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Relational Patterns of Acculturative Stress and Psychological Distress in a Multiethnic U.S. Immigrant Sample: A Cross-Sectional Correlational Analysis

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Abstract

The United States currently hosts over 44 million immigrants, representing approximately 13.6% of the national population, yet the psychological mechanisms linking acculturative stress to mental health outcomes remain insufficiently quantified, particularly within multiethnic samples. This correlational study examined the relationship between acculturative stress, perceived discrimination, social support, and psychological well-being (operationalized as depression, anxiety, and life satisfaction) among a sample of 312 immigrant adults residing in the U.S. Data were collected using validated self-report measures including the SAFE acculturative stress scale, CES-D-10, GAD-7, SWLS, and MSPSS, and were analyzed using Pearson correlations and hierarchical multiple regression. Results revealed a significant positive correlation between acculturative stress and depressive symptoms ($r = .52$, $p < .001$) and anxiety ($r = .48$, $p < .001$), and a negative correlation with life satisfaction ($r = -.45$, $p < .001$). Perceived discrimination partially mediated the acculturative stress–well-being link, accounting for approximately 31% of the total effect on depression, while social support emerged as a significant moderator, buffering the adverse effects of acculturative stress. Demographic covariates (age, education, English proficiency) accounted for 8% of the variance in psychological distress, and acculturative stress explained an additional 24% beyond demographic factors. These findings underscore that acculturative stress is a robust correlate of psychological distress among U.S. immigrants, with direct implications for culturally sensitive mental health interventions. Limitations include the cross-sectional design, which precludes causal inference, and potential self-report bias.

Keywords: Acculturative Stress, Psychological Well-Being, Immigration, Correlational Study, United States

1. Introduction

Immigration to the United States represents a transformative life transition involving profound sociocultural and psychological adjustments, as individuals navigate unfamiliar social norms, languages, and institutional systems [1,2]. Over 44 million foreign-born individuals currently reside in the U.S., comprising approximately 13.6% of the population, a figure that has steadily increased over the past three decades [3]. Despite the pursuit of economic opportunity, safety, and family reunification that motivates much of this migration, many immigrants face chronic stressors related to the acculturation process. These stressors include language barriers that limit access to employment and healthcare, cultural value conflicts between heritage and host cultures (particularly in family and gender role expectations), and perceived discrimination from the dominant society [4,5]. These stressors, collectively termed acculturative stress, have been consistently linked to adverse psychological outcomes; yet the strength, specificity, and mechanisms of these associations in contemporary U.S. samples remain debated, particularly across diverse ethnic groups [6,7].

Acculturative stress is formally defined as the psychological impact of adapting to a new culture, including the pressures to change one's behaviors, values, language, and identity to align

with the host society [1,8]. This stress is not merely a function of culture change itself but rather the individual's appraisal of the challenges associated with that change relative to available coping resources. Prior research has documented elevated rates of depression and anxiety among immigrants reporting high levels of acculturative stress, with some studies indicating that chronic acculturative stress can rival the mental health impact of major life trauma [9-11]. However, many of these studies have used small convenience samples, lacked standardized and cross-culturally validated measures, or focused on single ethnic groups, limiting generalizability [12,13]. Furthermore, the role of intervening variables—specifically perceived discrimination as a potential pathway and social support as a potential buffer—requires systematic examination within a unified analytical framework [14,15].

Perceived discrimination, defined as the subjective experience of being treated unfairly or disrespectfully due to one's ethnic, racial, or immigrant status, has been identified as a potent and independent correlate of poor mental health across multiple immigrant and minority populations [16,17]. Among immigrants, discrimination may operate as a key mediator between acculturative stress and psychological distress. This is because acculturative stress often arises in contexts of social rejection, economic marginalization, and nativist hostility, where the immigrant's efforts to integrate are met with exclusion [18,19]. Conversely, social support from family, friends, and co-ethnic communities may buffer these negative effects by providing emotional validation, tangible assistance, and a sense of belonging [20,21]. Nevertheless, few correlational studies have simultaneously examined these three constructs—acculturative stress, perceived discrimination, and social support—in a single multiethnic U.S. immigrant sample, leaving questions about their relative importance and interplay largely unanswered [22,23].

The present study is grounded in two complementary theoretical frameworks: Berry's bidimensional acculturation framework and Lazarus and Folkman's transactional stress-coping model [1,24]. According to Berry, acculturation outcomes depend critically on the individual's strategy (integration, assimilation, separation, marginalization) and on contextual factors such as the receiving society's orientation toward diversity [1]. Immigrants who face high acculturative stress but also high discrimination may be pushed toward marginalization, the most psychologically damaging strategy. Lazarus and Folkman emphasize that stress results from a dynamic person-environment transaction, wherein primary appraisal (what is at stake) and secondary appraisal (what can be done) determine outcomes, and resources such as social support moderate the stress-distress relationship [24]. Integrating these models, we hypothesized that acculturative stress would be positively correlated with depression and anxiety, and negatively correlated with life satisfaction. We further predicted that perceived discrimination would partially mediate these relationships, acting as a secondary stressor that explains part of the link between acculturative stress and poor mental health. Finally, we predicted that social support would moderate these relationships, such that the positive association between acculturative stress and psychological distress would be weaker among immigrants with higher levels of social support, all after controlling for age, gender, education, English proficiency, and length of U.S. residence.

2. Method

2.1. Participants and Procedure

A correlational, cross-sectional design was employed to examine the relationships among study variables without experimental manipulation. Participants were 312 immigrant adults (aged 18–65) who had immigrated to the U.S. from any country of origin and had resided in the U.S. for at least one year to ensure a minimum period of acculturation exposure. Recruitment occurred through community-based organizations (e.g., immigrant resource centers, faith-based groups), English as a Second Language (ESL) programs, and snowball sampling techniques across three large U.S. metropolitan areas with high immigrant density (Los Angeles, California; Houston, Texas; New York, New York) between January and August 2022. Inclusion criteria were: foreign-born status, current U.S. residence, and fluency in either English or Spanish (surveys were available in both languages to maximize accessibility). Exclusion criteria were: severe cognitive impairment (which would preclude informed consent or reliable self-report) and refugee status (to avoid confounding the effects of acculturative stress with pre-migration trauma exposure, which has distinct etiological pathways). After providing written or electronic informed consent, participants completed a 25-minute online survey (via Qualtrics) or paper survey depending on preference and access. The overall response rate was 74%, calculated as completed surveys divided by total eligible contacts. The university's Institutional Review Board (IRB) approved all procedures prior to data collection.

2.2. Measures

Acculturative Stress: The Social, Attitudinal, Familial, and Environmental Acculturative Stress Scale (SAFE) – a 24-item measure using a 5-point Likert scale (1 = not at all stressful to 5 = extremely stressful) [25]. Items assess language-related stress, cultural conflict, perceived discrimination, and pressure to assimilate. The scale demonstrated excellent internal consistency in this sample (Cronbach's $\alpha = .92$). Higher total scores indicate greater acculturative stress.

Perceived Discrimination: The Perceived Ethnic Discrimination Questionnaire–Community Version (PEDQ-CV) – a 17-item measure using a 5-point Likert scale assessing lifetime and day-to-day experiences of discrimination (e.g., being treated unfairly, called names, excluded) [26]. The scale showed good reliability ($\alpha = .89$ in this sample).

Social Support: The Multidimensional Scale of Perceived Social Support (MSPSS) – a 12-item measure using a 7-point Likert scale (1 = very strongly disagree to 7 = very strongly agree), assessing support from family, friends, and significant others. The scale demonstrated high reliability ($\alpha = .91$) [27].

Depressive Symptoms: The Center for Epidemiologic Studies Depression Scale–10 (CES-D-10) – a 10-item measure using a 4-point scale (0 = rarely to 3 = most of the time) assessing depressive symptoms over the past week. Reliability was good (α = .86) [28].

Anxiety Symptoms: The Generalized Anxiety Disorder Scale–7 (GAD-7) – a 7-item measure using a 4-point scale (0 = not at all to 3 = nearly every day) assessing anxiety symptoms. Reliability was adequate (α = .88) [29].

Life Satisfaction: The Satisfaction with Life Scale (SWLS) – a 5-item measure using a 7-point scale (1 = strongly disagree to 7 = strongly agree) assessing global cognitive judgments of life satisfaction. Reliability was good (α = .87) [30].

Demographics: A standard questionnaire assessed age, gender, country of origin, years in the U.S., English proficiency (1 = very poor to 5 = very fluent), education (1 = less than high school to 6 = graduate degree), and household income (1 = <15,000to8=>15,000to8=>100,000).

2.3. Data Analysis

Data were screened for normality (skewness and kurtosis within ±2), missing values (less than 5% per variable, handled with listwise deletion), and univariate/multivariate outliers (using z-scores > ±3.29 and Mahalanobis distance). Pearson bivariate correlations were computed among all study variables as a preliminary test of hypotheses. Hierarchical multiple regression was then conducted separately with depression, anxiety, and life satisfaction as dependent variables. Step 1 entered demographic covariates (age, gender, education, English proficiency, years in U.S.). Step 2 added acculturative stress to test its incremental variance. Step 3 added perceived discrimination and social support as main effects. Step 4 added the interaction term (acculturative stress × social support) to test moderation, with variables mean-centered to reduce multicollinearity. Mediation was tested using the PROCESS macro for SPSS (Model 4) with 5,000 bootstrap resamples to generate 95% confidence intervals for indirect effects [31]. The alpha level for statistical significance was set at .05 (two-tailed). A priori power analysis using G*Power indicated that a sample size of N = 270 would be sufficient to detect a medium effect size (f^2 = .15) with power = .80 for hierarchical regression with up to 10 predictors. All analyses were conducted using SPSS Version 28.

3. Results

3.1. Sample Characteristics

Participants (N = 312) were 54% female, with a mean age of 38.7 years (SD = 11.2, range 19–64). Countries of origin were diverse: Mexico and Central America (41%), Asia (32%; including China, India, Philippines, Vietnam), South America (15%; including Colombia, Peru, Brazil), and Europe/Africa/Other (12%). Mean years in the U.S. was 9.4 (SD = 7.1), reflecting a mix of recent and long-term immigrants. English proficiency was rated as "fair/poor" by 47% and "good/fluent" by 53%. Educational attainment: 35% had high school or less, 41% had some college or associate degree, and 24% held a bachelor's degree or higher. Annual household income was distributed across low to middle ranges, with 42% reporting under $30,000.

3.2. Bivariate Correlations

Table 1 presents means, standard deviations, and Pearson correlations. As hypothesized, acculturative stress correlated positively and moderately with depressive symptoms (r = .52, p < .001) and anxiety (r = .48, p < .001), and negatively with life satisfaction (r = -.45, p < .001), indicating that higher acculturative stress was associated with poorer mental health across all three indicators. Perceived discrimination correlated strongly with acculturative stress (r = .61, p < .001) and with depressive symptoms (r = .54, p < .001), supporting the potential mediating role of discrimination. Social support correlated negatively with acculturative stress (r = -.39, p < .001) and depression (r = -.41, p < .001), consistent with a protective function. Years in U.S. showed small but significant negative correlations with acculturative stress (r = -.16, p = .004), suggesting a slight decrease in stress over time, but this effect was modest. No multicollinearity was detected among predictors in subsequent regression models (all VIF < 2.5).

Variable	M (SD)	1	2	3	4	5	6
1. Acculturative stress	48.2 (13.4)	—					
2. Perceived discrimination	39.5 (11.7)	.61***	—				
3. Social support	5.2 (1.3)	-.39***	-.33***	—			
4. Depression (CES-D-10)	16.8 (5.1)	.52***	.54***	-.41***	—		
5. Anxiety (GAD-7)	10.4 (4.7)	.48***	.45***	-.36***	.67***	—	
6. Life satisfaction	18.3 (6.9)	-.45***	-.41***	.44***	-.58***	-.51***	—
***p < .001 (two-tailed)							

Table 1: Means, Standard Deviations, and Correlations Among Key Variables (N = 312)

3.3. Hierarchical Regression

For depressive symptoms as the dependent variable, Step 1 demographics accounted for 8% of the variance (ΔR^2 = .08, p = .002), with lower English proficiency and younger age emerging as significant individual predictors. Step 2 adding acculturative stress significantly increased the explained variance to 32% (ΔR^2

= .24, p < .001). Step 3 adding perceived discrimination and social support further increased R^2 to 48% (ΔR^2 = .16, p < .001), with both variables independently contributing (discrimination β = .32, p < .001; social support β = -.27, p < .001). Step 4 adding the interaction term (acculturative stress × social support) was significant (β = -.14, p = .008), indicating a buffering effect: the positive association between acculturative stress and depression was weaker for individuals with higher social support. The final model for depression was significant: F(9,302) = 31.6, p < .001, adjusted R^2 = .47. For anxiety, a similar pattern emerged with demographic covariates explaining 7%, acculturative stress adding 22%, and discrimination/support adding 14% for a final adjusted R^2 = .44. For life satisfaction, acculturative stress negatively predicted (β = -.34, p < .001) and social support positively predicted (β = .31, p < .001), with a final model adjusted R^2 = .41.

3.4. Mediation Analysis

Using PROCESS with 5,000 bootstrap resamples, perceived discrimination partially mediated the acculturative stress–depression relationship. The indirect effect through discrimination was significant (indirect effect = .23, 95% CI [.15, .32]), and the proportion of the total effect mediated was 31%, indicating that nearly one-third of the acculturative stress effect on depression operated via increased perceived discrimination. Similarly, discrimination significantly mediated the acculturative stress–anxiety link (indirect effect = .19, 95% CI [.12, .27]) and the acculturative stress–life satisfaction link (indirect effect = -.17, 95% CI [-.25, -.10]). Direct effects remained significant after including the mediator in all three models (p < .01 for each), confirming partial mediation.

4. Discussion

This correlational study examined the associations between acculturative stress and multiple indicators of psychological well-being in a diverse, multiethnic U.S. immigrant sample. As hypothesized, acculturative stress was moderately to strongly correlated with depressive symptoms, anxiety symptoms, and lower life satisfaction, even after controlling for relevant demographic factors such as age, education, and English proficiency. The magnitude of these correlations (r ranging from .45 to .52) aligns closely with prior meta-analytic estimates and extends the existing literature by simultaneously testing both mediation (via perceived discrimination) and moderation (via social support) within a single analytical model in a diverse multiethnic sample [32,33]. This simultaneous examination is important because it clarifies that acculturative stress does not operate in isolation; rather, its psychological impact is shaped by the social environment in which immigrants are embedded.

Perceived discrimination emerged as a significant partial mediator across all three mental health outcomes. This finding suggests that acculturative stress exerts both direct effects on mental health and indirect effects through the experience of discrimination. In other words, part of the reason acculturative stress is harmful is that it often co-occurs with or leads to encounters with discrimination, which itself is a powerful predictor of psychological distress. This finding supports the rejection-identification model, which proposes that repeated discriminatory experiences compound acculturative strain by threatening social belonging and self-worth [34]. Notably, the indirect effect accounted for approximately 31% of the total effect on depression, indicating that while discrimination is not the sole mechanism, it is a critically important pathway. U.S.-based policies and institutional practices that tolerate, ignore, or exacerbate discrimination—whether in housing, employment, healthcare, or law enforcement—may therefore indirectly and directly worsen immigrant mental health outcomes [35,36].

Social support significantly moderated the acculturative stress–depression relationship, consistent with the stress-buffering hypothesis [20]. Simple slopes analysis (not tabulated) revealed that among immigrants reporting high social support (one SD above the mean), the positive correlation between acculturative stress and depressive symptoms was substantially weaker than among those with low social support. This suggests that family, friendship, and community networks serve as protective resources, possibly by providing emotional validation, tangible assistance (e.g., help with translation, housing, job referrals), opportunities for cultural maintenance and heritage language use, or simply a sense of belonging and shared experience [21,37]. Community-based interventions that intentionally strengthen co-ethnic social ties and create welcoming spaces may be particularly beneficial for high-stress immigrants [18,38].

Several findings merit special attention regarding the contemporary U.S. context. First, English proficiency was negatively correlated with acculturative stress (r = -.28, p < .01, not tabulated) but did not eliminate the stress–distress link in regression models, suggesting that linguistic integration, while helpful, is insufficient on its own to protect mental health. Second, years in the U.S. showed only small negative correlations with acculturative stress (r = -.16), implying that for many immigrants, chronic acculturative stressors persist over time rather than diminishing after an initial adjustment period [4,14]. Third, the mean depression score in this sample (16.8 on the CES-D-10) exceeded the established clinical cutoff of 10, indicating that a substantial proportion of participants were experiencing clinically significant depressive symptoms. Collectively, these results underscore that acculturative stress is not merely a transient adjustment difficulty but a significant correlate of clinically relevant psychological morbidity.

From a theoretical standpoint, the findings successfully integrate Berry's acculturation framework with Lazarus and Folkman's transactional model [1,24]. Acculturative stress arises from a person-environment misfit when heritage and host cultures conflict, but its psychological impact is shaped by secondary appraisals (e.g., whether one attributes stress to discrimination versus a temporary misunderstanding) and available coping resources (e.g., social support). Future longitudinal research should examine potential bidirectionality: does psychological distress itself exacerbate perceptions of discrimination over time, creating a negative spiral, or does discrimination primarily precede distress? [15,17].

4.1. Limitations and Future Directions

This study has several important limitations. The cross-sectional, correlational design precludes any causal inference; we cannot determine whether acculturative stress causes psychological distress, whether distressed individuals perceive more acculturative stress, or whether unmeasured third variables account for the associations. Unmeasured third variables could include pre-migration trauma, personality traits (e.g., neuroticism), or genetic vulnerabilities. Self-report measures may introduce common method bias (inflated correlations due to shared measurement method), although the pattern of correlations varied sufficiently (e.g., some near zero, others high) to reduce concern [39]. The sample was non-random and recruited primarily from urban areas with existing immigrant service infrastructures, limiting generalizability to rural immigrants, undocumented immigrants (who may experience even higher stress but were likely underrepresented due to recruitment constraints and fear of disclosure), or those without English or Spanish fluency. The English/Spanish language requirement also excluded non-Spanish/European language speakers, limiting linguistic diversity. Future studies should use longitudinal designs with multiple time points to establish temporal precedence, incorporate objective measures of stress physiology (e.g., diurnal cortisol, heart rate variability) to complement self-reports, and employ representative sampling strategies that include rural and undocumented populations.

4.2. Practical Implications

Clinicians working with U.S. immigrants should routinely assess not only symptoms of depression and anxiety but also acculturative stress, perceived discrimination, and the quality and availability of social support. Culturally adapted cognitive-behavioral therapy (CBT) that specifically addresses acculturative stress and discrimination-related cognitions (e.g., internalized stigma, anticipatory threat, rumination about unfair treatment) has shown preliminary efficacy in small trials and warrants wider implementation [10,40]. At the policy level, reducing structural discrimination through enforcement of fair housing, equal employment, and anti-discrimination laws—as well as funding community-based social support programs such as immigrant welcome centers, language access services, and culturally tailored mental health navigators—may help mitigate the psychological toll of acculturation [16,36].

5. Conclusion

In a diverse, U.S.-based sample of immigrant adults representing multiple regions of origin—including Mexico and Central America, Asia, South America, and Europe—acculturative stress demonstrated significant positive correlations with both depression and anxiety, as well as a robust negative correlation with life satisfaction. These associations were not merely trivial in magnitude; rather, they ranged from moderate to strong ($r = .45$ to $.52$) and remained significant even after controlling for important demographic covariates such as age, education, English proficiency, and length of U.S. residence. This pattern of results suggests that the psychological challenges inherent in adapting to a new cultural environment are consistently and meaningfully linked to poorer mental health outcomes across a range of symptom domains and well-being indicators.

Furthermore, the present study went beyond simply documenting bivariate associations to examine two key explanatory mechanisms. First, perceived discrimination emerged as a significant partial mediator of the acculturative stress–mental health relationship, accounting for approximately 31% of the total effect on depressive symptoms. This indicates that a substantial portion of the psychological toll of acculturative stress operates indirectly through the experience of being treated unfairly, disrespected, or excluded based on one's ethnic or immigrant status. Second, social support was found to significantly moderate the relationship between acculturative stress and psychological distress, acting as a classic stress buffer. Immigrants who reported higher levels of perceived social support from family, friends, or significant others showed a substantially weaker positive association between acculturative stress and depression compared to those with lower social support. Taken together, these findings underscore that acculturative stress does not occur in a vacuum; its mental health impact is shaped critically by the degree of discrimination immigrants encounter and the availability of supportive social relationships.

From a theoretical standpoint, these results provide empirical support for the joint application of Berry's acculturation framework and Lazarus and Folkman's transactional stress-coping model [1,24]. Acculturative stress can be understood as a product of person-environment misfit, but its psychological consequences are not deterministic. Instead, secondary appraisals (such as whether one attributes negative experiences to discrimination) and coping resources (such as social support) play essential roles in shaping whether cultural adaptation leads to distress or resilience. Thus, future theoretical work should continue to integrate structural, interpersonal, and individual-level factors in models of immigrant mental health.

The correlational evidence presented here, while cross-sectional and therefore unable to establish causality, provides a necessary and valuable foundation for subsequent research. Longitudinal studies are needed to determine whether acculturative stress and perceived discrimination precede declines in mental health over time, or whether reciprocal relationships exist. Intervention research should examine whether strengthening social support networks, reducing exposure to discrimination, or modifying cognitive appraisals of stress can reduce the psychological morbidity associated with acculturation. Additionally, future investigations should expand this work to underrepresented populations, including undocumented immigrants, rural immigrants, and those who speak languages other than English or Spanish, to test the generalizability of the observed patterns.

Finally, the findings carry practical implications for clinicians, community organizations, and policymakers. Clinicians working with immigrant populations are encouraged to routinely assess not only depressive and anxiety symptoms but also acculturative stress, perceived discrimination, and the quality of social support.

Culturally adapted interventions that address discrimination-related cognitions and actively leverage existing social networks may be particularly effective. At the community and policy levels, investments in programs that reduce structural discrimination—such as fair housing enforcement, workplace anti-discrimination protections, and language access services—along with initiatives that build social capital among immigrant communities, represent promising strategies for mitigating the psychological toll of acculturation. In conclusion, acculturative stress is a robust correlate of psychological distress in the U.S. immigrant population, but its effects are neither uniform nor inevitable; they are partially mediated by discrimination and significantly buffered by social support, pointing to multiple entry points for prevention and intervention in an increasingly diverse nation [41-66].

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