AMERICAN JOURNAL OF PSYCHOLOGICAL RESEARCH

Volume 5, Number 1
Submitted: July 28, 2009
Revisions: October 12, 2009
Accepted: October 12, 2009
Publication Date: October 15, 2009

An Exploratory Study of Resilience and Coping Strategies Among Portuguese-Speaking Immigrant Women Survivors of Domestic Violence

Carla Maria dos Santos Bernardes, Sukanya Ray, and Debra Harkins

Department of Psychology, Suffolk University

Boston, Massachusetts, USA

dharkins@suffolk.edu

ABSTRACT

The purpose of this study was to examine the variation in stress coping strategies (adaptive and maladaptive) among Portuguese-speaking immigrant women across short-term and long-term residency status. This study also examined the role of resilient characteristics (self-esteem, hope, optimism, spirituality, and religiousness), perceived stresses (cultural adaptation, relational, financial) and perceived prejudice as predictors of adaptive and maladaptive coping strategies. Participants were 28 Portuguese-speaking immigrant women recruited from community organizations in Massachusetts. All participants completed several self-report questionnaires that assessed resilience characteristics (self-esteem, hope, optimism, spirituality, and religiousness), perceived stresses (cultural adaptation, relational, financial), perceived prejudice and coping strategies. Results indicated higher mean scores on adaptive coping (seeking social support for instrumental reason) among women with long-term residency status. Women with short-term residency status indicated their usage of maladaptive coping strategy (mental disengagement) more than their long-term counterparts. Resilience

characteristics (hope, spirituality), and perceived stress (cultural adjustment and financial stress) were significant positive predictors of adaptive coping strategies (planning, restraint coping, positive reinterpretation and growth). We found perceived prejudice to be a significant negative predictor of maladaptive coping strategy (behavioral disengagement).

INTRODUCTION

In recent years, the topic of domestic violence, particularly, intimate partner abuse remains an important and pervasive social and public health problem in the USA and the world (Krane, 1996; Walker, 1999). In the USA, estimates of physical, verbal and psychological abuse against a woman by her husband or intimate partner has indicated that between 50% and 60% of women experience domestic violence at some point in their lives (Astin, Lawrence, & Foy, 1993; Walker, 1979; Werner-Wilson, Zimmerman, & Whalen, 2000). The percentage of immigrant women in the USA experiencing domestic violence is thought of being even higher than 60%, however statistical evidence is unavailable because research on issues concerning domestic violence in immigrant communities remains limited (Menjivar & Salcido, 2002).

Research on migration indicates immigrants face multiple challenges when they resettle in a foreign country (Berry, 1997; Furnham & Bochner, 1986; Menjivar & Salcido, 2002). Thus when immigrant women experience domestic violence the additional stress and trauma of the abuse is added to their existing acculturative stresses. These challenges impact their psychological well-being but some are found to be resilient. Moreover, research has shown that resilient individuals employ adaptive or healthy coping strategies when dealing with stressful situations and thus are less vulnerable to development of psychopathology (Cicchetti & Garmezy, 1993; Higgins, 1994; Turner, 2001; Valentine & Feinauer, 1993; Werner-Wilson, et.al., 2000). Although extensive research has been conducted on domestic violence, coping strategies, and psychopathology, little research exists that has examined the relationship in terms of resilient characteristics.

Broadly speaking, domestic violence or battering includes acts of verbal, sexual or physical force, coercion or life-threatening deprivation, directed at an individual woman that causes physical or psychological harm, humiliation or deprivation of freedom. Physical and psychological outcomes of domestic violence include addiction, PTSD, depression and other mental health problems (Herman, 1997; Krane, 1996). Herman (1997) states that battered women experience sexual humiliation, feelings of disgust and being violated when they are coerced into sexual practices. Feelings of intense fear, helplessness, loss of control, and threat of humiliation are the common denominator of psychological trauma, which can lead to Complex Post-Traumatic Stress Disorder (PTSD) – a more intricate form of PTSD that accounts for prolonged, repeated trauma (Herman 1997).

Clinical research on coping has attracted a great deal of attention because of its potential benefits to the health and well-being of individuals. Broadly defined, it is the

efforts used by individuals to deal with the demands and stresses of life (Herbert, Silver, Ellard, 1991; Wong, 2002). Coping strategies vary among individuals such as problem-focused coping and emotion-focused coping to deal with the stressful situation (Carver, Scheier, & Weintraub, 1989). Moreover, coping strategies are divided into to broad categories such as adaptive coping and maladaptive coping strategies. Adaptive problem-focused coping strategies include taking action to get rid of the stressful situation, and getting support from someone that can help the situation, while emotional-focused coping strategies include sharing feelings with someone concerning one's stressful situation. Maladaptive problem-focused coping strategies include: use of alcohol or drugs to forget the stressful situation (avoidance), while maladaptive emotional-focused coping strategies include denial (Carver, et al., 1989; Donnelly, 2002; Wong, 2002). Adaptive coping strategies have been associated with psychological well-being, while maladaptive coping strategies have been associated with the development of various psychopathologies. Some of the survivors of domestic violence use adaptive coping strategies (seeking social and emotional support, actively attempting to leave the situation, and talking to others about the abuse) while others employ maladaptive coping strategies such as feelings of helplessness around stopping or changing the situation; denial; and avoidance (Higgins, 1994).

Research on resilience is a fairly new area in the clinical field which has highlighted victims' incredible strengths in the face of adversity and maintenance of a sense of well-being. Resilient individuals have a repertoire of coping skills that help them to adapt to the specific situation. These coping skills allow them to effectively manage stressful situations, thereby transforming the situations into less stressful ones or enabling the individuals to come to terms with aspects of life that are uncontrollable. Furthermore, resilient individuals view change as challenging but inevitable and manageable. This outlook on life makes them less likely to perceive situations as stressful (Aroina & Norris, 2000; Grossman, Cook, Kepkep, & Koenen, 1999; Turner, 2001; Valentine & Feinauer, 1993). The characteristics necessary to establish resiliency include: the ability to find emotional support outside the family; the ability to think well of oneself; the ability to develop and sustain relationships with positive adults; a sense of humor; a sense of direction or mission; intellectual capacity; self-esteem; religion or spirituality; hope; optimism; and initiative (Turner, 2001; Valentine & Feinauer, 1993).

Acculturation is defined as the process of mutual cultural exchange resulting from contact between cultures, during which each culture influences the other. It is part of the adjustment process of immigrant groups to the culture of the dominant group (host culture). Acculturation involves learning traits, such as behaviors (e.g., language, lifestyle), beliefs and values of a host culture. Studies have identified a close link between acculturative stress, adaptation pattern and psychological well-being of immigrants (Berry, 1990; Ward & Kennedy 1994). The perspective on acculturation strategies proposed by Berry (1990) underlines immigrants' need to strike a balance between maintaining their own culture and participating in the new culture. Of the four acculturation strategies described by Berry (1990), he identifies integration (a blend of the original and new culture) as the most adaptive for immigrants' psychological well-being, while marginalization (alienation from both the dominant and original culture) has

been identified as the least adaptive. Studies have found that when immigrants use healthy, adaptive coping strategies to deal with acculturative stress, there is a decrease their experience of low self-esteem and psychopathology, such as depression and anxiety (Ward & Kennedy, 1994).

Portuguese-speakers in the USA consist of a combination of several distinct subgroups from specific countries, including Angola, Brazil, Cape Verde, East Timor, Guinéa-Bissau, Mozambique, Portugal, and São Tomé & Principe. All of these groups share a similar Latin[1] culture and speak Portuguese as their official language. The larger percentage of Portuguese-speaking immigrants in USA are from Brazil, Cape Verde and Portugal and they are the second largest linguistic group in Massachusetts, comprising an estimated 800,000 to 1 million people (Araujo, 1996). The socialization values of Latino culture emphasize gender role hierarchy (*machismo),* and *familism* (loyalty, reciprocity, and solidarity among family members) and the issue intimate relationship violence is sometimes considered a manifestation of love in this community (Araujo, 1996; McIntyre & Augusto, 1999; Vasquez, 1998).

The present research explored the existing resilient characteristics and coping strategies among Portuguese-speaking women survivors of domestic violence. The relationship dynamics among individuals' stresses (acculturative, relational, etc.) and protective factors (resiliency, social support, etc.) are to be examined carefully to understand both individual and culturally specific adjustment patterns of immigrants. Specifically, this study examined the stress coping strategies (adaptive, maladaptive) among Portuguese-speaking immigrant women across short-term (resided in the USA for 6 years or less) and long-term (resided in the USA from 7 to 16 years) residency status.

Several hypotheses were explored: (1) it was hypothesized that participants with long-term length of residency status would differ from participants with short-term length of residency status in their scores on adaptive coping strategies; (2) participants with long-term length of residency status would differ from participants with short-term length of residency status in their scores on maladaptive coping strategies; (3) participants' long-term length of residency, greater level of resilient characteristics, lower rate of perceived stresses and perceived prejudice would be positively related to their use of adaptive coping strategies; and finally, the maladaptive coping strategies will indicate a negative relationship with the above mentioned variables.

METHOD

Participants

Twenty-eight women from community support groups who identified themselves as Portuguese-speaking immigrants were recruited as participants for this study. All of these women have experienced a domestic violence situation. Participants were recruited

[1] Portuguese-speaking cultures are Latin cultures. They are part of the wider Latino culture that exists outside of Latin America, and which speak languages other than Spanish but still have Latin as the base of their language and culture.

through community organizations in Massachusetts. Each participant filled out a packet of questionnaires. Participants were also requested to partake in a short open-ended interview. A total of 28 women were recruited from a pool of 45 women. Participants' age ranged from 22 to 50 years (*M*=35.71, *SD*=8.71). Participants' age of arrival in the USA ranged from 16 to 42 years (*M*=27.18, *SD*=7.91), and the length of residency in USA ranged from 1 to 16 years (*M*=8.07, *SD*=4.25). Participants represented three Portuguese-speaking countries. Overall, 89.3% of the sample spoke Portuguese as their primary language, while 10.7% were bilingual. Participants were divided into two groups with fourteen in each group, such as short-term (resided in the USA for 6 years or less) and long-term (resided in the USA from 7 to 16 years) as determined by the migration history of Portuguese-speakers (Massachusetts Alliance of Portuguese Speakers, 2003).

Measures

*Demographic information.*A demographic information form was used to obtain participants' information regarding their age, country of birth, native language, and primary language spoken, age at arrival and length of residency in USA.

The resilience characteristics were assessed by using specific measures (self-esteem, hope, optimism, spirituality and religiousness).

Self-Esteem Scale. Self-esteem was measured by Rosenberg's (1965) Self-Esteem Scale (see Appendix C). This scale was designed to measure individuals' global self-esteem including feelings of self-worth or self-acceptance. The scale consists of 10 items measured on a four-point Likert scale with responses ranging from "strongly agree" (4) to "strongly disagree" (1). The scale had a Cronbach's alpha of .88.

Hope Scale. The Hope Scale (Snyder et. al., 1991) identifies respondents' cognitive set that is composed of a reciprocally derived sense of successful goal-directed determination (agency) and planning of ways to meet such goals (pathways). This is a 10 item scale including four filler items. Respondents were asked to imagine themselves across time and situational contexts and provided their responses on a four-point Likert scale ranging from "definitely false" (1) to "definitely true" (4). The scale had a Test-retest reliability of .85.

Optimism Scale. Optimism was assessed by using the Life Orientation Test-Revised (Lot-R) (Scheier, Carver, & Bridges, 1994). This is a 10-item self-report measure that evaluates respondents' generalized expectancies for positive versus negative outcomes. Three of the 6 items are worded in a positive direction and 3 are worded in a negative direction. Respondents were asked to indicate their degree of agreement on a five-point Likert scale ranging from "strongly disagree" (1) to "strongly agree" (5). The scale had a Test-retest reliability of .79.

Spirituality/Religiousness Scale. Items were selected from the Ironson-Woods Spirituality/Religiousness (SR) Index (Ironson, et. al., 2002) to capture both spirituality and religiousness of participants. The scale contains four dimensions: a) *Sense of Peace,* b) *Compassionate View of Others,* c) *Faith in God,* and d) *Religious Behavior.*

Participants were asked to provide their answer for this 18 item scale on a five-point Likert scale, with responses raging from “strongly disagree” (1) to “strongly agree” (5). The scale had a Test-retest reliability of .88.

Acculturation Scale. Acculturation was measured using Sodowsky and Plake’s (1991) *The American-International Relations Scale* (AIRS). This scale has been used to measure the acculturation patterns of international populations (students, scholars, academicians) and immigrants (short-term and long-term) groups to the White-dominant American society. The subscale *Perceived Prejudice* of AIRS was used. The *Perceived Prejudice* subscale consists of 20 items that assess international populations’ experiences of stereotypes, discrimination as experienced in American society. The full scale had a Cronbach’s alpha of .89 and .88 for the subscale.

COPE Inventory. A total of 19 items were selected from the COPE Inventory developed by Carver, Scheier, and Weintraub (1989) to measure coping style (adaptive and maladaptive). Seven adaptive (active coping; planning; restraint coping; seeking social support for instrumental reasons; seeking social support for emotional reasons; positive reinterpretation and growth; and acceptance) and five maladaptive (focus on and venting emotions; denial; behavioral and mental disengagement; and alcohol-drug disengagement) subscales were used to assess adaptive and maladaptive coping strategies that respondents use to deal with stressful events. The scale had a Test-retest reliability of .86.

Interview form. Respondents were interviewed to assess their perceived stresses (cultural adjustment, relational, and financial). Participants’ responded on a six point rating scale raging from “no stress” (1) to “severe stress” (6).

All measures were translated into Portuguese language by a bilingual professional, and they were then translated back into English to ensure accuracy. Participants were given a choice of selecting measures on either language.

RESULTS

Comparison of Adaptive and Maladaptive Coping Strategies across Short-term and Long-term Residency Groups

A multivariate analysis of variance (MANOVA) was performed on coping strategies to identify differences across length of residency. Significant differences were found in the use of coping strategies (adaptive and maladaptive) across length of residency status Pillai’s $F(1, 26) = 2.59$, $p < .05$. The long-term residency group (M=6.86, SD=.96) differed significantly from short-term residency group (M=4.86, SD=2.17) only on seeking social support for instrumental reasons (adaptive coping strategy) subscale. Mean scores for long-term residency group were found to be higher than the short-term residency group. The main effect of length of residency was found to be significant only for mental disengagement (maladaptive coping strategy) subscale. Mean scores for short-term residency group (M=2.93, SD=1.14) were found to be higher than the long-term

residency group (*M*=2.17, *SD*=1.00) (see Table 1).

Table 1

Univariate Analysis of Variance for Length of Residency Groups

Subscale	Short-Term Residency (1-6 years) Mean, *SD*	Long-Term Residency (7-16 years) Mean, *SD*	*df*	*F*
Adaptive Coping				
Active Coping	7.50, *2.17*	9.00, *2.22*	1	3.42
Planning	7.64, *2.53*	8.79, *2.36*	1	1.53
Restraint Coping	6.86, *2.21*	3.32, *3.49*	1	1.13
Seeking Social Support for Instrumental Reasons	4.86, *2.17*	6.86, *.96*	1	11.13**
Seeking Social Support for Emotional Reasons	6.29, *2.23*	7.43, *.94*	1	3.12
Positive Reinterpretation and Growth	9.89, *2.61*	9.67, *2.21*	1	.06
Acceptance	6.93, *3.19*	7.39, *2.73*	1	.11
Maladaptive Coping				
Focus on and Venting of Emotions	8.14, *2.49*	9.46, *1.55*	1	2.56
Denial	3.71, *1.59*	3.67, *1.34*	1	.07
Behavioral Disengagement	2.71, *1.48*	2.96, *1.19*	1	.09
Mental Disengagement	2.93, *1.14*	2.17, *1.00*	1	4.48*
Alcohol-Drug Disengagement	1.14, *.53*	1.17, *.37*	1	.20

Note. $*p < .05$. $**p < .01$.

Relationship of Adaptive and Maladaptive Coping Strategies among Female Participants

Pearson correlation analysis (see Table 2) showed resilient characteristics (self-esteem, hope, optimism, spirituality/religiousness) positively related to adaptive coping strategies (active coping, planning, positive reinterpretation and growth). Financial stress was positively related to the restraint (adaptive) coping strategy. We found significant negative relationships among specific resilient characteristics (self-esteem, hope, spirituality, religiousness) and maladaptive coping strategy (behavioral disengagement).

Table 2

Intercorrelations among Length of Residency, Perceived Stresses, Perceived Prejudice, Resilient Characteristics and Coping Strategies (adaptive and maladaptive) for Participants (N = 28)

Variable	Length of Residency	Resilient Characteristics					Perceived Stresses			Perceived Prejudice
		Self-Esteem	Hope	Optimism	Spirituality	Religiousness	Cultural Adjustment Stress	Relational Stress	Financial Stress	
Coping Strategies Adaptive										
Active Coping	.16	.51**	.52**	.50**	.23	.16	.02	.07	.07	-.05
Planning	.12	.49**	.45*	.44*	.16	.15	.09	.08	.26	.02
Restraint Coping	.17	.19	.10	.18	-.15	.13	-.13	-.19	.39*	-.20
Seeking Social Support for Instrumental Reason	.33	.33	.25	.20	-.05	.10	-.10	.09	.26	-.02
Seeking Social Support for Emotional Reason	.33	.32	.26	.04	-.04	-.14	-.14	-.20	-.16	.02
Positive Reinterpretation and Growth	-.04	.54**	.43*	.46*	.53**	.11	-.13	.19	-.00	-.28
Acceptance	-.07	.10	.27	-.02	-.08	-.09	-.12	-.20	-.11	-.10
Maladaptive										
Focus on and Venting of Emotions	.33	-.07	-.06	-.26	.03	-.06	-.03	-.25	-.19	.17
Denial	-.07	-.36	-.21	-.37	.13	.12	-.08	-.02	-.03	.14
Behavioral Disengagement	.14	-.39*	-.38*	-.27	-.43*	-.11	.23	.09	.25	-.05
Mental Disengagement	-.34	-.31	-.09	-.20	-.08	-.13	-.06	.00	.00	-.08
Alcohol – Drug Disengagement	-.07	-.01	-.25	.12	-.21	-.01	.13	.23	.17	.06

Note. *p < .05. **p < .01.

Participants' Acculturation Patterns in the Host Culture

Participants' acculturation patterns (use of language and cultural affiliation) were explored from the self-report measure (American-International Relations Scale). Participants' responses were categorized based on frequency data (see Table 6). Responses indicated that 82% (N = 23) of participants preferred Portuguese language only, while 18% (N = 5) used both Portuguese and English equally. The data revealed that 75% (N = 21) of participants affiliated with only their native culture, while 25% (N = 7) affiliated equally with both host and native cultures. Affiliation with host language and culture was not preferred by any respondent (see Table 3).

Table 3

Participants' Acculturation Patterns (Use of Language and Cultural Affiliation) (N = 28)

Language Subscale	N (Percentage)
Native Language (Portuguese only)	23 (82%)
Bilingual (Portuguese and English equally)	5 (18%)
Host Language (English only)	0 (0%)
Acculturation Subscale	N (Percentage)
Native Culture	21 (75%)
Bicultural (Native and American cultures)	7 (25%)
Host Culture (American culture only)	0 (0%)

Interview Data on Participants' Use of Support Systems in the Host Culture

These data were obtained only from 14 participants who completed the interview. Participants' interview responses regarding their support systems indicated five major sources of support, such as use of community support center, religious centers, and friends and family. The data indicated that most participants used support group at the community center as their support system (71.4%), while 57.1% used individual therapy at the center as their support system. Thirty-six percent of respondents used religious centers as their support system. Finally, 41.2% indicated their support system being their friends, while 7.1% used family as their support system (see Table 4).

Table 4

Participants' Use of Support Systems in Host-Culture (*N* = 14)

Sources of Support	Percentage	N
Community Services		
Attending support group at the community center	71.4%	10
Attending individual therapy at the community center	57.1%	8
Religious Centers		
Received support from her church	35.7%	5
Friends and Family		
Received support from friends	41.2%	7
Received support from family members	7.1%	1

Note. Percentages do not add to 100% because respondents were permitted to identify more than one support system.

Interview data on participants' perception of their immigration experience. These data were obtained from only 14 participants who completed the interview. Participants' responses concerning their immigration experience in the host culture indicated both positive and negative themes. The data indicated that most participants perceived their immigrant experience as being negative (see Table 8). The specific themes of negative immigrant experiences included: stresses (71.4%), discrimination (57.1%), isolation (35.7%), and fear (14.3%) for these respondents (see Table 5).

Participants' interview data on coping with cultural adjustment stress. These data were obtained from only 14 participants who completed the interview. Participants' interview responses regarding their dealing with cultural adjustment stress indicated use of both adaptive and maladaptive coping patterns. These coping patterns identified specific themes (see Table 9). The data on adaptive coping patterns indicated themes concerning use of language fluency (35.7%), personal strength (21.4%), use of religion (21.4%), and use of community support (14.3%). The themes for maladaptive coping patterns included use of substitute activities and thoughts (21.4%), and emotional distress (14.3%). The data indicated that most participants employed adaptive coping strategies. In particular, most participants coped by working hard to learn English and improve their education (35.7%) (see Table 6).

Table 5

Themes in Participants' Perception of Their Experience as an Immigrant (*N* = 14)

Participants' Perceptions	Percentage	N
Positive		
The experience was good overall	14.3%	2
Negative	85.7%	12
It was a stressful and difficult/brutal experience	71.4%	10
I experienced discrimination from Americans	57.1%	8
It was a lonely/isolating experience	35.7%	5
It was a scary/terrifying experience	14.3%	2

Note. Percentages do not add to 100% because respondents were permitted to identify more than one perception.

Table 6

Themes in Participants' Methods of Coping with Adjusting to a New Culture (*N* = 14)

Participants' Coping Patterns	Percentage	N
Adaptive Coping		
I worked hard to learn English and improve my education	35.7%	5
The hardship I faced made me a stronger person	21.4%	3
I turned to my religion and church to help me through it	21.4%	3
I turned to my community and other immigrant friends	14.3%	2
Maladaptive Coping		
I turn to work and dreamed of going back to my country	21.4%	3
I cried a lot	14.3%	2

Note. Percentages do not add to 100% because respondents were permitted to identify more than one coping method.

*Interview data on participants' views on culturally prescribed gender roles and re relationship values.*These data were obtained from only 14 participants who completed the interview. Participants' interview responses regarding culturally prescribed gender roles and relationship value system indicated themes concerning their agreement on traditional gender roles and relationship values (see Table 7).

Table 7

Themes in Participants' Views on culturally prescribed gender roles and relationship values (*N* = 14)

Participants' Views	Percentage	N
Gender Roles		
Men control the money. They are the breadwinners	85.7%	12
Women stay at home, take care of the house, the children and the husband	71.4%	10
Women are not supposed to have needs or opinions	28.6%	4
Women are seen as worthless and as a sexual object	14.3%	2
Relationship Values		
It is accepted that men can control and abuse women	41.2%	7
It is expected that women should stay in an abusive relationship (marriage)	28.6%	4
It is accepted that men can have partners outside of marriage	7.1%	1

Note. Percentages do not add to 100% because respondents were permitted to identify more than one view.

DISCUSSION

The first hypothesis concerning the rates of adaptive coping strategies across length of residency groups was partially supported. These findings support a previous study on long-term Chinese immigrants in Hong Kong who used greater rates of healthy/adaptive stress coping (problem solving, acceptance, positive reinterpretation, talking about it) strategies than their short-term immigrants counterparts (Wong, 2002). Plante, Manuel, Menendez, and Marcotte (1995) also found that long-term Salvadoran immigrants in the USA utilized a high rate of adaptive stress coping strategies. These

data can be better understood from studies on immigrants' adaptation patterns. Berry (1997) identified that long-term immigrants usually have had a chance to develop a repertoire of adaptive/healthy coping strategies (language skills, use of social/community network) that allows them to engage in positive adaptation to the new cultural context. Portuguese-speaking immigrant women were found to be resourceful in adjusting to stress by using adaptive coping strategies, which is more commonly observed among long-term immigrant women. More studies are required in this area.

The second hypothesis concerning maladaptive coping strategies was partially supported. Results showing higher level of mental disengagement scores (maladaptive coping strategy) among short-term residency participants supported the previous data on use of unhealthy coping style among these immigrants who tend to use unhealthy coping styles due to lack of access to resources (Furnham & Bochner, 1982; Wong, 2002).

The third hypothesis was partially supported. Results indicated significant positive relationship between resilient characteristics and adaptive coping strategies, which supports past findings that resilient women utilize adaptive/healthy coping strategies when faced with adversity and abuse (Grossman, et. al., 1999; Higgins, 1994; Valentine & Feinauer, 1993). The present data supports the past findings on immigrants who exhibit resiliency to deal with economic and other adversities. It was observed that Portuguese-speaking immigrants had moved to the USA to improve their family's impoverished conditions by sending money home (Araujo, 1996; Ward & Kennedy, 1994; Wong, 2002), which increases their attempt to control their expenses. This explains the current data on use of restraint coping as an adaptive coping strategy.

Resilient characteristics (self-esteem, hope, and spirituality) were found to have a significant negative relationship with usage of maladaptive coping strategy (behavioral disengagement), thus when Portuguese-speaking immigrant women are faced with discrimination and adjustment stress in a host culture they tend to show resilience by exploring adaptive/healthy ways to cope with these stresses.

Participants' Acculturation Patterns, Use of Support Systems, Immigrant Experience and Cultural Views on Gender Roles and Relationship Values

A final interest of the study was to explore and identify participants' acculturation patterns (use of language and cultural affiliation), their use of support system in the host culture, their experience as immigrants and their views of culture-specific gender roles and relationship values. These data were obtained through interviews.

Overall the data show that these Portuguese-speaking immigrant women have a strong affiliation with own community, which is consistent with their use of their own community resources and support. This indicates that seeking social support (adaptive coping) in their own community is their preferred means of coping. These findings support data presented by the Massachusetts Alliance of Portuguese Speakers (MAPS) (2003) on Portuguese-speaking immigrants' preference of and need of receiving health and human services from a Portuguese-speaking community organization that can break

down language and cultural barriers to health and social services, which allows immigrants to seek and receive such services.

Examination of the open-ended questions regarding participants' immigrant experience and their coping with cultural adjustment indicated that most participants identified immigration as a stressful and discriminatory experience. However, these Portuguese-speaking immigrant women, who have dealt with domestic violence, have indicated use of adaptive coping patterns (language proficiency, community support, development of personal strength) to achieve their instrumental needs. The literature on Portuguese-speaking immigrant women's adaptation is limited and thus results are inconclusive. Therefore, more research is needed in this area.

Finally, participants' identified stressful and traditional gender roles and relationship values prescribed by their culture. This indicates that these Portuguese-speaking immigrant women are faced with stress and adversity in their intimate relationships. Nevertheless, these women in the face of adversity are exhibiting resilient characteristics and using adaptive coping patterns in dealing with stress and hardship. These findings support our previous notion that Portuguese-speaking immigrant women, although experiencing high levels of stress in their relationship and cultural adjustment, are showing resiliency and therefore using adaptive coping strategies to deal with the stress. These findings are in accordance with data presented by MAPS (2003) on the necessity to develop and fund additional support services for the Portuguese-speaking community because there is such a high search for support services from the community and not enough support services available.

In summary, the data is not conclusive because some of the hypotheses were only partially supported, which suggests the need for more in-depth research. However, it is interesting to observe the dynamics of immigrant women's resilience, coping strategies and adjustment patterns in a host culture. The results of this study also support that Portuguese-speaking immigrant women with long-term residency status showed greater usage of adaptive coping strategies and survival skills in an unfamiliar culture. Although several interesting findings have been presented, there are several limitations to this study, such as small sample size and selection of Portuguese-speaking immigrant women survivors of domestic violence which reduces generalizability. Furthermore, the use of self-report measures and lack of other demographic information (education, income, marital status, physical and psychological health, and immigration history) restrict our insight into their acculturative stresses and adjustment pattern. Overall this study provides preliminary information on psychological trauma, resilience and coping strategies of Portuguese-speaking immigrant women. These data are useful for building culturally appropriate community resources, support services, and psycho-educational programs for women survivors of domestic violence as this will empower them to face the challenges and reduce their acculturative stress experiences.

REFERENCES

Araujo, Z. A. (1996). Portuguese families. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.*), Ethnicity and family* therapy (pp. 583-594). New York: Guilford Press.

Aroina, K. J., & Norris, A. E. (2000). Resilience, stress and depression among Russian immigrants to Israel. *Western Journal of Nursing Research, 22*(1), 54-67.

Astin, M. C., Lawrence, K. J., & Foy, D. W. (1993). Posttraumatic stress disorder among battered women: Risk and resiliency factors. *Violence and Victims, 8*(1), 17-28.

Berry, J. W. (1990). Psychology of acculturation: Understanding individuals moving between cultures. In R. W. Brislin (Ed.), *Applied Cross-Cultural Psychology* (pp.232-253). Newbury Park, California: SAGE Publications.

Berry, J. W. (1997). Immigration, acculturation and adaptation. *Applied Psychology: An International Review, 46*(1), 5-34.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56*(2), 267-283.

Cicchetti, D., & Garmezy, N. (1993). Prospects and promises in the study of resilience. *Development and Psychopathology, 5*(4), 497-502.

Donnelly, T. T. (2002). Contextual analysis of coping: Implications for immigrants' mental health care. *Issues in Mental Health Nursing, 23*(7), 715-732.

Furnham, A., & Bochner, S. (1982). Social difficulty in a foreign culture: an empirical analysis of culture shock. In A. Furnham & S. Bochner (Eds), *Cultures in Contact: Studies in Cross-Cultural Interaction.* Oxford: Pergamon.

Grossman, F. K., Cook, A. B., Kepkep, S. S., & Koenen, K. C. (1999). *With the Phoenix rising: Lessons from ten resilient women who overcame the trauma of childhood sexual abuse.* San Francisco: Jossey-Bass Inc.

Herbert, T. B., Silver, R. C., & Ellard, J. H. (1991). Coping with an abusive relationship. *Journal of Marriage and the Famiy, 53*(2), 311-325.

Herman, J. (1997). *Trauma and recovery*. New York: BasicBooks.

Higgins, G. O. (1994). *Resilient adults*. San Francisco: Jossey-Bass.

Ironson, G., Solomon, G. F., Balbin, E. G., O'Cleirigh, C., George, A., Kumar, M., Larson, D., & Woods, T. E. (2002). The Ironso-Woods Spirituality/Religiousness Index is associated with long survival, health behaviors, less distress, and low cortisol in people with HIV/AIDS. *Annals of Behavior Medicine, 24*(1), 34-48.

Krane, J. E. (1996). Violence against women in intimate relations: Insights from cross-cultural analyses. *Transcultural Psychiatric Research Review, 33*(4), 435-465.

Massachusetts Alliance of Portuguese Speakers. (2003). *2003 Annual Report*.

McIntyre, T. M., & Augusto, F. (1999). The martyr adaptation syndrome: Psychological sequelae in the adaptation of Portuguese-speaking immigrant women. *Cultural Diversity and Ethnic Minority Psychology, 5*(4), 387-402.

Menjivar, C. & Salcido, O. (2002). Immigrant women and domestic violence. *Gender and Society, 16*(6), 898-920.

Miller, C. T., & Kaiser, C. R. (2001). A theoretical perspective on coping with stigma. *Journal of Social Issues, 57*(1), 73-92.

Plante, T. G., Manuel, G. M. Menendez, A. V., & Marcotte, D. (1995). Coping with stress among Salvadoran immigrants. *Hispanic Journal of Behavioral Sciences, 17*(4), 471-479.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, New Jersey: Princeton University Press.

Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994). Distinguishing optimism from neuroticism: A reevaluation of the Life Orientation Test. *Journal of Personality and Social Psychology, 67*(6), 1063-1078.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T. Yoshinobu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*(4), 570-585.

Sodowsky, G. R., & Plake, B. S. (1991). Psychometric properties of the American-International Relations Scale. *Educational and Psychological Measurement, 51*(1), 201-216.

Turner, S. G. (2001). Resilience and social work practice: Three case studies. *Families in Society, 82*(5), 441-448.

Valentine, L., & Feinauer, L. L. (1993). Resilience factors associated with female survivors of childhood sexual abuse. *The American Journal of Family Therapy, 21*(3), 216-224.

Vasquez, M. J. T. (1998). Latinos and violence: Mental health implications and strategies for clinicians. *Cultural Diversity and Mental Health, 4*(4), 319-334.

Walker, L. E. (1979). *The Battered Woman*. New York: Harper & Row.

Walker, L. E. (1999). Psychology and domestic violence around the world. *American Psychologist, 54*(1), 21-29.

Ward, C., & Kennedy, A. (1994). Acculturation strategies, psychological adjustment, and sociocultural competence during cross-cultural transitions. *International Journal of Intercultural Relations, 18*(3), 329-343.

Werner-Wilson, R. J., Zimmerman, T. S., & Whalen, D. (2000). Resilient response to battering. *Contemporary Family Therapy, 22*(2), 161-188.

Wong, D. F. K. (2002). Stage-specific and culture-specific coping strategies used by mainland Chinese immigrants during resettlement in Hong Kong: A qualitative analysis. *Social Work Health and Mental Health, 35*(1/2), 479-499.