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INVESTIGATING PSYCHOSOCIAL WELL-BEING AMONG ETHNICALLY DIVERSE RURAL WOMEN: EXPECT THE UNEXPECTED

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ABSTRACT—The purpose of this study was to examine patterns of similarity and difference in psychosocial well-being among 42 first-generation, Spanish-speaking Latinas, 23 second-generation, English-speaking Latinas, and 25 English-speaking Caucasian women residing in five unique rural Nebraska communities. Participants completed a series of self-report survey instruments to assess indices of psychosocial health, including: marital satisfaction, marital communication, family communication, social support, and depression. Spanish-speaking Latinas and English-speaking Caucasians evidenced the greatest *similarity* in patterns of experience. Twenty-eight percent of the total sample ($n = 25$) scored above the clinical cutoff for depression. Implications and suggestions for future work are discussed.

Key Words: Non-Latina Caucasian, Latina, Midwest, psychosocial well-being, rural, women

INTRODUCTION

Latinos comprise the largest ethnic minority group in the United States, a significant percentage of whom were born in foreign countries (Garcia 2005). Culturally diverse communities are no longer the sole purview of border states (e.g., Arizona, California, and Texas) and urban gateway cities. Traditionally homogenous Great Plains states are becoming increasingly ethnically diverse due to an influx of immigrant newcomers. Nebraska is no exception. Between 1990 and 2000 Nebraska's Latino growth rate (108.8%) eclipsed national averages (38.8%) (WebArchives 2000); Nebraska hit the top ten list of states experiencing the highest Latino population growth during the decade of the 1990s (Marotta and Garcia 2003). In Nebraska, as in many other Great Plains states, immigrant newcomers are establishing permanent residence in rural communities at an unprecedented rate. Moreover, approximately 20% of the total U.S. population of women, specifically, live in rural areas, half (10%) of whom are women from racial and ethnic minorities.

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Rural women, and ethnically diverse rural women in particular, experience a host of personal, cultural, and environmental challenges that may jeopardize psychosocial well-being. For instance, compared to their urban counterparts, women living in rural areas often experience geographic and informational isolation, fragmentation of services, transportation and educational limitations, and disproportionate poverty (Murty et al. 2003). Women of color experience all of these in addition to cultural differences, different health-care beliefs, racism, language barriers, migratory patterns that further fragment services and health care, abject poverty, and inequalities of political and economic access (Hargraves 2002).

Rural women, especially immigrants, represent a particularly vulnerable population. Still, issues impacting the psychosocial well-being of rural populations, generally speaking, and rural women in particular, have received negligible attention in the academic literature. Limited accessibility, variable legal status, cultural and language barriers, and transitional residence patterns render research with rural immigrant populations difficult. Yet immigrant influx into rural geographies is not expected to subside but to continue growing steadily—especially as social networks in receiving communities become more dense and multidimensional (Garcia 2005). Lacking adequate knowledge, service providers are ill equipped to meet the unique needs of an increasingly diverse rural population. This investigation was designed to address gaps in the literature and to provide a springboard for continued dialogue, research, and scholarship. To this end, the purposes of this investigation were to (1) examine psychosocial well-being (e.g., depression, marital satisfaction, and social support) among ethnically diverse rural women, and (2) identify patterns of similarity and difference between rural immigrant Latinas and their non-Latina Caucasian peers. Such information is vital for allocating limited resources to better meet the needs of *all* community residents, regardless of ethnicity or nativity. Literature is discussed below in relation to the variables of interest, with emphasis on Latinos in particular, where such information exists.

REVIEW OF THE LITERATURE

Psychosocial Well-Being in Relation to Marital Satisfaction and Depression

Marital satisfaction is an important indicator of psychological health. People with strong marriages tend to report feeling happier and more fulfilled than those with unhappy marriages (Doherty et al. 1989; Amato 2000). When marital conflict exists, it typically centers on communication and power struggles (Whisman et al. 1997), finances (Zagorsky 2003), and division of household and family labor (Coltrane 2000)—problems that are often exacerbated given challenges associated with immigration and acculturation (Hondagneu-Sotelo 1992; Dalla et al. 2006; Padilla and Borrero 2006).

There is a growing body of work linking depressive symptoms with marital satisfaction, and both variables often co-occur (Denton et al. 2003). Aranda et al. (2001), for instance, examined gender differences in stress, social support, and coping in relation to depressive symptoms among Mexican Americans. Interestingly, among the men, psychological well-being was impacted by social support from outside sources; among the women, however, support from the marital relationship was related to psychological well-being. Women with low levels of spousal support reported the greatest depressive symptoms. In other words, marital *quality* may be particularly significant for women's, rather than men's, psychological health.

Although not yet well understood, some research suggests that *acculturation* may influence perceptions of marital satisfaction as well. Vega et al. (1988) examined marital strain, coping, and depression among 500 urban Mexican American women. Low levels of acculturation were linked to increased marital strain and self-denigration, and decreased use of negotiation in response to spousal conflict. They suggest that marginal acculturation may function as an independent stressor within marriage, as less acculturated individuals may not be as well equipped compared to their more acculturated peers to manage the external environment, leading to isolation and alienation.

Yet others have found the opposite. Casas and Ortiz (1985) compared marital satisfaction among Mexican American couples born in Mexico with those born in the United States; results revealed higher marital satisfaction among the Mexican-born (i.e., less acculturated) couples. These authors suggest that more *highly* acculturated couples may experience unique stressors in their marital relationships, particularly in relation to redefining traditional husband and wife roles. Similarly, Negy and Snyder (1997) compared marital satisfaction between 75 Mexican American and 66 non-Hispanic white couples using the Marital Satisfaction Inventory-Revised (MSI-R). Mexican American respondents reported greater distress on three scales (i.e., Global Distress, Problem-Solving Communication, and Aggression). Further analyses

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revealed significant associations between acculturation and three other MSI-R scales for the *wives only*, indicating "higher distress or a more critical appraisal of the marriage given higher levels of acculturation to White American culture" (419). The level of acculturation was unrelated to marital distress for the Mexican American husbands. Given the limited and sometimes discrepant data, additional inquiry into the role of acculturation on marital dynamics and psychosocial health, for women in particular, appears warranted.

Psychosocial Well-Being and Social Support

Social support often moderates depression among both European American and Mexican American families. Mexican immigrants reporting more social support have a lower risk for depression than those who report less support (Golding and Burnam 1990; Vega et al. 1991). Such findings are consistent with research on samples of mixed ethnicities, suggesting that limited social support may put individuals at risk for negative emotional outcomes, including depression (La Roche and Turner 1997). Support from family and friends may moderate the effects of stress by helping individuals to cope with problems, organize resources, share the burden of stress, and provide emotional or instrumental assistance (La Roche and Turner 1997). Social networks are critically important to the immigration process as well, as they facilitate movement to the receiving country, and help ease adaptation by providing assistance in securing employment (Massey et al. 2002; Garcia 2005).

Yet access to and availability of support may be strongly related to residence and nativity; limited interaction with family members due to physical separation, for instance, may strain family relationships or render network support impotent (Cervantes and Castro 1985). Zambrana et al. (1992) found that, compared to Mexican immigrant women, Mexican American women (MA) reported larger networks of relatives in close proximity, were more likely to live with members of their families of origin, and were more likely to receive help from family members. In contrast, the Mexican immigrant women had limited family network members in the area, were more likely to live with in-laws, and less likely to seek assistance from those family members. Similarly, Vega (1990) found that, compared to Mexican immigrants, Mexican Americans are more likely to have broader social networks with support systems consisting of "multigenerational kin and friend contacts" (1019). Simply stated, first-generation immigrants may have exceedingly limited social support and familial resources. Limited support may be exacerbated by social isolation among those residing in rural areas, placing them at greater risk for negative psychosocial outcomes.

Still, few have examined social support by nativity while *simultaneously* exploring differences based on geography (i.e., rural vs. urban), although one study is particularly relevant to the present investigation. Saldaña et al. (1999) examined the caregiving burden among English-speaking Mexican Americans (ESMAs), Spanish-speaking Mexican Americans (SSMAs), and European Americans (EAs) residing in both urban and rural contexts. Differences were found based on geography, ethnicity, and acculturation. In urban areas, stresses were rated highest by *Spanish speakers*, but in rural areas stresses were rated highest by *English speakers* (both EAs and ESMAs). Urban residents also tended to report greater levels of caregiver stress and greater use of coping responses. Moreover, urban-based Spanish-speaking Mexican Americans reported greater use of certain cognitive coping strategies than their peers, whereas in rural areas, English-speaking Mexican Americans reported greater use of the same strategies. Given the limited research using geography as a factor influencing psychosocial health while simultaneously comparing ethnically diverse samples, many questions remain. The present investigation was meant to address some of these gaps in the literature.

The body of work explored here argues strongly for additional research into variables of psychosocial well-being given geographic, ethnic, and acculturation differentials. Our investigation was intended to fill gaps in the literature, through exploration of psychosocial well-being among rural-based, ethnically and culturally diverse women.

METHODS

Participant Recruitment

Data were collected in five rural communities located in central and northeast Nebraska. Communities were selected based on substantial increases in their Latino populations over the previous decade and high concentrations of Latino residents. (Counties in which the target communities were located ranged in total population from 9,497 to 36,035; between 1990 and 2000 all evidenced dramatic increases in their Latino population, from 317% to 1,259% [U.S. Census Bureau 2000].) Participants were recruited in three ways. First, the Extended

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Education Coordinator at the Northeast Research and Extension Center distributed bilingual (Spanish/English) flyers describing the study to rural Latinas participating in an online distance-education program; each distributed the flyers to family members, friends, or acquaintances fitting study criteria. The flyers included a toll-free number to call to learn more about the study. Second, an advertisement describing the study and including the same toll-free number was placed in two rural Nebraska Spanish-language newspapers. Finally, Catholic priests located in two of the five target communities displayed the flyers on tables in their church reception halls.

Participation required individuals be female, 19 years of age or older, living within one of the target communities (or surrounding areas), and either first- or second-generation immigrant Latina or non-Latina Caucasian. Additional criteria required participants be married (or cohabiting with a male partner) with at least one biological child, aged 16 or younger, residing in the home.

Procedures

A Colombian bilingual research assistant (RA) monitored the phone line, answered potential participants' questions, confirmed that individuals met participation criteria, and arranged all data collection sessions. Data were collected through the use of focus groups and self-report survey indices. The process of arranging data collection was complex because we needed roughly 6 to 10 participants per group (see Krueger and Casey 2000), fitting the same ethnic and nativity demographics, residing in the same community, and able to meet for a minimum of three hours at a time convenient for all. When enough participants with the same demographic characteristics within a particular community agreed to participate, the data collection sessions were scheduled. All participants were contacted again, several days prior to the scheduled meeting, as a reminder.

Data collection occurred in elementary schools, high schools, extension buildings, conference centers, and churches. A total of 13 focus groups were conducted (i.e., six with first-generation immigrant Latinas, three with second-generation Latinas, and four with non-Latina Caucasians). As participants arrived, they were greeted and provided refreshments and then given a folder containing the informed consent forms and survey indices (in Spanish and English). After all were seated, the informed consent form was read aloud to the group, questions were answered, and the forms were then signed; participants kept one for themselves and returned the second to the folder. Next, the survey packets were removed from the folder (all had been pre-coded with an anonymous identification number). Survey directions were read out loud and participants were instructed to work on them independently, although individual assistance was provided as needed. Once all survey indices were complete, they were returned to the folders and collected. (This paper focuses on results from the survey data only, and thus, procedures for collecting data through the focus-group sessions are not included.) Completion of survey indices took approximately one hour; participants were compensated for their time.

Instrumentation

In addition to a demographic form, Latina participants completed six self-report survey indices; the non-Latina Caucasian women completed five.

Depression. The Beck Depression Inventory (BDI) (Beck et al. 1988) is a 21-item self-report inventory measuring characteristic attitudes and symptoms of depression. Each of the 21 items is scored on a scale ranging from 0 to 3. Total BDI scores can range from 0 to 63, with scores of 16 or above indicating moderate to severe symptoms of depression. The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and nonpsychiatric populations, respectively. It demonstrates adequate reliability and validity when used with Latino populations (Contreras et al. 2004).

Marital Satisfaction. The Kansas Marital Satisfaction (KMS) survey (Schumm et al. 1986) is a three-item instrument designed to provide a brief measure of marital satisfaction. The response scale for each item ranges from 1 to 7, with a total summed score ranging from 3 to 21; higher scores indicate greater satisfaction. The KMS demonstrates excellent internal consistency (alpha of .93) and concurrent validity, significantly correlating with the Dyadic Adjustment Scale (see Schumm et al. 1986).

Marital Communication. The Primary Communication Inventory (PCI) is a 25-item instrument designed to assess marital communication. The response scale for each item ranges from one to five. After reverse scoring three items, all are then summed so that higher scores indicate more positively viewed marital communication. The PCI has excellent concurrent validity, correlating significantly with the Locke-Wallace marriage Relationship Inventory and has excellent known-group

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validity, distinguishing distressed and nondistressed couples and couples seeking therapy from nonclinical couples (Navran 1967).

Family Communication. The Family Problem Solving Communication (FPSC) inventory (McCubbin et al. 1996) is a 10-item instrument measuring both positive and negative patterns of communication. Response choices range from 0 to 3. After reverse scoring three items, a total scale sum may be obtained with higher scores indicating more positive communication patterns. The FPSC has excellent internal consistency (alpha of .89 for the total scale) and stability, with a test-retest correlation of .86 (see McCubbin et al. 1996).

Social Support. The Personal Resource Questionnaire Part 2 (PRQ85) (Weinert 1987) is a 25-item scale assessing perceptions of social support. Sample items include: "I belong to a group in which I feel important," and "I spend time with others who have the same interests I do." Participants indicate the extent to which they disagree or agree with each statement using a response scale ranging from Strongly Disagree (1) to Strongly Agree (7). A Total Support score is obtained by summing all items (ranging from a possible low of 25 to a high of 175). Five items were reverse coded so that higher scores indicated perceptions of more effective social support networks. The PRQ85 demonstrates adequate internal consistency (.85 to .93), test-retest reliability (.72), and construct validity among general and Mexican American samples (Weinert 1987; Hovey and Magaña 2002).

Language Preference/Acculturation. The Language Preference Scale (Cuellar et al. 1980) (completed by the Latinas only) consists of 12 items measuring language preference (Spanish/English) on a five-point Likert scale (1 = Spanish only to 5 = English only). The scale is intended to assess acculturation, with higher scores (greater English use) indicating greater acculturation. A score of three or greater indicates primary English-language usage.

Participants

Ninety women participated, of whom 51 were first-generation immigrant Latinas (i.e., born in Mexico or other Latin American country), 14 were second-generation Latinas (i.e., born in the United States, with parents born in Mexico or other Latin American country), and 25 were non-Latina Caucasians. Using ethnicity (Latina vs. non-Latina) and language use (primarily Spanish vs. primarily English) as proxies for acculturation, the 90 participants were divided into three groups: Spanish-speaking Latinas, English-speaking Latinas, and English-speaking non-Latina Caucasians.

Demographic Data. *Spanish-Speaking Latinas* (SSLs) (n = 42) ranged in age from 19 years to 54 years (mean = 33.4). The number of children ranged from one to five (mean = 2.7). Most (n = 32) identified themselves as Mexican or Mexican American. Forty were married and two lived with a male partner. The number of household members ranged from 3 to 10 (average = 5.0). Years of formal schooling ranged from 4 to 14 years (mean = 8.9). As a group, their median annual household income was between $20,000 and $29,000. Most worked either full-time (n = 23) or part-time (n = 5). Thirteen were unemployed. They had lived in their respective communities an average of 6.7 years.

English-Speaking Latinas (ESLs) (n = 23) ranged in age from 19 years to 50 years (mean = 30.4). They averaged 2.5 children (range = 1 to 4). Most (n = 21) were married and self-identified as either Mexican or Mexican American (n = 12) or Latina (n = 10). Years of formal schooling ranged from 6 to 14 (mean = 11.7). Number of household members varied greatly, from 3 to 13 (mean = 5.2) and most reported an annual household income between $10,000 and $29,999 ($n$ = 15). The majority worked either full-time (n = 11) or part-time (n = 5). They had lived in their respective communities, on average, about 10 years.

English-Speaking Non-Latina Caucasians (ESCs) (n = 25) ranged in age from 21 years to 52 years (mean = 38.8). On average, they had three children each (range = 1 to 5) and most (n = 24) were married. They averaged 13 years of formal education (range = 11 to 14 years) and about 4.5 household members (range = 3 to 7). Most worked either full-time (n = 15) or part-time (n = 7) and the majority (n = 15) reported an annual household income over $50,000. These women had lived in their respective communities an average of 18.5 years. Complete demographic data for all participants are located in Table 1.

Data Analysis

Preliminary analyses examined demographic differences between the three groups. Contingency tables were computed with the distribution tested by calculating a Pearson's chi-square test statistic and analysis of variance (ANOVA). Pairwise comparisons were conducted when

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TABLE 1
PARTICIPANT DEMOGRAPHIC DATA

	Latinas		Caucasians
	SSL (N = 42) %Mean (SD)	ESL (N = 23) %Mean (SD)	ESC (N = 25) %Mean (SD)
Age (in years)*[a]	33.4 (7.5)	30.4 (7.6)	38.8 (7.9)
Number of children	2.7 (1.1)	2.5 (1.2)	3.0 (1.2)
Ethnicity*[b]			
Central American	7.1	4.3	0.0
Hispanic/Latina	16.7	43.5	0.0
Mexican/Mexican American	76.2	52.2	0.0
Caucasian	0.0	0.0	100.0
Marital status			
Married	95.2	91.3	92.0
Separated	0.0	0.0	4.0
Cohabiting	4.8	8.7	4.0
Formal education*[c]	8.9 (3.0)	11.7 (1.9)	13.2 (1.0)
Years in community*[d]	6.7 (4.2)	10.3 (3.6)	18.5 (13.7)
Number in household	5.1 (1.3)	5.2 (2.0)	4.5 (1.1)
Employment status			
Full-time	55.0	48.0	60.0
Part-time	12.0	22.0	28.0
Unemployed/Looking	7.1	13.0	8.0
Unable to work	24.0	17.4	4.0
Annual Income*[e]			
<$10,000	4.8	0.0	4.0
$10,000–$19,999	19.0	26.1	28.0
$20,000–$29,999	31.0	39.1	8.0
$30,000–$39,999	7.1	17.4	4.0
$40,000–$49,999	17.0	0.0	12.0
$50,000 or more	0.0	13.0	60.0
Don't know	19.0	4.3	4.0

*$p \leq .001$.
[a]F (2, 87) = 7.705, p = .001, post-hoc comparisons: SSLs and ESCs are statistically significantly different from one another and ESL and ESC are statistically significantly different from one another.
[b]χ^2 = 97.671, p = .000, post-hoc comparisons: SSLs and ESCs are statistically significantly different from one another and ESL and ESCs are statistically significantly different from one another.
[c]F (2, 82) = 28.567, p = .000, post-hoc comparisons: all three groups are statistically significantly different from each other.
[d]F (2, 80)=15.808, p = .000, post-hoc comparisons: all three groups are statistically significantly different from each other.
[e]χ^2 = 49.881, p = .000, post-hoc comparisons: all three groups are statistically significantly different from each other.

three-way comparisons indicated significant differences between the groups. When the variances across groups were not assumed to be homogeneous, post-hoc comparisons were made using the Dunnet's C test. Otherwise, a Tukey HSD test was used. To assess the relationships among the marital satisfaction and psychosocial health variables within each group, a Pearson's Correlations Coefficient was computed for each bivariate relationship among SSLs, ESLs, and ESCs separately. Fisher's r to z transformations were calculated to assess whether differences in correlations among each of the groups were statistically significant.

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RESULTS

Significant differences in age, education, years in the community, and annual income were found (see Table 1). On average, ESLs were the youngest, with SSLs slightly older, and ESCs the oldest of the three groups. ESCs were the most educated of the women, followed by ESLs and then SSLs. Pairwise comparisons show all three groups as significantly different from each other. ESCs had, on average, the most years living within their respective communities and SSLs the least. Pairwise comparisons revealed significant differences between all three groups. The final demographic difference emerged for annual income. ESCs reported the highest income, followed by ESLs and then SSLs.

Comparisons of mean scale scores on the psychosocial variables of interest across the three groups revealed only one significant difference. SSLs reported significantly *lower levels* of social support than ESCs. However, we noticed that scores on the depression scale *ranged* appreciably across all participants (from a low of 0 to a high of 37). Subsequent analyses were conducted. Women with a total scale score below the clinical cut-off of 16 (n = 60) were assigned to a "low" depression group, and those with a total scale score of 16 or above (n = 25) were assigned to a "high" depression group. (Thirteen women in the "high" depressive group were SSLs [31% of the total SSL group], seven were ESLs [30% of the total ESL group], and five were ESCs [20% of the total ESC group].) In comparisons between the "low" and "high" depression groups on the remaining variables of interest, significant differences emerged. Women reporting more depressive symptoms also reported experiencing significantly lower levels of marital satisfaction, less social support, and less positive communication with their partners and families (see Table 2).

Correlational analyses were then used to examine *patterns* of similarity and difference in the interrelationships among the variables of interest across the three groups. More similarities than differences emerged (see Table 3), particularly between the ESCs and the SSLs—the two groups expected to evidence the greatest amount of difference. Depression was significantly negatively correlated with social support and spousal communication for all three groups regardless of ethnicity or language use. However, depression was significantly negatively correlated with family communication for SSLs and ESCs, but *not* for ESLs. Correlations between depression and marital satisfaction were not statistically significant for any of the groups. Followup r to z transformations revealed no statistically significant differences in correlates of depression among the groups with one exception. The correlation between depression and social support was significantly stronger for ESCs than for ESLs (Fisher's

TABLE 2
MARITAL SATISFACTION, SOCIAL SUPPORT, AND FAMILY AND SPOUSAL COMMUNICATION BY DEPRESSIVE-SYMPTOM GROUP

	Depression		
	High (N = 25)	Low (N = 60)	
	Mean (SD)	Mean (SD)	t statistic
Marital satisfaction	4.41 (1.64)	5.66 (1.78)	3.03**
Social support	125.24 (18.14)	142.95 (14.87)	4.75 *
Marital communication	3.33 (0.57)	3.86 (0.52)	4.16**
Family communication	1.97 (0.50)	2.37 (0.47)	3.56**

*$p \leq .01$; **$p \leq .001$.

TABLE 3
INTERCORRELATIONS OF MARITAL SATISFACTION AND PSYCHOSOCIAL HEALTH BY GROUP

	1	2	3	4	5
1. Depression	—				
2. Marital satisfaction					
SSLs (N = 42)	-.243	—			
ESLs (N = 23)	-.398	—			
ESCs (N = 25)	-.384	—			
3. Social support					
SSLs	-.540**	.254	—		
ESLs	-.443*[a]	.415*	—		
ESCs	-.768**[a]	.344	—		
4. Family communication					
SSLs	-.481**	.439**	.594**	—	
ESLs	-.321	.264	.366	—	
ESCs	-.426*	.601**	.506**	—	
5. Marital communication					
SSLs	-.343*	.476**	.438**	.443**	—
ESLs	-.532**	.503*	.621**	.291	—
ESCs	-.409*	.550**	.681**	.651**	—

*$p \leq .05$; **$p \leq .01$.
[a]Fisher's z = 1.746*.

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z = 1.764). (No other r to z transformations of the correlations of the remaining variables revealed statistically significant differences among the groups.)

For all groups, marital satisfaction was significantly positively correlated with marital communication. However, slight differences emerged in the relationship between marital satisfaction and social support versus family communication. Among ESLs only (not SSLs or ESCs), marital satisfaction was significantly positively associated with social support. In contrast, family communication was significantly positively associated with marital satisfaction among SSLs and ESCs but *not* ESLs.

Social support was significantly associated with marital communication for all three groups. Again, however, slight differences were revealed. Social support was significantly positively correlated with family communication for SSLs and ESCs but *not* for ESLs. And finally, family communication and marital communication were significantly positively correlated for both SSLs and ESCs but *not* for ESLs.

DISCUSSION

The goals of this investigation were to examine patterns of experience among a unique and often neglected population of women in relation to variables deemed significant for psychosocial health, and further, to identify patterns of similarity and difference among rural, immigrant Latinas and their non-Latina Caucasian peers. Patterns of similarity and difference, it was believed, would open dialogue and suggest avenues for continued scholarship and service provision. Results revealed several noteworthy findings, both expected and unexpected.

Despite ethnic, cultural, and English-language proficiency differences, the women were remarkably similar on many demographic characteristics. In fact, although significant differences emerged on several items (i.e., age, number of years in the community, formal education, and income) there were *no significant differences* between them in employment status, number of children, or number of people residing within their respective households. The women's shared experiences on many of the psychosocial variables of interest also revealed unexpected patterns of similarity. The two groups in which we expected to find the *greatest* divergence (i.e., Spanish-speaking Latinas and English-speaking Caucasians) evidenced the *most* similarity. Specifically, SSLs and ESCs reported common experiences with regard to associations between *all* psychosocial variables of interest. In comparing the three groups of women, the English-speaking Latinas emerged as most distinct. Two differences, in particular, deserve further discussion.

First, significant associations emerged between *family communication* and all other variables of interest (i.e., depression, marital satisfaction, marital communication, and social support) for both SSLs and ESCs. Such a pattern *did not* emerge for the ESLs. Family communication appeared surprisingly *insignificant* in relation to all other psychosocial variables for ESLs. Second, a significant association between marital satisfaction and social support emerged for the ESLs only, but *not* for SSLs or ESCs. Interpretation of these findings is informed by examination of the broader socio-environmental contexts in which these women live. Specifically, it can be argued that, due to dual-language proficiency (English and Spanish), ESLs have access to a broader range of social support network sources. Thus, bilingual competency has likely allowed ESLs to develop a supportive network comprised of individuals *beyond* the immediate and extended family; a support network not limited due to language constraints. In contrast, SSLs and ESCs may focus their energies *within* the family and thus, family-related variables (i.e., family communication) may play a much larger role in issues associated with personal, marital, and family dynamics (i.e., depression, marital communication and satisfaction, and social support).

One must also consider the role of perceived discrimination and prejudice in influencing the role of "family" and family communication in relation to other psychosocial variables among the SSLs and ESCs. SSLs likely experience greater discrimination than their ESL peers due to language barriers. If such is the case, it is possible that their energies are focused on those with whom they have the greatest in common (i.e., family, extended family). For the ESCs, one might reasonably assume that many are uncomfortable with the rapid increase in size and diversity of their former ethnically homogenous communities. Perhaps many have consciously chosen to limit exposure to "outside" influences, thereby focusing instead on their nuclear families—again explaining the significant role family communication played for these women in relation to other psychosocial variables of interest. Such interpretations are not without support, as prejudicial attitudes and discriminatory behavior is well documented within rural communities experiencing rapid immigrant influx (Gouveia and Stull 1995; Broadway 2000). In a recent investigation of non-Latino Caucasians' perceptions of community change due to rapid immigration, Dalla et al. (2004) found evidence of prejudicial attitudes and language barriers limiting

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contact between ethnically diverse groups. Specifically, "[Caucasian] participants felt that their once 'small town' communities were beginning to splinter, the result being two distinct communities: one non-Hispanic White and the other Hispanic" (240). However, we can only speculate about the effects of such on *family relationships* (including family communication and marital dynamics) due to limited scholarship in this area. Nonetheless, results of this investigation reveal clear distinctions in patterns of experience among ethnically diverse rural women indicating that English-speaking Latinas stand apart from both their mono-language (either Spanish- or English-speaking) peers. Additional research exploring family relationship variables across ethnically diverse populations, and the meaning of such for psychosocial health and family dynamics, is clearly warranted. Further, practitioners and community service providers are encouraged to explore, and then develop, strategies for bridging the divide between cultural groups living within their communities. Communitywide cultural education, perhaps through "cultural mediators," might be helpful. Cultural mediators are individuals whose sole purpose is to work within communities to mediate, educate, and enhance communication between diverse cultural groups. Their assistance may be particularly valuable in small communities experiencing rapid cultural and ethnic diversity.

From this investigation, depression also deserves greater attention, as results revealed findings that were both expected and unexpected. Depression was associated with each of the other variables representing psychosocial health in the *expected* directions—regardless of ethnic or language group. What was unexpected, however, was the large percentage of women in each of the three groups with depressive scores above the clinical cutoff (ranging from 20% to 31%). Also unexpected was the marked differences *between* women with high and low depressive-symptom scores on *every* other psychosocial variable of interest. Women in the high depressive group reported significantly less marital satisfaction, social support, and positive marital and family communication compared to their nondepressed peers. However, it is important to note that results of these analyses reveal relationships only, not patterns of *causation*. Future research designed to explore linkages and *causal associations* among indicators of psychosocial well-being would prove valuable for intervention and service provision.

Literature examining depression among the general population also informs the present study. Specifically, depression is more common among individuals of lower socioeconomic status and those who are unemployed or underemployed and less educated (McGrath et al. 1990). Such demographic characteristics apply to many of the participants in this study. In addition, rural residence may influence feelings of isolation, and mitigate career and economic advancement due to limited educational and employment options, which may exacerbate mental health difficulties. Unfortunately, rural residence significantly limits treatment options as well, as professional mental health services are notoriously scarce in rural geographies (Human and Wasem 1991; Rost et al. 2002). Even when services are available, mental health accessibility by Latinos or other ethnic minority groups is often constrained due to linguistic and cultural barriers, and lack of health insurance coverage (Mueller et al. 1999; Casey et al. 2004). Such findings are particularly disturbing because, in this investigation, Spanish-speaking Latinas—those most likely to be disenfranchised and least likely to receive appropriate mental health care—were most representative in the "high" depressive group. In a recent investigation comparing service utilization by Mexican immigrants and Mexican Americans, Vega et al. (1999) found that Mexican immigrants had a utilization rate two-fifths that of Mexican Americans. They conclude that Mexican immigrants are "unlikely to use mental health services, even when they have a recent disorder, but may use general practitioners, which raises questions about the appropriateness, accessibility, and cost-effectiveness of mental health care for this population" (928). We concur and challenge rural health-care practitioners to examine the availability, accessibility, and cultural relevance of mental health care service delivery for ethnically and culturally diverse residents. Further, it is important to keep in mind that *acculturative stress* (i.e., psychological conflict and social disintegration resulting from the acculturation process) (Parrillo 1991) is not uncommon among immigrant populations and may result in psychosocial and mental health problems (Thomas 1995; Miranda and Matheny 2000). Greater acculturative stress among the SSLs may also explain their higher rates of depressive symptoms compared to their ESL and ESC peers. Social service providers must be trained to identify symptoms of acculturative stress and to utilize culturally appropriate intervention strategies (Castex 1994).

Finally, in terms of scholarship, results of our study argue for continued examination of (1) patterns of similarity and difference in psychosocial health among ethnically diverse, geographically isolated populations, and the collection of data from both *wives and husbands* to further delineate family dynamic processes, (2) mental health and its attendant associations with family-dynamic

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variables, and (3) effective strategies for successful mental health service delivery to ethnically diverse rural populations.

Limitations

Despite the knowledge and insight gained from this investigation, it is not without limitations. First, due to the small sample size, the *generalizability* of results is limited. Our group of English-speaking Latinas (ESLs), in particular, was quite small despite significant recruitment efforts. Moreover, due to the small sample size we were limited in the type of analysis that could be conducted. Future research that expands upon the work here, by including a larger sample, is warranted.

Second, also due to sample size, one could argue that the lack of findings for the ESLs is more likely an issue of statistical power and the risk of a Type II error, not finding a difference from the null hypothesis that is actually present. However, the sample size of the ESLs (23) is not dramatically different from the ESCs (25), whereas both are substantially smaller than SSLs (42). The fact that correlations significant for ESCs were not significant for ESLs highlights the strength of the association present among the ESCs. Further, the fact that the level of significance for the ESCs was at $p \leq .01$ in 6 of the 8 statistically significant correlations, the same level for the SSLs (with one exception) suggests these two groups share similarities that neither share with the ESLs. If the phenomena were present for all groups but not identified due to a Type II error, we would likely see a difference in significance level associated with sample size differences, which we do not. However, because of the limitations associated with sample size the findings of this investigation should serve as a springboard for subsequent inquiry with a larger sample.

Finally, although participants were recruited from five different communities in an effort at diversification, all communities were located in Nebraska. Data collection *across* state lines is recommended; such would allow for cross-state comparisons and provide a more representative picture of psychosocial health among ethnically diverse *rural residents*, generally speaking, regardless of state of residency.

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