-Morton, Crump, Haynie and Saylor (1999) surveyed several schools in the United States (4263 participants). They found that school bonding was positively associated with students' prosocial behaviours and high academic achievement, and negatively associated with problematic behaviours such as vandalism, fighting, truancy, bullying and substance abuse. The findings of this study were consistent with the suggestion that a sense of belonging to school may be protective against psychological and behavioural problems. Positive feelings toward school and feeling respected and accepted by teachers

and peers not only influence students' psychological and social well-being but also predict future success and positive school adjustment (Israelashvili, 1997).

A cross-sectional survey on health and behaviour of school-age children was conducted in Canada to examine the effects of school experiences on a number of health outcomes and behaviours of Canadian young people (Ma & Zhang, 1999). A number of factors such as personal and family characteristics have been found to affect Canadian young people's health outcomes and behaviours. However, school experience was hypothesised to have a critical impact on adolescents' health outcomes and behaviours over and above their personal and family characteristics. Results of this study supported the proposition that school experiences have profound effects on adolescents' health outcomes and behaviours. The influence of school experience on adolescents' health outcomes was over and above their individual characteristics in almost all health outcome measures. Based on the results of this cross-national study, Ma and Zhang concluded that similar to adults, adolescents need to feel that their environment (school being a crucial environment for adolescents), is fair and is one in which they are supported by teachers, peers and other authorities.

Similar to this study, Dornbusch, Erickson, Laid and Wong (2001) analysed the data of the National Longitudinal Study of Adolescent Health to examine the extent to which attachment to family and school influence adolescent behaviours such as cigarette smoking, alcohol use, marijuana use, delinquency and aggressive behaviours. Adolescent attachments to family and school were found to reduce the frequency and intensity of deviant behaviour.

In summary, the present review indicates that a sense of connectedness to school and the broader community is important to adolescents' well-being. Racial discrimination in school may hinder ethnic adolescents' ability to form and maintain a sense of connectedness to their school. Figure 2 depicts the hypothetical relationship between discrimination, acculturative stress, psychological sense of school membership and depression.
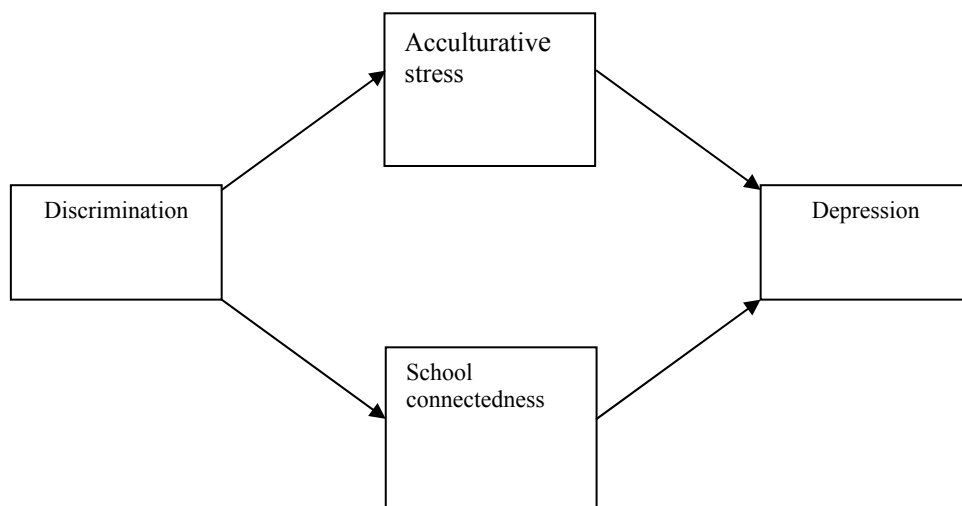
Figure 2: Hypothetical Relationship Between Discrimination. Acculturative Stress, School Connectedness and Depression

6.5 Hypotheses

It is hypothesised that:

1. Discrimination will positively associate with acculturative stress and negatively associate with a sense of connectedness to school.

2. Higher levels of acculturative stress and lower levels of connectedness to school will associate with depressive symptoms.

CHAPTER 7: METHODOLOGY

7.1 Participants

Participants were 106 Vietnamese Australian students (35 males and 71 females), living in Brisbane. Age ranged from 14 to 18 years (mean = 15.52, SD = 1.24), and grade ranged from year 8 to 1st year of tertiary study (mean = 10, SD = 1.58). All participants were living with one or both biological parents and had been in Australia for at least two years. Of these adolescents, 61.4 % were born in Australia, and 38.7% were born in Vietnam. Of those who were born in Vietnam, 36 migrated to Australia before 12 years old and five migrated to Australia after 12 years. The average years these Vietnamese Australian adolescents lived in Australia was 8.97 (*SD* = 3.90). Approximately 20% of participants did not speak Vietnamese at all or very little, the remainder spoke Vietnamese reasonably well to very well. Most adolescents in this study stated that they spoke English well or very well (92.5%), and the remaining 7.5% reasonably well. In contrast to the adolescents, only 13.2% of mothers spoke English well or very well, 55.6% little or not at all, and 31.1% reasonably well. Twenty six percent of fathers spoke English very little, 52% reasonably well, and 21 % well.

7.2 Procedure

Vietnamese surnames were identified in the telephone book and used to create a list of approximately 600 Vietnamese families residing in Brisbane. These families were contacted by telephone and asked if they had adolescents. If a family had an adolescent, the purpose of the study was explained and they were invited to participate. A consent form and questionnaires (including instructions),

were sent to families who agreed to participate. Approximately 50% of people who agreed to participate returned completed questionnaires. To maintain anonymity, participants were not required to write their names on completed questionnaires. All returned questionnaires were complete and appeared reliable and valid for data analysis. Upon the receipt of the questionnaire, a $15 money order, a 'thank you' card and a list of helping organisations were sent to the participants.

7.3 Measures

The assessment protocol included: a) a consent form written in Vietnamese for parents and in English for participants; b) a demographic questionnaire designed to collect information on age, grade, gender, generational status, length of time living in Australia, English proficiency, and parents' educational levels; and c) a battery of self-report questionnaires. Participants completed the following measures: Reynolds Adolescent Depression Scale (RADS), Family Environment Scale (FES): Cohesion subscale (FES-Cohesion) and Conflict subscale (FES-Conflict), Asian-American Family Conflict Scale (AAFCS), Parent-Adolescent Communication Scale (PACS), and the Family Conflict Styles Questionnaire (FCSQ), Adolescent Discrimination Distress Index (ADDI), Psychological Sense of School Membership Scale (PSSM), and Social Attitudinal Familial Environmental Acculturative Stress Scale (SAFE).

Reynolds Adolescent Depression Scale, Family Environment Scale: Cohesion and Conflict subscale, and Social Attitudinal Familial Environmental Acculturative Stress Scale were described in the first study.

7.3.1 Asian-American Family Conflict Scale

The Asian-American Family Conflict Scale (AAFCS) is a self-report questionnaire developed to assess family conflicts that reflect both intergenerational and acculturation differences between Asian American adolescents and their parents. (Lee, Choe, Kim & Ngo, 2000). The scale consists of 10 family situations that reflect disagreements in values and practices between adolescents and their parents. Respondents rate the likelihood of the situation occurring in their family on a five-point Likert scale ranging from 1 = almost never to 5 = almost always. Higher scores indicate greater likelihood of a conflict occurring. Examples of items are, "You have done well in school, but your parents' academic expectations always exceed your performance", "You want to state your opinion, but your parents consider it to be disrespectful to talk back", and "Your parents argue that they show you love by housing, feeding, and educating you, but you wish they would show more physical and verbal signs of affection". Three studies were conducted to establish reliability and validity of the scale. The scale has good convergent and discriminant validity as it was moderately correlated with family based acculturative stress (r=.53), but has a weaker correlation with society and environment-based acculturative stress (r = .32). The scale has shown good internal reliability with reported alpha coefficients ranging from 0.81 to 0.89. This study obtained an internal consistency alpha of .86. For the purpose of this study, this variable is referred to as transcultural parent-adolescent conflict.

7.3.2 Parent-Adolescent Communication Scale

The Parent-Adolescent Communication Scale (PACS) consists of 20 items and is divided into two subscales: (1) open communication with mother/father; and (2) closed communication with mother/father (Barnes & Olson, 1985). Responses were scored on a five-point Likert scale ranging from strongly disagree to strongly agree. The Open Family Communication (PAC-Open) subscale assesses positive aspects of communication between adolescents and parents with higher scores reflecting greater openness in communication. The Closed Communication (PAC-Closed) subscale measures negative and inhibited aspects of communication between adolescents and parents. Higher scores indicate difficulty in communication. The internal consistency reliability in the open communication and closed communication subscales has been reported as $\alpha = 0.87$ and 0.78 respectively. The 4-5 week test re-rest reliability of the open communication subscale is $r = 0.78$ and the closed communication is $r = 0.77$. The alpha levels obtained in this study were $\alpha = 0.70$ and $\alpha = 0.69$ for mother and father respectively.

7.3.3 Family Conflict Styles Questionnaire

Adolescents' conflict-resolution styles were measured using Troth's (1992) Family Conflict Styles Questionnaire (FCSQ), adapted from an earlier scale, measures styles of conflict resolution: attack, avoidant, and compromise. This adapted version has 12 items (4 for attacking, 4 for avoiding and 4 for discussing). Examples of items in this scale include, "I really get mad and start yelling", "I try to avoid talking about it", and, "I try to reason with my parents".

Each statement has four response categories: (1) describes not at all, (2) describes not too well, (3) describes fairly well, (4) describes very well. Good levels of internal consistency were achieved on all three subscales of Troth's CRSQ adapted version, with the alpha values ranged from .70 to .86. In this study, the CRSQ was used to assess adolescents' perceptions of their own conflict resolution behaviours with their parents. Four conflict situations were presented to participants with the instructions that if they had experienced these hypothetical situations with their parents, they were to circle the FCSQ statement that best described their reaction. These conflict situations were created specifically for this study, as they portrayed the most relevant conflicts in Asian families, and they have not been addressed in previous research (Lee et al., 1999; Yau & Smetana, 1993). The conflictual situations present as following:

Situation 1

You really want to attend this party as all your friends are going. You ask your parents' permission. Your parents firmly say "No".

Situation 2

You really want to dye your hair (e.g blond or light colours like Europeans). You express this intention to your parents. They consistently say that you are not allowed to dye your hair, and because you are Vietnamese you should keep your hair black.

Situation 3

You have done reasonably well in school (for example you have obtained mostly A or B grades), but your parents have never been satisfied with

your academic performance. You are watching your favourite television show, your parent asks you to turn off the television, and do some study. You think this is unfair as you think you deserve a break.

Situation 4

Your parents have been constantly telling you to clean your room. You think your room does not need cleaning and that your parents should keep out of your room. You feel that they are interfering in your personal matters.

7.3.4 Adolescent Discrimination Distress Index

Fisher et al. (2000) developed the Adolescent Discrimination Distress Index (ADDI) to assess ethnic minority students' perceived instances of racial discrimination. The ADDI scale consists of 15 items which measures adolescent distress in response to perceived situations of racially motivated discrimination in institutional, educational and peer contexts. Respondents are asked to indicate whether they have experienced discrimination because of their race or ethnicity and if they have, how much the experience upset them. Examples of items include, "You were hassled by police", and, "You were called racially insulting names". In the current study, respondents were only asked to rate the frequency of their experience of discrimination. The ADDI internal consistency alpha of this study was .72.

7.3.5 Psychological Sense of School Membership Scale

The Psychological Sense of School Membership Scale (PSSM) was developed by Goodenow (1993) to assess students' feelings toward their school and the degree of respect, acceptance and value they perceive from teachers and

peers. Participants indicate on a five-point Likert scale (where 1 = not all true, to

5 = completely true), the extent to which they agree with such statements as, "I

feel proud of belonging to this school", "I wish I were in a different school", and,

"I feel very different from most other students in this school". The possible total

score ranges from 18 to 90. Goodenow reported internal consistency reliability

alphas from 0.77 to 0.88 for samples of middle school students from urban and

suburban samples. The PSSM internal consistency alpha of this study was .85.

The outcome score for this scale is also referred to herein as school

connectedness.

CHAPTER 8: RESULTS

8.1 Preliminary Analyses

The fit between the data set and the assumptions of multivariate analysis was assessed. Results of the preliminary screening revealed no missing data, skew or extreme outliers. Each variable and all linear combinations of the variables were normally distributed. Initially, two composite communication scores were computed: adolescent's perception of communication with (a) their mother, and (b) their father. As other measures assessed adolescents' perception of their family, the subscales for communication with mother and communication with father were added together to make one score for both parents. The correlations between mother closed communication and both parent closed communication were ($r = .90$), mother open communication and both parent communication ($r = .89$), father closed communication and both parent closed communication ($r = .90$) and father open communication and both parent communication ($r = .85$).

8.2 Descriptive Data

Means and standard deviations of all variables are shown in Table 4. Approximately 20 percent of participants scored ≥ 75 on the RADS, indicating they were experiencing clinical levels of depressive symptoms. The descriptive results of the second study were comparable to the first one. Although the second study was conducted one year later with a different sample, the incidence of depressive symptoms among Vietnamese Australian adolescents was similar to the first study. The results suggest that the incidence of clinical levels of

depressive symptoms (as defined by the RADS) that found in this sub-population was robust and reliable. Also, similarly to the first study, the mean of the FES obtained in this study was lower than in the standardised sample, and lower than the mean of FES obtained in the study of Ross et al. (1999).

8.3 Correlation Analyses

In this study Pearson's correlation coefficient was also used to estimate the overall correlation between depression, family environment cohesion and conflict, acculturative stress, Asian conflict, open and closed communication, school membership, discrimination and conflict resolution strategies. Correlations among all measures are presented in Table 4. All variables except for the Conflict Resolution Compromise-subscale were significantly associated with depression. Correlations between variables in the hypothesised pathways shown in Figures 1 and 2 were of particular interest. Table 4 shows that transcultural parent-adolescent conflict (measured by the AAFCS), family conflict, open parent communication, closed parent communication and avoidant conflict resolution were significantly related to family cohesion and depression. Cohesion was moderately related to depression. Discrimination was significantly related to acculturative stress, school membership and depression. Acculturative stress and school membership were moderately associated with depression.

Table 4

Means, Standard Deviations and Intercorrelations (n=106)

	Variable	Mean	SD	1	2	3	4	5	6	7	8	9	10	11	12
1	RADS	61.31	14.42	-	-.49**	.32**	.43**	.41**	-.41**	.22*	-.42**	.34**	.33**	.29**	-.12
2	FES: Cohesion	5.70	2.32		-	-.50**	-.27**	-.46**	-.52**	-.33**	-.50**	-.28**	-.25**	-.41**	.28**
3	FES: Conflict	3.72	2.12			-	.13	.20*	-.42**	.29**	.25*	.24*	.21*	.19	-.22*
4	SAFE	44.42	12.71				-	.23*	-.14	.12	-.23*	.46**	.28**	.16	-.03
5	AAFCS	31.40	8.62					-	-.53**	.34**	.30**	-.14	.22*	.35**	-.31**
6	PACS: Open	61.34	14.34						-	-.24*	-.31**	-.16	-.23*	-.30**	.47**
7	PACS: Closed	63.15	12.15							-	-.15	.00	.12	.27**	-.19
8	PSSM	63.47	10.93								-	-.41**	-.31**	-.12	.08
9	ADDI	24.30	7.94									-	.39**	.10	.10
10	FCSQ: Attack	29.81	9.70										-	.07	-.13
11	FCSQ: Avoidant	37.07	8.31											-	-.29**
12	FCSQ: Compromise	38.78	10.14												-

RADS: Reynolds Adolescent Depression Scale,
FES: Cohesion – Family Environment Scale
FES: Conflict – Family Environment Scale
SAFE: Social Attitudinal Familial Environmental Acculturative Stress Scale
AAFCS: Asian-American Family Conflict Scale
PACS: Open – Parent-Adolescent Communication Scale, Open Subscale
PACS: Closed - Parent-Adolescent Communication Scale, Closed Subscale

FCSQ: Attack – Family Conflict Styles Questionnaire
FCSQ: Avoidant - Family Conflict Styles Questionnaire
FCSQ: Compromise - Family Conflict Styles Questionnaire
ADDI: Adolescent Discrimination Distress Index
PSSM: Psychological Sense of School Membership

** correlation is significant at $p < .01$ level; * correlation is significant at $p < .05$ level

8.4 Rationale for Using Both Mediational Testing and Structural Equation

Modelling to Test the Hypothesised Models

The mediation hypothesis was tested using a series of three multiple

regression analyses, as recommended by Baron and Kenny (1986). Following this

procedure, Structural Equation Modelling (SEM) (using Amos 4) was used to test

the goodness of fit to the data (Arburckle & Worthke, 1999). Both approaches

were used because the sample size is relatively small (N=105). Kline (1998)

suggests that ideally it is desirable to have a sample which provides 20 cases for

each estimated parameter in a recursive model, 10 cases per estimated parameter

may be more realistic, while five cases for each estimated parameter would be a

cause of concern. With regard to regression model, Tabachnick and Fidell (2001)

suggested that the sample size for regression analyses should be $N \geq 50 + 8m$

cases, where m is the number of independent variables. For model One, the

hypothesised relationship between family variables and depression, there were

five independent variables predicting the mediating variable family cohesion,

which in turn was predicting depression, giving approximately 18 participants per

IV. According to Tabachnick and Fidell's formula, 98 participants would have

been sufficient. For model Two there were three IVs predicting depression, which

would be more than sufficient per IV. Hence, the sample size of this study was

adequate for regression analysis. However, for model One and Integrated model,

there was some concern about sufficient participant numbers for SEM. For

example, Tachnick and Fiddell state that if the effect size is small for covariates

in SEM, 100 participants is a poor sample size. Therefore, regression analysis

was used to establish the strength of mediational pathways of the hypothesised models, and then they were confirmed using SEM.

Secondly, because this study was of an exploratory nature and the subject under investigation was still in its infant stage, there is no definitive model. Thus the mediation hypotheses were firstly established by using a series of three multiple regression analyses as recommended by Baron and Kenny (1986). Paths that were not significant mediators were eliminated from the model. The SEM was then used to confirm the mediational pathways of the hypothesised models.

8.5 Overview of the Mediational Testing

The objectives of this study were, (1) to investigate the specific family interactions that were believed to contribute to a low level of family cohesion observed in Vietnamese immigrant families, and that may consequently contribute to Vietnamese immigrant adolescents' depressive symptoms (Pathway 1). Specifically, family cohesion was predicted to mediate the relationship between family variables and depression (figure 1). 2) To investigate whether there was an impact of discrimination on acculturative stress and a sense of school connectedness, which subsequently could contribute to these ethnic adolescent's developing depression (Pathway 2). Specifically, acculturative stress and a sense of school connectedness were hypothesised to mediate the relationship between discrimination and depression (figure 2).

According to Baron and Kenny (1986), for a variable to function as a mediator, three conditions must be met: (1) predictor variables must significantly be related to the dependent variable, (2) predictor variables must be significantly

related to the mediator variable, and (3) mediator variables must be significantly related to the dependent variable. If all conditions hold in the predicted direction, then addition of the mediator should decrease the effect of the predictor variables on the dependent variable. With regard to Condition 3, a variable can function as a partial or complete mediator (Baron & Kenny). If partial mediation is occurring, the effect of the independent variable would be reduced but it would continue to serve as a significant predictor. This outcome would indicate the operation of multiple mediation factors. In contrast, perfect mediation is achieved if predictor variables have no effect when the mediator variable is controlled. If the effect was reduced to zero, there would be strong evidence for the operation a single mediator (Baron & Kenny).

8.6 Overview of Structural Equational Modelling

SEM (using Amos 4) was used to test the hypotheses. SEM is most properly used as a confirmatory approach to data analysis, with the researcher proposing and testing the model based on theory (Byrne, 2001). The proposed models can be tested statically in a simultaneous analysis involving the entire variables to determine the extent to which it is consistent with the data. Furthermore, if the initial theory-based model is rejected, the application of SEM may be used to modify the initial model on the basis of either theoretical or statistical considerations, and the modified model is then tested for goodness of fit to the data (Byrne).

The Amos package includes a graphical interface allowing the researcher to draw a model on theoretical predictions and then present the graphical pattern

of causal relationships among a set of variables under study. The overall fit of the path model to the data is evaluated by the package. If the goodness of fit is adequate, the model argues for evidence of postulated relations among variables, if it is inadequate, the tenability of these relations is rejected.

Amos 4 reports several indices that are used to indicate the goodness of fit between the model and the data. The first is the minimum discrepancy or CMIN, which represents the likelihood ratio test statistic, most usually expressed as a chi-squared statistic. With a good fit the chi-squared statistic is non-significant ($p > .05$). However, as the chi-squared statistic is sensitive to sample size other indices may be more useful (Byrne, 2001). One of these, CMIN/DF, should be less than 2 for a good fit (Arbuckle & Wothke, 1999). Specific goodness of fit indices include the Goodness of Fit Index (GFI) and the adjusted GFI (AGFI). Further, both of these indexes range from zero to 1. For example, if the values of GFI and AGFI are greater than .95, this indicates a good-fitting model. The Standardized Root Mean Square Residual (SRMR) is the average value of all standardized residuals and for a good fit is less than .05. The Root Mean Square Error of Approximation (RMSEA) will also be less than .05 for a good fit, but values up to .08 may indicate a reasonable fit. The probability value for a related test of closeness of fit (PCLOSE) should exceed .5 for a good fit (Byrne, 2001).

The assumptions about the data used for structural equation modelling are similar to those for most multivariate analyses: the data are assumed to be linear, normally distributed, and without outliers. Further, there should be no

systematically missing data, there should be no multicollinearity, and there should be sufficient cases for the model to be tested. Before using SEM Amos 4 to test the goodness-of-fit, the data was examined for assumptions of normality, linearity, missing data, univariate and multivariate outliers and multicollinearity, with transformations applied where necessary. Multiple regression analyses were used to establish the mediators and eliminate unnecessary variables from the models.

The distinction between exogenous and endogenous variables is presented graphically in the path model. For Pathway 1, family conflict, transcultural conflict, parent open communication, closed communication and conflict resolution avoidant style were considered to be exogenous variables as their variability was assumed to be determined by causes outside the causal model. Family cohesion and depressive symptoms were considered endogenous variables as their variability were explained by the exogenous and endogenous variables in the causal model (figure 1). Similarly, discrimination in Pathway 2 was considered to be an exogenous variable, and acculturative stress, sense of school connectedness, and depression were determined to be endogenous variables (figure 2).

The paths presented in these causal models (figure 1 and 2) are unidirectional, and the one-way arrows draw from the variables viewed as cause (exogenous) to the variables taken as effects (endogenous). The paths leading from family conflict, transcultural conflict, parent open communication, closed communication and conflict-resolution avoidant-style to family cohesion, and

from family cohesion to depression in the diagrammed model indicate a presumed direct causal influence of these variables on depression. By convention (Byrne, 2001) observed variables are represented by rectangles while circles represent unobserved variables, being in this case only error variables. Further, single headed arrows represent prediction paths and double headed arrows represented correlations betweens variables (Figure 3, 4 and 5). The results of the SEM are shown as the following: the standardised weights are shown beside the path arrows, and correlation coefficients (Pearson's r) are shown adjacent to correlation indicators. The proportion of variance accounted for (r^2) by the model is shown above and adjacent to each of the endogenous variables which are those variables predicted to be dependent on earlier variables (figures 3, 4, 5).

8.7 Pathway 1: Family Cohesion as a Mediator of the Relationship Between Family Variables and Depression

To obtain path coefficients for the pathway depicted in Figure 1, three separate regression equations were computed. First, family cohesion was regressed on transcultural parent-adolescent conflict, family conflict, avoidant conflict resolution, closed parent communication and open parent communication. Family cohesion was significantly correlated with transcultural parent-adolescent conflict ($\beta = -.20$, $p < .05$), family conflict ($\beta = -.32$, $p < .001$), avoidant conflict resolution ($\beta = -.19$, $p < .05$), and open parent communication ($\beta = .20$, $p < .05$). Family cohesion was not significantly correlated with closed parent communication ($\beta = -.07$, $p > .05$). Together this regression analysis yielded an $R^2 = 0.45$. Due to the non-significant association

between closed parent communication and family cohesion, closed parent communication was deleted from the model and excluded from subsequent analyses. Secondly, depression was regressed on transcultural parent-adolescent conflict, family conflict, avoidant conflict resolution, open parent communication and family cohesion. Family cohesion remained the only significant predictor (β = -0.27, p < .05). This regression analysis yielded an R^2 = 0.307.

The effect of family conflict, avoidant conflict resolution, closed parent communication and open parent communication on depression were substantially reduced and no longer served as significant predictors when family cohesion was added to the equation. However, although the direct effect of transcultural parent-adolescent conflict on depression was no longer significant when family cohesion was added to the equation, this path approached significance (p = .07). Therefore, the path between transcultural parent-adolescent conflict and depression was initially removed from the model, however the SEM analysis indicated a poor fit, thus this path was restored in a subsequent analysis, because it was necessary for a good fit. This is explained further below.

Thirdly, depression was regressed on family cohesion. Depression was significantly related to family cohesion (β = -0.49, p < .001, R^2 = 0.24). These results showed that transcultural parent-adolescent conflict, family conflict, avoidant conflict resolution and open parent communication significantly predicted family cohesion, which in turn significantly predicted depression. Finally, the finding that the effect of all predictor variables was reduced to non-significant when family cohesion was placed in the regression model indicated

these variables exerted a significant indirect effect on depression through family cohesion, satisfying Baron and Kenny's (1986) condition 4 for mediation to be present.

In the final step, the overall fit of the path model to the data was evaluated using SEM. As stated above, the direct path between transcultural parent-adolescent conflict and depression was initially removed from the model because it lost its significant effect on depression. However, without this direct path, this model was a poor fit by all indices, even though all paths were significant. The residuals (SRMR = .06, FMIN = .095, RMSEA = .12) were all very high and non-significant. The chi-squared test was significant, $\chi^2 = 9.85$, $df = 4$, $p = .043$. Clearly there was shared variance which was not accounted for by the model.

Thus, the proposed Pathway 1 (figure 1) was tested, omitting the path from closed parent communication and family cohesion, and the path between transcultural parent-adolescent conflict and depression was retained. This new model (figure 3) required the estimation of 18 parameters, which with $N = 105$ provides 5.8 cases for each estimated parameter. The ratio of cases to parameters is relatively small which may be a cause for concern (Kline, 1998). However, the results showed that the overall model fit was good. The chi-squared test was not significant, $\chi^2 = 2.93$, $df = 34$, $p = .40$. Other goodness of fit statistics indicated a good fit: GFI = .99, AGFI = .94, NFI = .98, FMIN = .03, RMSEA = .05, Standardised Root Mean Square Residual = .02, and PCLOSE = .39. All paths were significant with $p = < .05$. The model explained 45% of variance in family cohesion and 29% of variance in depression.

The results indicated that this model is a good fit with the data. Although the result does not indicate that the model is the best, or the only possible model for relationships between family functionality and depression, it does indicate that specific family interactions in Vietnamese families influence the levels of their family cohesion, which in turn influences adolescent depression. The transcultural parent adolescent conflict which typically presents in immigrant families significantly decreased family cohesion and also directly contributed to immigrant adolescent depression. Thus, the proposed Pathway 1 (figure 1) in Chapter 6 was to a great extent supported by the data.

Chi-squared = 2.93, *df* =34, *p* = .40, GFI = .99, AGFI = .94, NFI = .98, FMIN = .03, RMSEA = .05, SRMSR= .02, PCLOSE = .39.
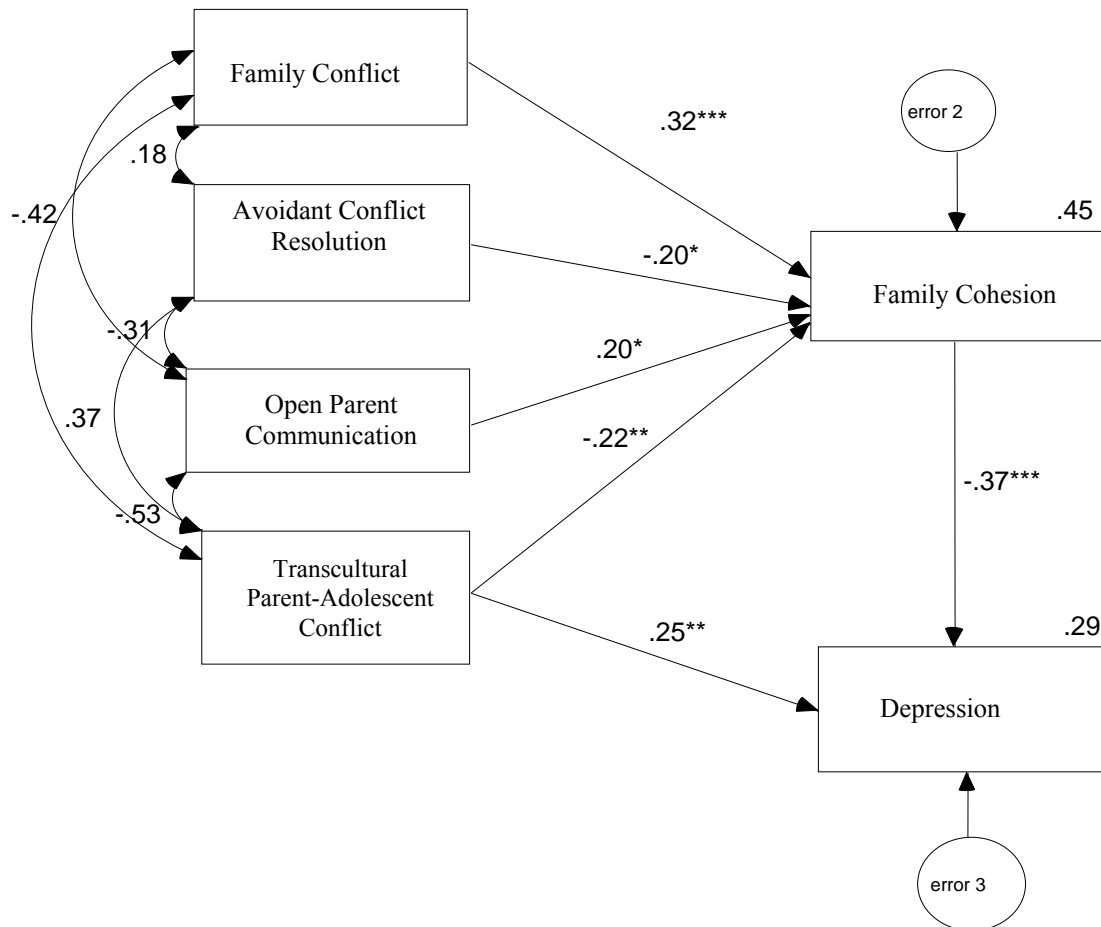
Figure 3. The relationship Between Family Variables and Depression.

Note: For regression path * *p* < .05, ** *p* < .01, *** *p* < .001

8.8 Pathway 2: Acculturative Stress and a Sense of School connectedness as

Mediators of the Relationship between Discrimination and Depression

For Pathway 2, the results obtained were also consistent with Baron and

Kenny's (1986) conditions. Discrimination was significantly associated with

depression, acculturative stress and school membership. Acculturative stress and

school membership were significantly associated with depression. Regression

analyses were computed to obtain path coefficients for Pathway 2. Acculturative

stress and school membership were separately regressed on discrimination and

the results of these analyses were $\beta = 0.46$, $R^2 = 0.21$, $p < .001$, and $\beta = -0.41$, R^2

$= 0.17$, $p < .001$ respectively. Depression was also regressed on acculturative

stress and school membership. The results of these analyses showed that

depression was significantly related to acculturative stress ($\beta = 0.35$, $p < .001$)

and school membership ($\beta = -0.34$, $p < .001$). The multiple regression equation

was significant, $R^2 = 0.293$, $p < .001$. Finally, depression was regressed on

discrimination, acculturative stress, and school membership, also yielding a

significant result of $R^2 = 0.295$, $p < .001$. The effect of discrimination on

depression was diminished to non-significant ($\beta = .05$, $p > .05$), thus indicating

that acculturative stress and school membership mediated the relationship

between discrimination and depression.

SEM was used to evaluate the overall fit of paths to the data of the

proposed Pathway2. The following paths were estimated: the causal path to a

sense of school connectedness and acculturative stress from discrimination; and,

the causal paths to depression from a sense of school connectedness and

acculturative stress. As expected, the SEM and regression approaches produced identical standardized parameters and significance tests for individual paths.

This model (figure 4) required 8 parameters to be estimated, which with N = 105 provided 13 cases for each parameter which is within the acceptable range (Kline, 1998). Goodness-of-fit indices indicated that the model was a good fit the data; the chi-squared statistic was not significant, χ^2 = .49, df=2, p =.78, GFI =.99, AGFI = .99, NFI = .99, FMIN = .005, and RMSEA = .00. Standardized Root Mean Square Residual was .02, PCLOSE = .83.

Thus this model represents one acceptable explanation of the paths by which the experience of racial discrimination predicts acculturative stress and a lower sense of connectedness to school. Acculturative stress and a lower sense of connectedness to school in turn predicted adolescent depression. The analyses showed that discrimination accounted for 21% of variance in acculturative stress and 17% of variance in school membership. The whole model accounted for 29% of variance in depression scores. Both acculturative stress and school membership mediated the influence of discrimination on depression so discrimination does not contribute significant unique variance to depression. The hypothesised Pathway 2 (figure 2) in Chapter 6 was confirmed by the data.

Chi-squared =.49, *df* =2, *p* =.78, GFI =.99, AGFI = .99, NFI = .99, FMIN = .005,

RMSEA = .00. SRMSR = .02, PCLOSE = .83.
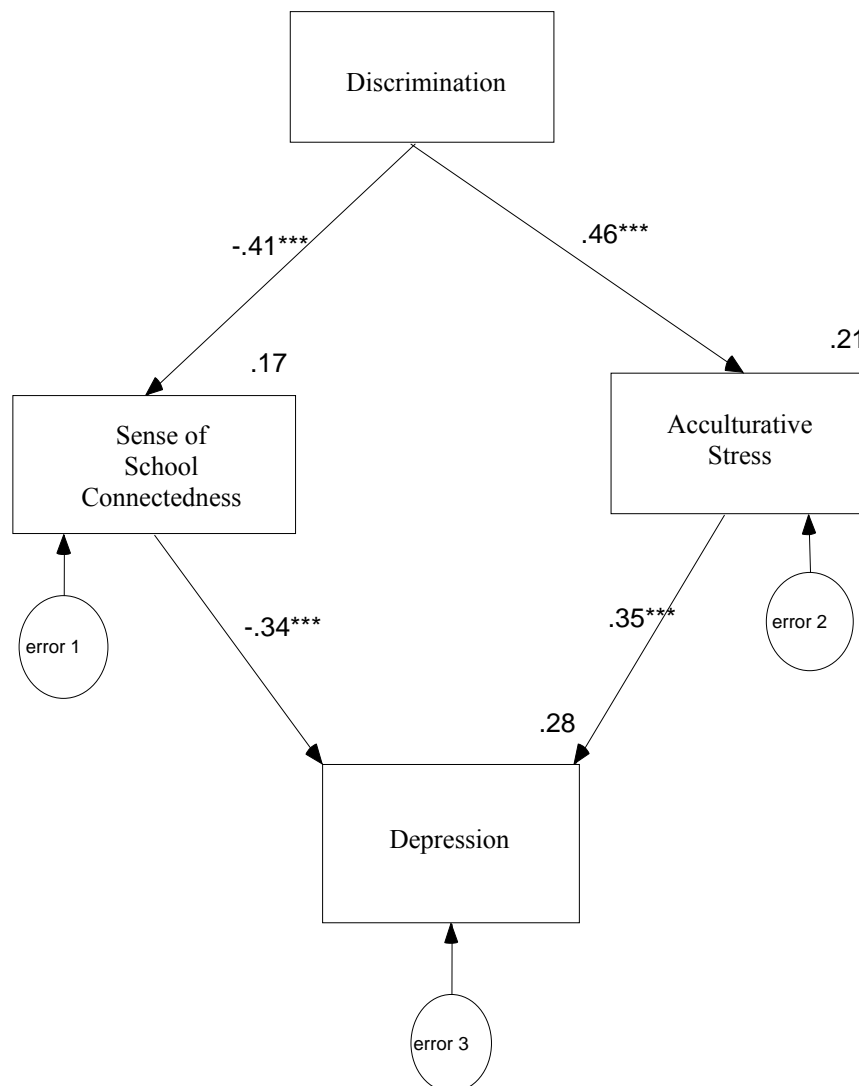
Figure 4: *The Relationship Between Discrimination, Acculturative Stress, a Sense*

of School Connectedness and Depression

Note: For regression path * *p* < .05, ** *p* < .01, *** *p* < .001

8.9 Summary of the results

In summary, similar to the finding of the first study, 20 % of participants in this study reported clinical levels of depressive symptoms. The results of Study Two showed that transcultural parent-adolescent conflict, family conflict, avoidant conflict resolution and open parent communication significantly predicted family cohesion, which in turn significantly predicted depression. The findings showed that the effect of all predictor variables was reduced to non-significant when family cohesion was placed in the regression model, therefore these variables exerted a significant indirect effect on depression through family cohesion. However, SEM analysis indicated that the path from transcultural parent adolescent conflict to depression was significant. Furthermore, although discrimination was significantly related to depression, it lost its significance when acculturative stress and a sense of school connectedness variables were introduced to the regression model. This result indicated that acculturative stress and school membership mediated the relationship between discrimination and depression.

Some correlation results are noteworthy to review in this section. Family cohesion was moderately correlated with a sense of school membership ($r = -50$), transcultural parent-adolescent conflict was also moderately correlated to parent-adolescent open communication ($r = -.52$). Further, avoidant conflict resolution style was significantly correlated with transcultural-parent-adolescent conflict ($r = .35$), but was not significantly related to family conflict. Furthermore, although compromise conflict resolution was not our focus, it is worthwhile to mention

because this variable was moderately correlated with parent-adolescent open communication ($r = .47$).

8.10 Integrated Pathway

An integrated pathway (see figure 5) was constructed based on the results of Pathway 1 and 2 and the correlation analyses. According to Bronfenbrenner (1979) children's development is influenced by multiple levels. The results of this study suggested that depression is influenced by contextual factors, which are rooted in the adolescents' environment. In this case, the environment is the adolescents' family, school, and broader society. Therefore, it is useful to further examine the affect of the two integrating Pathways on Vietnamese Australian adolescents' depression. This ecological perspective provides a clearer picture of the dynamics of adolescent-context relations occurring within a specific setting (e.g., the home), within which an adolescent develops, and the interconnected set of specific systems (e.g., the home and the school). Only family cohesion was included in this integrated pathway because family cohesion fully mediated other variables and it is the key contributor to depression. Also, family cohesion is the only family variable that correlated with a sense of school connectedness moderately.

This model requires the estimation of 18 parameters, which with $N = 105$ provides approximately 9 cases for each parameter which is within the acceptable range (Kline, 1998). Goodness-of-fit indices indicated that the model was a good fit for the data; the chi-squared statistic was not significant, $\chi^2 = .33$, *df* $= 3$, *p*

=.34, CMIN/DF =1.11, GFI =.98, AGFI = .94, NFI = .79, FMIN = .032, RMSEA = .033, and PCLOSE = .45.

The results indicated that this model is a good fit with the data. The result does not indicate that the model is the only possible model for relationships between family variables, a sense of school connectedness, acculturative stress and depression. However, it does indicate that family cohesion positively influenced school connectedness, which in turn predicted adolescents' development of depression symptoms. Moreover, family cohesion not only directly influenced immigrant adolescent depression, but it also indirectly affected depression through a sense of school connectedness. For example, family cohesion alone contributed 33% of variance to a sense of school connectedness. Importantly, the model explained 34% of the variance in depression. The result also indicated that Vietnamese Australian adolescents' depression was influenced by multiple levels, hence an ecological perspective should be considered for the development of any programme that aims to intervene or prevent depression in this sub-population.

Chi-squared =.33, *df* = 3, *p* =.34, CMIN/DF =1.11, GFI =.98, AGFI = .94, NFI = .79, FMIN = .032, RMSEA = .033, PCLOSE = .45.
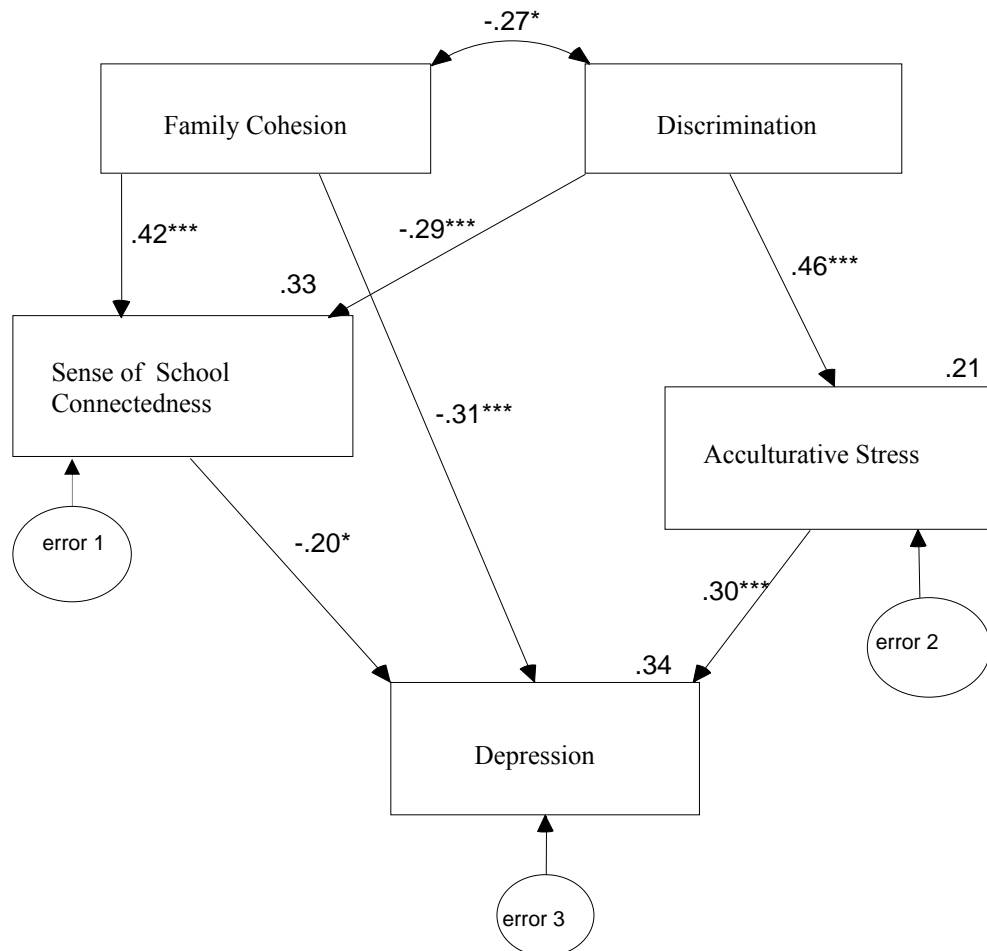
Figure 5. The Relationship Between Family Cohesion, Discrimination, School Connectedness, Acculturative Stress and Depression

Note: For regression path * *p* < .05, ** *p* < .01, *** *p* < .001

CHAPTER 9: DISCUSSION

9.1 Overview

An objective of these two studies was to investigate the frequency and possible correlates of depressive symptoms among Vietnamese Australian adolescents. In both studies results revealed that a large number of Vietnamese Australian adolescents had an elevated risk for developing depression, with 20% of participants reporting clinical levels of depressive symptoms. Although the two studies were conducted one year apart, the percentage of participants who reported clinical levels of depressive symptoms was identical. This suggests that the results of these studies are reliable and consistent. Further, the results of both studies are consistent with previous studies that investigated the frequency of depression among ethnic minority adolescents (e.g., Aldwin & Greenberger, 1987; Greenberger & Chen, 1996; Hovey & King, 1996; Okazaki, 1997; Sam & Berry, 1995).

Furthermore, this study has explored two theoretical pathways: (1) the relationship between family variables and depressive symptoms; and (2) the relationship between discrimination, acculturative stress and school connectedness. However, instead of conducting a between-groups comparison between Vietnamese and Anglo Australians, the within-group (Vietnamese Australian) variability in family and social contexts was examined. The results confirmed two independent pathways to depression among Vietnamese Australian adolescents: (1) family interactions contributed to low levels of family cohesion which in turn contributed to immigrant adolescent depression, and (2)

perceived discrimination led to increased acculturative stress and to a decreased sense of school connectedness, which in turn affected adolescent depression. The result of the integrated pathway suggested that the interconnection between adolescents' home environment, the school and broader social context simultaneously influence their mental health. Moreover, the results suggested an ecological approach for interventions to prevent depression in Vietnamese Australian adolescents.

9.2 Pathway 1

Inconsistent to the proposed Pathway 1 (figure 1) closed parent adolescent communication lost its significant influence on family cohesion when all family variables were entered into the equation. Thus, this family variable was not included in the SEM analysis. In contrast to closed parent adolescent communication, transcultural parent-adolescent conflict, family conflict, avoidant conflict resolution style and open parent adolescent communication were individually significantly influencing levels of family cohesion in Vietnamese immigrant families, which in turn significantly contributed to depressive symptoms in Vietnamese Australian adolescents. As predicted, family cohesion serves a key mediating function between family interaction and depression. It is also the most important family predictor of depressed mood for Vietnamese Australian adolescents.

Comparable to the finding of Study One, the effect of family conflict on depression was also reduced to non-significant when family cohesion was added into the regression model. Thus, family conflict did not function as an

independent contributor to depression; instead, it was fully mediated by family cohesion. This finding is inconsistent with Anglo American samples (e.g., Kaslow et al., 1994, Sheeber et al., 1997) where family conflict was found in these studies to consistently associate with depressive symptoms.

In contrast to the non-significant finding for family conflict, it was found that transcultural parent-adolescent conflict was a significant path to depression in the SEM analysis, and approached significance ($p = .07$) in the full regression model. This finding supports the proposition that the development of an acculturation gap in immigrant families creates conflicts that reflect the cultural differences between parents and their adolescents (Dinh et al., 1994; Lee at al., 2000; Lee at al., 2001; Nguyen & William, 1988). Further, this result is consistent with the findings of Aldwin and Greenberger (1987). Although Aldwin and Greenberger did not measure transcultural conflict in their study, perceived parental traditionalism was a significant predictor of depression among Korean Americans, and parental modernism was a protective factor. In contrast to Korean Americans, traditionalism and modernism were not strong predictors for White Americans. Thus, transcultural conflict exerts greater influence on the mental health of immigrant adolescents than normal family conflict.

Furthermore, this study found that above and beyond family conflicts that occur in most families, transcultural conflict not only directly contributed to adolescent depression, but it also diminished family cohesion. The result of the Pathway 1 can be explained by the acculturation framework of Williams and Berry (1991). The transcultural conflict found in this study suggests that

Vietnamese Australian parents still embrace their cultural values and imposed those values on their adolescents, whereas their children appeared to relinquish some of the traditional values and instead adopted some Australian individualistic values. It is clear that adolescents in this study would like to have more autonomy regarding decision making, to achieve their individual goal rather than family goal, to state their opinion when differences between them and parents arise. They and their parents disagreed on the importance of having a social life and the exceeding parental expectation of their academic expectation. These adolescents also would like their parents to accept them for being who they are, and to show more physical and verbal signs of affection (see AAFCS, Appendix B). However, these individualistic values and lifestyles that were preferred by immigrant adolescents often conflict with the traditional belief and expectation that their parents hold. The cultural distance between immigrant parents and their adolescents makes family interactions more difficult and leads to weakened family bonds. This finding is similar to the results of two previous studies (Lee et al., 2000; Lee et al., 2001). It was found in these studies that Vietnamese immigrant college students in the US reported highest levels of family transcultural conflict among Asian American ethnic groups. Transcultural conflict level was not elevated in Asian American families where both parents and adolescents were highly acculturated to the Western culture (Lee et al.)

Moreover, in Vietnamese culture, family harmony is essential; therefore family members should not express disagreement between each other. Further, family members are not only discouraged from expressing dissenting opinions,

but they are also discouraged from positive emotional expression, including

showing affection (Nguyen, 1990). By contrast, the definition of parental love

that emphasises emotional expression and closeness in Western culture was not

found to be crucial in Vietnamese families. Instead, within Vietnamese culture

instrumental help and support was previously found to be the most appropriate

expression of parental love (Nguyen, 1990).

Although, Vietnamese people have settled in Western countries for many

years, many parents still attend to their children's instrumental needs more than

their children's emotional needs (Pyke, 2000). However, this might be in contrast

to the expectations of their children who are growing up in the Western cultures.

For example, immigrant Vietnamese adolescents can compare and contrast the

pattern of parent-adolescent interactions in their family with those of their

Western peers. Also, family styles that are portrayed in American or Australian

Anglo television programs can pervasively influence these acculturating

adolescents' views of what behaviours occur normatively in families. Thus, they

might use the families that are typically portrayed in Anglo television programs

as an interpretive framework when giving meaning to their own family function

(Pyke). From the Vietnamese American adolescents' point of view, American

families are more emotionally nurturing, supporting, understanding and

forgiving. In contrast, their Vietnamese parents are perceived as overly strict,

emotionally distant, unaffectionate, unexpressive, uncommunicative, and over

controlling (Pyke, 2000; Herz & Gullone, 1999; Dinh et al., 1994). Hence it

could be possible that in immigrant Vietnamese families, closeness between

parent and adolescent seems to be impeded due to parenting practices that emphasize affectionless control, and focus on providing instrumental, practical forms of love. Whereas, acculturating Vietnamese adolescents crave parental expression of affection, understanding and emotional support (Pyke, 2000; Herz & Gullone, 1999).

Furthermore, the findings also confirmed that avoidant conflict resolution style, which was preferred by Vietnamese people (Dsilva & Whyte, 1997), is no longer adaptive in Australia, because in this study it was associated with decreased levels of family cohesion. For example, participants who used avoidant conflict resolution style also portrayed their family as less cohesive. This is consistent with the Vietnamese cultural expectation that when conflicts arise, people who are lower in the hierarchy should remain quiet. Further, in Vietnamese families, Vietnamese adolescents are expected to use a non-confrontational conflict resolution style in order to maintain harmonious family relationships, even in situations where they experience negative emotions such as sadness, shame and regret; the traditional expectation is that they would still be considerate of their parents' authority. Thus, it is also possible that Vietnamese ethnic adolescents who reported being in low cohesive families did not feel adequate support and acceptance for them to express their disagreement, or to negotiate the differences between them and their parents.

Interestingly, avoidant conflict resolution style was not related to general family conflict, however it was significantly associated with transcultural conflict ($r = .35$). This suggests that Vietnamese ethnic adolescents who tended to use

avoidant conflict resolution style also have families with higher levels of transcultural conflict. Although acculturation levels of parents and adolescents were not assessed, it appeared that Vietnamese parents who were rooted in their traditional cultural values had more conflict with their adolescents, and the adolescents in these families tended to defer more to their parents when disagreements arose. Nevertheless, this avoidant conflict resolution style, favored by collectivist cultures, appears to be maladaptive in Australia, as adolescents' psychological well-being was indirectly affected in its presence.

The result of this study has also confirmed a positive link between parent-adolescent open communication and family cohesion, and this is consistent with previous research (e.g., Olson, Mccubbin & Barnes, 1983; Tulloch, Blizzard & Pinkus, 1997). Hence, it could be stated that open communication within a family is important for the development of a closer family relationship, and family cohesion. For example, adolescents reported a more cohesive family when communication between themselves and their parents was liberal and expressive (as measured by the PACS). Thus, it appears that good parent-adolescent communication leads to a closer family relationship, and consequently protects adolescents from developing depressive symptoms. The result also suggested that the Vietnamese traditional style of communication, that resembles closed communication in Western culture, was no longer perceived as adaptive by many of the Vietnamese Australian adolescents in this study.

Although the link between parent-adolescent open communication, family conflict, and transcultural family conflict was not the focus of this study, these

variables were moderately correlated. Open communication was significantly negatively related to family conflict ($r = -.42$) and transcultural conflict ($r = -.53$). These results indicated that good parent-adolescent communication not only reduces general family conflicts that occur during adolescence, but it also reduces transcultural conflict that normally arises in immigrant families. Open communication appears to create an atmosphere that allows family members to express their differences as well as resolve disagreements constructively. Good parent-adolescent communication also seems to facilitate the understanding of individual differences in the family even when parents and adolescents might disagree about cultural values and lifestyles. Open communication within the family also seemed to mitigate serious conflict between parents and adolescents, which may further protect adolescents from developing mental health problems (Jackson et al., 1998).

In summary, the results of Pathway 1 indicated that the relationships between family conflict, parent open communication, and avoidant conflict resolution were fully mediated by family cohesion, whereas transcultural conflict both directly and indirectly contributed to family cohesion and depressive symptoms. Hence, it is clear from the results that family cohesion was the most important family variable that linked to depression in this sample.

9.3 Pathway 2

The hypothesis that discrimination would positively predict acculturative stress and would negatively predict a sense of school connectedness, which in turn would positively predict depressive symptoms in Pathway 2, was confirmed.

The results also suggested that adolescents who experience discrimination are more likely to experience acculturative stress and less likely to feel a sense of connectedness to their school, which in turn places them at greater risk for depression. These results support a growing body of literature on the relationship between perceived discrimination and mental health among people with ethnic minority (e.g., Jackson et al., 1996; Mossakowski, 2003; Noh et al., 1999; Szalacha et al., 2003).

Discrimination was not directly linked to depressive symptoms in this current study. Rather, depression was mediated by increased acculturative stress and decreased school connectedness. Discrimination was a contributing factor to acculturative stress was not surprising since prejudices, discrimination and exclusion were found to increased acculturative stress (Berry, 1998). Perceived discrimination systematically increased acculturative stress and decreased mental well-being of acculturating adolescents in this study.

Previous findings illustrated that acculturation is an inevitable process that occurs as a result of contact between different cultures (Liebkind et al., 2000; Liebkind, 1996; Sam, 1995; Sam & Berry, 1995). Efforts to learn a new language, to understand the new customs and cultural values and integrate those into a person's identity are often accompanied by the feeling of stress. Acculturative stress experienced by a person may not always result in ill health. However, a high level of stress experienced by a person over a long period of time may result in damaging the person's mental and physical health. In particularly, if the person does not have an adequate social support system such

as a supportive family, adaptive adjustment in mainstream culture would be impeded. This finding clearly supports previous findings on the negative influence of acculturation among ethnic minority adolescents (Hovey & King, 1996; Liebkind et al., 2000; Vega et al., 1995).

While previous studies have demonstrated a relationship between acculturative stress, discrimination and depressive symptoms (Fisher et al., 2000; Hovey & King, 1996; Liebkind, 1996), the concurrent relationship between these variables with school connectedness has not previously been researched in immigrant adolescents. The current findings indicated that racial discrimination at school adversely affected the well-being of ethnic adolescents. It has previously been found that it is important for human well-being to form and maintain meaningful relationships with others, objects, environments and society (Baumeister & Leary, 1995). It appeared that experienced discrimination at school hinders immigrant adolescents from developing positive relationships with others which then hinders their ability to develop a sense of school connectedness.

Moreover, being different in appearance, coupled with a lack of English fluency could contribute to ethnic adolescents' feelings of insecurity about making new friends and fitting into a group. Hence, when added to their existing difficulties, the feeling that they are not accepted and respected by teachers and peers could further hinder their ability to form a sense of belonging to the peer group, and could also prevent formation of a sense of connectedness to the school. These findings are in line with the assertion that hindrances to a person's

ability to form and maintain a sense of connectedness to others and their social

settings may lead to psychological and social disturbances (Sargent, et al., 2002).

The results also support the theoretical framework of (Wehlage et al., 1989;

William & Berry, 1991) and previous studies on the influences of these variables

on adolescent mental health (Kuperminc et al., 2001; Roeser et al.,1996).

9.4 Integrated Pathway

The results of the Integrated Pathway (see figure 5) showed that

adolescent depression is influenced by multiple levels. Family cohesion was

significantly contributed to a sense of school connectedness and correlated with

discrimination which consequently directly influenced on adolescent depression.

The findings of the integrated pathway are consistent with an ecological

perspective on adolescent development (Bronfenbrenner, 1979). The findings

suggest that when acculturating adolescents feel supportive and acceptant at

home, they also feel a higher sense of school connectedness.

Surprisingly, family cohesion was significantly associated with

discrimination even though, at a modest level. It is possible that adolescents from

high cohesive families might be equipped with the social skills that could assist

them to develop positive relationships with others in school and hence, these

adolescents attracted less discriminatory behaviours that were directed at them.

Parents from high cohesive families may have more readily prepared their

children to cope with discrimination and these families might operate as social

support systems that may enhance their children's coping efforts. Experienced

parental and family support may ease the acculturative process. For example,

Liebkind and Jasinskaja (2000) found that parental acceptance of mainstream culture buffered acculturational problems among adolescent immigrants. Thus, family cohesion and parental support and acceptance may assist immigrant adolescents to cope with acculturation difficulties, which may then help them to adapt to their new social context more effectively (Liebkind & Jasinskaja).

9.5 Limitations of the Study

The results must be viewed in light of several limitations. In this study, only 50% of distributed questionnaires were returned. Thus, the convenience sampling procedures in this study and the low recruitment rates may affect the validity of the results. Further, there may be uncertainties about the representativeness of the population under study, and therefore generalization of the results should be done with caution. Furthermore, self-selection biases may inflate, or deflate the significance of the results, including the incidence of depression. We were unable to explicitly identify the factor that led to only 50% of potential participants sending back the questionnaire, although previous researchers (Sam, 1995; Sam & Berry, 1995) have suggested that immigrants from developing countries are not familiar with the Western concept of psychological research, hence they hesitate to take part in the research. Despite, Sam (1995) and Sam and Berry's suggestion, some of these unknown factors could be important and may contribute to pathways to depression in this population, and this could not be addressed by the design of the current study.

Secondly, all measures were administered in English and distributed among high school students. Thus, it is likely that Vietnamese Australian

adolescents with poor English language skills, and those who were disengaged

from school were not included in the study. However, such a sampling bias is

likely to yield an underestimated rate of depressive symptoms, as language

difficulties and dropping out of school may place those adolescents at greater risk

for developing depression.

Thirdly, because this current study was cross-sectional, it was not possible

to determine causal flow among the variables. For example, although structural

equation modeling can determine whether a hypothesised model is consistent

with the data, it does not always clearly establish whether a particular variable is

cause or effect of another variable. It may be that adolescents who show more

depressive symptoms may be more biased in their perception of their family

interactions and relationships. Depressed adolescents might perceive their home

and school environment negatively, and could thus interpret people's neutral

actions as discriminatory.

Fourthly, results of this current study rely solely on self-report data. All

data in this study was based on adolescents' self-appraisal. Hence, this may mean

that the relationships found between their family functionality and their social

environment and their depressive symptoms were inflated. Also, generation gap

between parent-adolescent was not assessed in this study, thus the intensity of

transcultural conflict could not be discerned from the design of this study.

Fifthly, this current study did not employ a control group, thus, it is

uncertain whether Vietnamese Australian adolescents have higher incidences of

depression than their Anglo Australian counterparts. Without a control group, the

results should be view with caution as there is no direct evidence that the identified family variables in the current study were due to the cultural differences in family interactions between Vietnamese Australians and Anglo Australians. Also, without a control group, it is unclear whether the identified family variables were associated with higher level of depression exclusively among Vietnamese Australian adolescents, or whether these family variables might also be risk factors for other cultural groups. Finally, the samples of both studies were relatively small and consisted of only one ethnic group. Therefore, the findings are difficult to generalise to other ethnic minority groups.

GENERAL DISCUSSION (Study One and Two)

Although Study One and Two were conducted in one year apart, the incidence of depressive symptoms among Vietnamese Australian adolescents in both studies was identical. Both studies revealed that 20% of Vietnamese Australian adolescents experienced clinical levels of depressive symptoms. As a comparison, 12% of the standardised sample of the RADS (Reynolds, 1986) reported similar levels of depressive symptoms. This percentage is relatively high, suggesting that acculturating Vietnamese Australian adolescents may have higher risks for developing clinical depression. Both studies also illustrated that family cohesion was significantly linked to depression and remained the most important family variable that contributed to depression. Furthermore, Vietnamese Australian adolescents experiencing high levels of acculturative stress also reported higher levels of depressive symptoms. This finding was consistent in both Study One and Two.

The finding also suggested that acculturation is an inevitable process that occurs when people come to contact with a cultural context that is different to their ethnic cultural values and customs. This process however, creates an acculturation gap among family members and often younger people acculturate to the mainstream culture at a faster rate than the older family members (Berry, 1998; William & Berry, 1991). As a result of this acculturation gap, conflicts that reflect different cultural values between parent-adolescents commonly occurred in immigrant families. This type of conflict was found to be more important in influencing on Vietnamese Australian adolescents' mental health than normal

family conflict. Indeed, over two studies, family conflict was not found to be directly related to depressive symptoms. The results of Study Two showed that transcultural conflict not only directly linked to depression it also weakened the family cohesion. Beyond transcultural conflict, open parent adolescent communication which was not a traditional way of communication in Vietnamese families was found to be an adaptive factor in nurturing family cohesion. In contrast, avoidant conflict resolution style that was once preferred by Vietnamese people (Dsilva, & Whyte, 1997) was no longer adaptive in Australia. Moreover, racial discrimination did not relate to depression directly; however, it decreased a sense of school connectedness and increased acculturative stress.

Consistent with studies of adolescents in the general population, the importance of family experiences for the well-being of adolescents was evident in both current studies. In particular, family cohesion emerged as an important family variable in the development of depressive symptoms in both of the studies. Specific to the migration experience, the impact of acculturation as expressed by transcultural parent-adolescent conflict on family cohesion appears to be crucial to this sub-population. Acculturation gap in Vietnamese Australian families also seemed to decrease their family cohesion. This low level of family cohesion is perhaps not surprising, given that adolescence is the period in which young people are striving for personal autonomy and a sense of identity as well as competency (Barber, 1996). However, pursuing individual goals and interests is restricted in Vietnamese families, particularly where they strongly hold Vietnamese traditional values and customs (Nguyen & William, 1988).

These young Vietnamese Australian people are not only struggling with their own process of physical and psychological maturation, they also need to deal with the cultural differences between themselves and their family members. The results of the qualitative study provided rich information about parent-adolescent interactions in Vietnamese families. It is clear that many acculturating adolescents viewed their parents as overly strict, protective, authoritarian, uncommunicative, unexpressive and unaffectionate. These adolescents found that it is difficult to share with their parents about their personal issues, because open communication between them and their parents had not been introduced and reinforced when they were younger. Therefore, by the time they had reached adolescence, it was already difficult for them to talk to their parents when they were loaded with experiences of emotional difficulty. Clearly, the qualitative data revealed that young Vietnamese Australians yearned for personal freedom and open communication in the family, and for acceptance by their parents for who they were as individuals.

The qualitative data also demonstrated that Vietnamese Australian adolescents experienced racial discrimination, especially at school. For example, many participants in the focus group interview felt that they were rejected and excluded by school teachers and peers. This is fundamentally important because how students feel about school is largely determined by the quality of the relationship they have with their teachers and peers (Osterman, 2000). In the Study Two, the quantitative data revealed that perceived discrimination was a significant contributor to decreased school connectedness. It seems that students

need to be accepted and respected by peers and teachers in order to establish a sense of school connectedness. Because teachers and school peers play a major role in determining whether students feel cared for, and how they experience a sense of connectedness, receiving differential treatment based on race and/or appearance could hinder Vietnamese Australian students' ability to develop a sense of connectedness to their school (Baumeister & Leary, 1995; Roeser, Eccles & Sameroff, 2000). Clearly, discrimination at school created a lack of feelings of belongingness, which could have then increased the risk of a higher incidence of mental health problems in this group of adolescents.

Moreover, struggling between the two cultures was an important theme in the focus group interview. At home many Vietnamese Australian adolescents faced the difference in values and lifestyle between them and their parents. The parental expectation of their academic performance was not uncommon. Socialising with peers was restricted and seemed to be replaced by the pressure of study. Beyond home, these adolescents faced the cultural differences of the mainstream, the language that many of them could not master, and the Western communication and interpersonal styles that are not familiar. All these factors make it difficult for them to integrate into the larger society. Many participants discussed that they felt like there are barriers and it is difficult for them to break these barriers. The quantitative data of the two studies showed the relationship between acculturative stress and depression among this sub-population. Furthermore, perceived discrimination seems to complicate the process of acculturation and exacerbated the levels of acculturative stress found in this

study. It is obvious from the findings that these acculturative stressors impede the mental well-being of this sub-population.

Moreover, because of the process acculturation, some Vietnamese Australian adolescents may not be able to form a meaningful relationship with others. It has been suggested that an important part of the human experience is the ability to form and maintain meaningful relationships with others and their social environments. Family and school arguably are important social environments for young people (Baumeister & Leary, 1995). The Integrated Pathway (figure 5) showed that family cohesion significantly linked to a sense of school connectedness. It appears that those Vietnamese Australian adolescents who viewed their family as less cohesive also had a lower sense of school connectedness. These adolescents seemed to become estranged from their own family, and failed to connect to their school, which is an important context, second only to their family.

According to Hagerty et al. (1992), a sense of social connectedness develops early in life and extends throughout the life span. Within the family, parent-child attachment is a form of social connectedness that provides an initial sense of security and likeness with others. However, due to the acculturation gap that seemed to exist in the families of many Vietnamese Australian adolescents, healthy attachment between parent and child may have been impeded. For example, many of the acculturating adolescents in this study felt that their parents did not accept them for being who they are. Hence, because these Vietnamese Australian adolescents did not feel securely connected with their parents in their

home environment, and because they did not experience themselves as worthy of love and respect, it was difficult for them to connect with others in different social settings, and in this case, in their school environment. It is clear from the findings of both current studies that strong family bond between parents and adolescents is an important source of protecting adolescents from developing mental health problems. This is true for most children and adolescents in the general population, but may be more critical for ethnic minority children and adolescents because they require extra family support in order to successfully adjust to the mainstream society.

9.6 Suggestions for Future Research

Therefore, longitudinal research and clinical evaluations are needed to determine whether changes in family cohesion and school environment affect adolescents' depressive symptoms, or to determine if change in mood results in changes in the variables suggested as predictors of depressive symptoms in this study. Further, although low levels of family cohesion and transcultural conflict were evident in this study, the acculturation levels of both parents and adolescents were not assessed. It remains to be researched whether family cohesion and transcultural conflict were a result of an acculturation gap, or whether these variables were just the perceptions of depressed adolescents. Hence, levels of the acculturation gap between parents and their adolescents should be addressed in future research to clarify this relationship.

As this study only used single format self-report methodology, future research would benefit from inclusion of data from other sources (e.g. parents).

The present study addressed the relationships among family functionality, discrimination, acculturative stress and a sense of school connectedness within a sample of Vietnamese Australian adolescents. Thus it is not possible to draw distinctions between the experiences of Vietnamese Australian adolescents and other ethnic groups. Also, due to the limited sample size, the effect of demographic variables on adolescent depression and gender difference regarding the frequency of depressive symptoms was difficult to examine. Further study should use a design that increases the study's generalisability. For example, the relationships between family functionality, discrimination, school connectedness, acculturative stress and depression should be investigated with different ages, and ethnic groups. This study did not assess individual attributes such as stress coping skills, cognitive styles, self-confidence and acculturation strategies (assimilation, separation, integration and marginalisation). These individual attributes should be explored in further research to determine whether personal factors would increase the risk for acculturative stress, a sense of school connectedness and ultimately depression.

Sampling procedures were a concern in this current study because participants were not recruited at schools. However, contrary to schools' belief that their students would be disadvantage if they participate in the research, many participants in the focus group interviews expressed that they were grateful because their difficulties had been addressed, and they thus experienced a sense of validation. This issue should be explained to schools in future research so that a more representative sample could be obtained. Between group-comparisons

(e.g., Anglo, Vietnamese and other immigrant groups) could also be useful for future research to ascertain whether the identified family interaction in this study was only predominant in Vietnamese families or whether other cultural groups also share the same difficulties. The rates of depression among different groups also will be more evident if between group comparisons method is used.

9.7 Clinical Implications

Despite the mentioned limitations, the results of these two studies have important implications for clinical intervention with immigrant adolescents who suffer from depressive disorders. As adolescent depression has significant costs for individuals, their families and society, the need to reduce the elevated rates of adolescent depression in the Vietnamese immigrant population is imperative. This present study provides clear implications for designing an effective prevention and intervention program to reduce Vietnamese Australian adolescent depressive symptoms. Findings from this study clearly indicate that a prevention program for Vietnamese Australian adolescents should incorporate parenting practice components. For example, issues such as improving parent-adolescent communication, especially for improving parents' skills in expressing their love and approval for their children, should be a focus of any such parenting program. Further, Vietnamese Australian parents should be encouraged to allow their children to voice their disagreement in a safe manner. Furthermore, Vietnamese Australian parents need knowledge about acculturation processes, and about acculturative stress that their adolescents might be experiencing. Having this knowledge, Vietnamese Australian parents might find it easier to accept their

adolescents' new values and ways of behaving. Vietnamese Australian parents also should be encouraged to support their adolescents' education, by being actively involved with the school and by monitoring their adolescents' academic progress. Moreover, when these parenting practices are implemented, Vietnamese Australian parents should be encouraged to adopt these practices in their daily interactions with their adolescents. Importantly, because parenting practices influence adolescents' perceptions of their family environment and parental behaviours, improving these domains might enhance adolescent's positive evaluation of their family functionality. Additionally, adolescents could then transfer a sense of connectedness at home to other contexts, such as in their school and in their local community.

Results of this study showed that second to family, school is the most important stablising force in the lives of young ethnic minority students. It is evident that a sense of school connectedness is an important factor protecting ethnic minority adolescents from depression. As discrimination hinders ethnic minority adolescents developing a sense of school connectedness, school policies targeted at reducing discriminatory behaviours should be implemented. In order to reduce their elevated rates of depression, school staff should foster a school environment wherein ethnic minorities feel connected to their school, and where they feel comfortable to believe that the adults in their school care about them and their learning. In other words, it would be beneficial if schools not only created a beneficial learning environment in general, but also endeavoured to

create an atmosphere where immigrant students felt physically and emotionally safe.

Moreover, the present findings have implication for the evaluation, intervention and treatment of depressed ethnic minority adolescents. For adolescents who might suffer from depression, the findings highlight the importance of assessment and treatment within a cultural context. For example, when clinicians provide treatment for a Vietnamese Australian adolescent with depression, it is important to also assess the stress relating to acculturation and the level of family support and cohesion. It is also important to evaluate the acculturation gap between the adolescent and his/her family members in order to estimate the intensity of transcultural conflicts in that family. Clinicians need to make sure that family members of the depressed adolescents are aware of the cultural diversity within their family.

9.8 Conclusion

In conclusion, this study makes several contributions to the body of research with ethnic immigrant adolescents. The results confirm that Vietnamese ethnic adolescents reported elevated clinical levels of depressive symptoms. Parental open communication, family conflicts and conflict resolution style contributed to family cohesion, which in turn affected Vietnamese Australian adolescents' mental health. In this study, the existence of an acculturation gap exacerbated parent-adolescent transcultural conflict, which further diminished family cohesion and consequently significantly influenced Vietnamese Australian adolescent depression. Furthermore, perceived discrimination lead to increased

levels of acculturative stress and therefore hindered the immigrant adolescents'

ability to form a sense of school connectedness. Thus, it appears that the

experience of immigration has a paramount impact on the mental health of young

immigrant adolescents.

The findings of these studies indicate that Vietnamese Australian

adolescents are at risk for mental health problems. The elevated rate of depressive

symptoms in Vietnamese Australian adolescents highlights an important problem

that must be addressed. Clearly there is a need for an ecological approach to

interventions for the prevention of depression in Vietnamese Australian

adolescents. It appears that a sense of connectedness to both the family and

broader social contexts, such as in the school environment, is important in

reducing depressive symptoms in Vietnamese adolescents who are raised in

Western countries. Any treatment or prevention approach must take these

contextual factors into account.

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APPENDIX A

Demographic Information

Please indicate your

Gender: Male ☐   Female ☐

Age:_____

Grade:_____

Were you born in Australia?

Yes ☐   No ☐ ⟶ How long have you been in Australia? ____

Father's education

1. Primary school level ☐   2. Some high school ☐   3.High school ☐

4. Further training after high school graduate ☐   5.University degree ☐

6. Master degree and higher ☐

Mother's education

1. Primary school level ☐   2. Some high school ☐   3.High school ☐

4. Further training after high school graduate ☐   5.University degree ☐

6. Master degree and higher ☐

How would you describe your ability to speak Vietnamese?

1=Not at all   2 = A little   3 = Reasonably well   4= Well   5= Very well

How would you describe your ability to speak English?

1=Not at all   2 = A little   3 = Reasonably well   4= Well   5= Very well

How would you describe your father's ability to speak Vietnamese?

1=Not at all   2= A little   3 = Reasonably well   4= Well   5= Very well

How would you describe your father's ability to speak English?

1=Not at all   2= A little   3 = Reasonably well   4= Well   5= Very well

How would you describe your mother's ability to speak Vietnamese?

1=Not at all   2= A little   3 = Reasonably well   4= Well   5= Very well

How would you describe your mother's ability to speak English?

1=Not at all   2= A little   3 = Reasonably well   4= Well   5= Very well

APPENDIX B
Asian American Family Conflict Scale

The following statements are parent-child situations that may occur in families. Consider how likely each situation occurs in your present relationship with your parents. Read each situation and answer the following questions using the following rating scales:

How likely is this type of situations to occur in your family?

1………….……….2………….……..……3……………………….…..4………….……....5

| Almost never | Once in a while | Sometimes | Often or frequently | Almost always |

FAMILY SITUATIONS
LIKELIHOOD

1. Your parents tell you what to do with your life, but you want to make your own decisions……………………………..1 2   3   4   5

2. Your parents tell you that a social life is not important at this age, but you think that it is………………………………………1 2   3   4   5

3. You have done well in school, but your parents' academic expectations always exceed your performance. …………………….…...1 2   3   4   5

4. Your parents want you to sacrifice personal interests for the sake of the family, but you feel this is unfair…………………………………1 2   3   4   5

5. Your parents always compare you others, but you want them for accept you for being your self…………………………………………1 2   3   4   5

6. Your parents argue that they show you love by housing, feeding, and educating you, but you wish they would show more physical and verbal signs of affection……………………………………….…..1 2   3   4   5

7. Your parents don't want you to bring shame upon the family, but you feel that your parents are too concerned with saving face………….1 2   3   4   5

8. Your parents expect you to behave like a proper Asian male or female, but you think your parents are being too traditional………………….1 2   3   4   5

9. You want to state your opinion, but you're your parents consider it to be disrespectful to talk back…………………………………………..1 2   3   4   5

10 Your parents demand that you always show respect for elders, but you believe in showing respect only if they deserve it. ………………...1 2   3   4   5

APPENDIX C

Informed Letter for Student

Researchers

Dr. Ian Shochet, 3875 3353; Dr.David Shum, 3875 3370; Nga Vu 3393 1705

Dear student

My name is Bach Nga Vu. I am currently undertaking a project entitled "Promoting Mental Health for Vietnamese Adolescent Who Reside in Australia" at Griffith University, under the supervision of Drs Ian Shochet and David Shum. This research project is being conducted to partly meet the requirement of a PhD degree. The purpose of this project is to explore the difficulties that Vietnamese Australian teenagers are facing.

As you may realize teenage years are times of many changes. Various challenges may arise, such as the demands of study, peer pressure, family conflicts etc. Most teenagers move through this without major problems, however some develop emotional difficulties.

Previous research showed that Vietnamese teenagers who live in Western countries have more stress than teenagers in general. It is very important to understand the reasons that contribute to difficulties arising for Vietnamese Australian teenagers. The results of this study will help researchers and counselors to develop ways to help Vietnamese Australian teenagers.

If you have been in Australia more than two years, and if your age is between 14-17 years, we would like to invite you to participate in this project. Your participation will greatly contribute to the understanding of the difficulties and challenges that Vietnamese Australian teenagers are facing. Your participation will help us to help many teenagers of Vietnamese background. Participation in this project is voluntary. It will involve you to respond to a packet of questionnaires which include part A to K. It would take about one and a half hour to complete. To keep the information anonymous, you do not need to put your name on the questionnaires. Also, information derived from this study will be kept in the strictest of confidence.

To compensate for your time, you will receive $15 once you send us the completed questionnaires. If at any time you have any questions or complaints concerning the way in which the project is being conducted, please contact the researchers that are listed above. If you prefer to speak to an independent person please contact:

The University's Research Ethics Officers, Office for research, Bray Centre, Griffith University, Kessels road, Nathan, Qld 4111, telephone (07) 3375 6618 or; The Pro Vice-Chancellor (Administration) Bray Centre, Griffith University Kessels road, Nathan, Qld 4111, telephone (07) 3375 7343.

Griffith University and the Researchers gratefully acknowledge and thank you for your contribution and the support you have provided to its research initiatives.

APPENDIX D
Informed Letter for Parents

Dr. Ian Shochet 3875 3353; Dr. David Shum 3875 3370; Nga Vu 3393 1705

Kính thưa quí đồng hương
        Xin phép tự giới thiệu, tôi tên là Vũ thị Bạch Nga,
nghiên cứu sinh tiến sĩ ngành tâm lý tại viện đại học
Griffith, Brisbane. Hiện tôi đang đảm nhận một đề án mang
tên là 'Chương trình nâng cao sức khỏe tinh thần cho thiếu
niên V.N cư ngụ tại Úic .
        Có lẽ quí vị cũng đã biết, tuổi thiếu niên
(adolescence) là giai đoạn chuyển tiếp từ trẻ con qua người
lớn, từ lệ thuộc vào cha mẹ sang thời kỳ muốn hoàn toàn độc
lập. Cũng trong thời kỳ này, tâm lý và sinh lý của các em
thay đổi mau lẹ. Chương trình trung học trở lên khó hơn,
và cha mẹ cũng như thầy giáo bắt đầu kiểm soát việc học
hành của các em và những sinh hoạt cá nhân gắt gao hơn. Vì
những thay đổi qúa nhanh này, có rất nhiều thiếu niên mắc
phải triệu chứng buồn nản qúa độ (depressive symptoms).

        Trạûng thái buồn nản quá độ có tiềm năng mang lại
nhiều điều không tốt cho người thiếu niên. Vì khi bị buồn
nản qúa độ, các thiếu niên dễ gây ra những sai lầm, thí
dụ: chễnh mảng chuyện học hành, và quá khích; khi thì lầm
lỳ ít nói, khi lại dễ gây sự đánh nhau. Nhiều thiếu niên
khi buồn nản quá độ, mất hy vọng vào tương lai không ngần
ngại tự tử hoặc xử dụng các loại thuốc cấm như cần sa và ma
túy.
        Căn bịnh thời đại này đang là mối quan tâm của các bậc
cha mẹ cũng như nhiều nhà nghiên cứu tâm lý. Nhiều nhà
nghiên cứu tại Mỹ và Châu Âu tường trình rằng tỉ lệ thiếu
niên gốc Á Châu bị những triệu chứng buồn nản qúa độ nhiều
hơn thiếu niên người bản xứ. Nguyên nhân nhiều thiếu niên
V.N bị những triệu chứng này cao hơn các bạn đồng lúa tuổi
bản xứ không rõ ràng.
        Mục đích của cuộc nghiên cứu này là tìm hiểu những
nguyên nhân làm cho các thiếu niên V.N cư ngụ tại Úc bị
triệu chứng buồn nản qúa độ, và những nguyên nhân giúp các
tthiếu niên có một đời sống vui vẻ. Chúng tôi mời gọi các
em thiếu niên tuổi từ 14 đến 17 tham dự cuộc nghiên cứu
này. Việc tham dự của các em hoàn toàn tự nguyện và chúng
tôi sẽ trả cho các em $15. Trong các bản tường trình, mọi
chi tiết cá nhân sẽ hoàn toàn không đề cập đếnü. Tất cả tài
liệu cung cấp cho cuộc nghiên cứu này sẽ được giữ kín và
bảo mật.
        Xin quí vị cho phép con em mình được tham dự cuộc
nghiên cứu này vì sự tham gia của các em là một đóng góp
rất lớn cho công trình nghiên cứu này. Kết qủa của cuộc
nghiên cứu này sẽ giúp những nhà nghiên cứu và chuyên viên
tâm lý tại Úïc hiểu được những khó khăn của thiếu niên V.N.

Mọi thắc mắc hoặc than phiền về phương thức cuộc nghiên cứu xin liên lạc nhóm nghiên cứu.

Hoặc nếu quí vị muốn tiếp xúc với những người không liên quan tới nhóm nghiên cứu xin liên lạc:

The University's Research Ethics Officers, Office for research, Bray Centre, Griffith University, Kessels road, Nathan, Qld 4111, telephone (07) 3375 6618 or; The Pro Vice-Chancellor (Administration) Bray Centre, Griffith University Kessels road, Nathan, Qld 4111, telephone (07) 3375 7343.

Đại Học Griffith vào nhóm nghiên cứu xin chân thành cám ơn sự tham gia của quí vị và các em thiếu niên.

APPENDIX E

CONSENT FORM (CHẤP THUẬN)

Tôi đã đọc mọi chi tiết và hoàn toàn hiểu rõ mục đích cũng như phương thức cuộc nghiên cứu đề án mang tên "Chương trình nâng cao sức khoẻ tinh thần cho thiếu niên V.N cư ngụ tại Úc". Tôi chấp thuận cho_____ tham dự cuộc nghiên cứu này. Tôi hiểu rằng phương thức nghiên cứu của đề án này sẽ được thi hành như chi tiết đã nêu rõ. Tôi cũng hiểu rằng tham dự vào cuộc nghiên cứu này sẽ không gây ảnh hưởng xấu gì cho con/em tôi.

Ký tên:

_____
Cha Mẹ   Ngày Tháng Năm

I agree to participate in the "Promoting Mental Health for Vietnamese Adolescent who reside in Australia" project and give my consent freely. I understand that the project will be carried out as described in the information letter, a copy which I have retained. I also understand that I can withdraw from the project at any time and that I do not have to give any reasons for withdrawing. I have had all questions answered to my satisfaction.

Signature:

_____
Student (participant)   Date

Dear student

Please send this page to me with your <u>completed questionnaires</u>. Write your name and address on the reply paid envelope so that I can send money to you. To keep the information anonymous, I will separate your completed questionnaires and your personal information (name and address on the envelope) before I look at your response. Money will be sent to you immediately afterward.

Thank you