Spring 2006

The Meaning of Health among Midlife Russian-Speaking Women in the United States

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THE MEANING OF HEALTH
AMONG MIDLIFE RUSSIAN-SPEAKING WOMEN
IN THE UNITED STATES

by

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Submitted to the Doctoral Faculty
of the School of Nursing in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

Duquesne University
2006
DUQUESNE UNIVERSITY
PhD PROGRAM

SCHOOL OF NURSING

APPROVAL OF FINAL DEFENSE OF DISSERTATION

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DISSERTATION TITLE: The Meaning of Health Among Midlife Russian-Speaking Women in the US

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3/23/01

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2006
THE MEANING OF HEALTH AMONG MIDLIFE RUSSIAN-SPEAKING WOMEN IN THE UNITED STATES

Lenore Marie Kolljeski Resick, PhD
Duquesne University, 2006

This study sought to explore the meaning of health among midlife Russian-speaking women from the Former Soviet Union. A hermeneutic, phenomenologic, descriptive and interpretive design following the Utrecht School was used. The setting was in an ethnic community in Southwestern Pennsylvania. The sample included 12 Russian-speaking women who also spoke English, ages 40-61, who migrated after 1991 to the United States. Methods included hermeneutic phenomenology, which combined descriptive and interpretive phenomenology, and content analysis of verbatim transcriptions of open-ended individual interviews. Six major themes were identified: health as a highly valued possession; being a stranger/seeking the familiar; grieving and loss/building a new life; experiencing changes and transitions; trusting self; and importance of hope. Conclusions were that the women value health, are knowledgeable about health, participate in self-care practices, trust their own abilities to make self-care decisions, and seek out health-related information. At the same time, this is a vulnerable population at risk for the onset of chronic medical conditions associated with the process of aging, past exposures, and current stressors related to migration and the tendency to avoid health screening. Implications for nursing practice include the need for interventions to build trust and to assess both self-care practices and values concerning
end-of-life issues. Future research recommendations include replication of this study with other samples within this population, further investigation of curative practices, and exploration of the meaning of death and end-of-life issues.
ACKNOWLEDGMENTS

The dissertation process has been a true life journey that would not have been possible without the encouragement, understanding, patience, and love of many people along the way. I am very grateful for the support I have experienced during this journey.

First, I would like to acknowledge my committee members, Dr. Joan Such Lockhart, my dissertation chair; Dr. Eileen Zungolo, and Dr. Juliene Lipson. Your inspiration, guidance, and friendship have been truly incredible.

This study could not have been possible without the Russian-speaking women who opened their homes and hearts to me. Thank you for sharing your personal stories with me. I am deeply grateful to Dr. Joan White who enabled me to travel to Russia and to my mentor and friend, Dr. Marie Hansen, whose work lives on through her former students.

Thank you to my colleagues at Duquesne University who supported me, covered for me, and were there for me. Thank you to Margarita Lemkov, my dear friend and teacher; Mary Anne Fello and Lea Carrone, who never seemed to tire of me “thinking out loud”; Melany Jo Hlad, for respite during the trips to Arkansas; Ray and Linda Kipping, for understanding; and Emillie Such for listening, especially during the difficult times.

Finally, I would like to extend my gratitude and appreciation to my family. First, to my children, Judith, Attila, and Sarah, thank you for your patience and for “taking over” when I was not able to “be there.” Most of all, thank you to my husband and my dearest friend, Martin. Your loving presence and gentle encouragement made all the difference.…
Dedicated to

my grandparents

Michael and Honorate Hamerski Harouse,

Stanley and Mary Ann Grochowski (Kolodziejczyk) Kolljeski,

and my parents

Michael and Lenora

in loving memory and heartfelt gratitude
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I. INTRODUCTION

A. Background of the Study

Immigrant women from the Former Soviet Union (FSU) are a group on the rise in the United States. Since the fall of the FSU in the early 1990s, a growing number of immigrants and refugees have entered the United States from the FSU (US Immigration and Naturalization Service [USINS], 2000). For example, in 1988, 2,949 immigrants from the FSU were admitted to the United States, while between the years of 1989 and 1998 immigration from the FSU increased to 455,742 (USINS, 2000). Recent data sources report that 30.6 percent of the refugees coming to the United States are from the republics of the former Soviet Union (USINS, 2000). Since approximately 25 percent of those immigrating from the FSU are women at midlife or older (Brod & Heurtin-Roberts, 1992), immigrants from the FSU are clearly one of the oldest groups coming to the United States.

Immigrant women often experience barriers to accessing and receiving health care (Kramer, Tracy, & Ivey, 1999; Meleis, Lipson, Muecke, & Smith, 1998). For example, new arrivals tend not to have a regular source of health care in the first 10 years following entry into the United States (US) (Frisbie, Cho, & Hummer, 2001; LeClere, Jensen, & Biddlecom, 1994). These barriers are often related to the lack of understanding by US health personnel about the health beliefs, values, and practices that the new
arrivals bring with them from the country of origin (Meleis, Lipson, Muecke, & Smith, 1998).

Conflicting reports exist in the literature with regard to health care utilization by immigrants from the FSU. Wei and Spigner (1994), who studied a representative sample of 743 patient records, concluded that health service utilization by immigrants from the FSU was significantly less than that by Southeast Asian immigrants. In contrast, a qualitative, case-oriented study by Aroian, Khatutsky, Tran, and Balsam (2001) reported perceived extensive use of health services by Russian-speaking immigrants. Although studies have addressed older immigrants (Aroian, Khatutsky, Tran, & Balsam, 2001; Wei & Spigner, 1994), and stress related to immigration (Miller & Chandler, 2002; Aroian, Norris, Patsdaughter, & Tran, 1998; Aroian, Spitzer, & Bell, 1996), little has been written about health within the context of immigration from the perspective of midlife Russian-speaking women in the United States.

Midlife is a time of transition (Schumacher & Meleis, 1994) that is associated with the onset of modifiable chronic illnesses (Eaker, Chesebro, Sacks, Wenger, Whisnant, & Winston, 1999; US Department of Health and Human Services [USDHHS], 1995; World Health Organization [WHO], 1994). These conditions can be mediated with health promotion and wellness interventions at midlife (Speroff, 1999). Since menopause is the primary midlife marker in women (McKinlay, 1996), this period is pivotal for intervention (Speroff, 1999) to modify the onset of chronic disease. Moreover, for health-related interventions to be acceptable, they must be culturally congruent, accessible, and appropriate to the needs of the population being served (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995).
Culture influences many aspects of people’s existence, including beliefs about wellness, health, and illness (Helman, 1994). Understanding culture involves understanding the meaning to an individual or group of a phenomenon such as health within the context of history, economic status, and social, political, and geographic elements such as immigration (Helman, 1994; Meleis, 1996).

The health care system experienced by women from the FSU in their homeland differs in many ways from the American system. The former Soviet Union provided universal health care coverage (Duncan & Simmons, 1996) that followed a paternalistic medical model (Remennick & Ottenstein-Eisen, 1998), with little emphasis on the importance of the individual’s lifestyle choices regarding maintenance of health and wellness (de Montigny-Korb, 1996).

National health objectives contained in the document *Healthy People 2000* established the national health goals of increasing the life span and the quality of life in these years for all Americans (USDHHS, 1991). The subsequent document, *Healthy People 2010*, in addition to building on the goals of *Healthy People 2000*, specified the additional aims of achieving health equity and eliminating health disparities (USDHHS, 1991; USDHHS, 2000).

The goal of eliminating disparities requires awareness of how environment, culture, race, and ethnicity influence the health and health beliefs of individuals as well as communities (USDHHS, 2000). Such awareness is essential for a better understanding of culturally appropriate strategies to improve access and utilization of health-related services (Spector, 2000). The health care provider must understand health from the perspective of the client in order to provide culturally competent care and to plan
culturally appropriate strategies to improve utilization of health-related services (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995).

B. Purpose of the Study

The purpose of this research study was to explore the meaning of health and health experiences among midlife women from the FSU in order to establish a foundation for designing culturally appropriate disease prevention and health promotion interventions that mediate the impact of chronic disease conditions associated with aging. This study sought to understand the meaning of health among midlife women from the FSU within the context of immigration.

C. Research Questions

The research questions were: 1) What is the meaning of health among midlife Russian-speaking women in the United States? 2) How has immigration influenced the experiences, values, and practices concerning the health of midlife Russian-speaking women in the United States? And 3) What are the health experiences of midlife Russian-speaking women in the United States?

D. Definition of Terms

In the context of this study, the term immigrant refers to those individuals who have emigrated either with refugee status or with immigrant status within the past 10 years or less to the United States. According to the United States Immigration and Naturalization Service, immigrants are permanent residents who have been issued
immigration visas by the Department of State overseas or who have been granted permanent resident status after entry through the United States Immigration and Naturalization Service (USINS, 1997). The term refugee refers to those individuals who have fled their homeland for political, ethnic, or religious reasons and remain unable or unwilling to return to their homeland due to actual or threatened persecution (Muecke, 1992). Refugees are eligible for permanent resident status after one year of living in the United States (USINS, 1997).

Midlife refers to women between 40 and 60 years of age. This age range has been used in other studies and is generally accepted as the age range for midlife (Remennick, 1999a; 2001; E-mail communication, L. Remennick, July 31, 2003).

Health experiences are those values and practices that result in promoting, maintaining, and restoring the experiences of well-being and high-level physical, psychosocial, and spiritual functioning as described by the study participants.

Russian-speaking immigrant women are identified as self-defined English-speaking women who claim the Russian language as the dominant language in their country of origin. The Russian language is the dominant language across the FSU and the “main axis of identity” for an otherwise diverse group of immigrants (Remennick, 1999b, p. 458).

Culture is defined using the classical summation of E. B. Taylor (1871), quoted in Leach (1982, pp. 38-39) as “That complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society.” Included in this summation is the role culture plays in determining common
ideas, concepts, and meanings about the world (Keesing, 1981) that have important implications for health and health-seeking behaviors (Helman, 1994).

*Culturally competent care* is defined as care “that is sensitive to issues related to culture, race, gender, and sexual orientation … and is provided within the cultural context of the clients.” (American Academy of Nursing Expert Panel on Culturally Competent Nursing Care, 1992, p. 278)

*The United States* refers to an urban setting in Southwestern Pennsylvania.

### E. Assumptions

Since the worldview of the researcher affects the researcher’s understanding of the problem and the method used for researching the problem (Piantanida & Garman, 1999; Polit & Hungler, 1999), it was important that the researcher outline the basic ontological, epistemological, axiological, and methodological philosophical categories (Piantanida, & Garman, 1999; Polit & Hungler, 1999) used for the inquiry of the research project. The paradigm for the inquiry in this study was based on the following assumptions:

**Ontological/Epistemological**

In order to focus on the meaning of health from the perspective of the individual, this study was guided by an ontological rather than an epistemological approach. That is, this study focused on the meaning of health and how health is experienced (Silva, Sorrell, & Sorrell, 1995) by midlife Russian-speaking women in the United States. The following points were included in the assumptions of the ontological approach to this study:
1) The participants in this study are able to talk about health and health experiences as a concept.

2) The participants in this study will provide responses that reflect true feelings and thoughts.

3) Understanding comes from the knowledge of the meaning of this experience.

4) People construct their own interpretations of the health that they experience.

5) The nature of the reality of health is that it is subjective, multiple, and identified by the individual.

6) Current Western models of nursing theories and models of health promotion and wellness may not be applicable across all cultures.

7) One’s words reflect one’s experience within the context of time.

*Axiological/Methodological*

The nature of the relationship of the researcher to the study participants is that the researcher and the study participants interact, and the resultant findings are a product of this interactive process (Polit & Hungler, 1999, p. 11). Thus the researcher becomes part of the research process (Lock, Spirduso, & Silverman, 2000), and values and subjectivity, as a result, are also necessarily part of the process (Polit & Hungler, 1999). The following points were included in the assumptions of the axiological and methodological approach to this study:

1) Health is a concept central to nursing science.
2) Persons give significance, meaning, and value to activities and things such as health and health experiences.

3) The significance, meaning, and value given by an individual to activities and things cannot be separated from the social, cultural, and historical standpoints of the individual.

4) Understanding the context of the immigration experience is necessary to understanding the cultural values and beliefs of the group.

5) Language and cultural behaviors, or language and being, are connected.

6) The hermeneutic phenomenological approach to research is compatible with the values and philosophical foundations of nursing practice.

7) There exists an important distinction between “interpreting” and “inferring” in both research and patient/nurse interactions.

8) The findings are reliable through verification.

F. Limitations

This study was limited in that the findings are not generalizable to all Russian-speaking midlife women who also speak English. Due to the nature of this qualitative study, the findings are limited to a specific situation, place, and time. This study did not address the special needs of Russian-speaking women who do not also speak English.

Specific measures, which are described in Chapter 3, were taken to limit researcher bias in this study. The dimensions of the researcher’s personal profile, educational preparation, work, and travel are listed below to outline how this researcher arrived at the questions, purpose, participants, and approach to this research project.
G. Aspects of the Personal Biography of Researcher Related to Study

The researcher is a midlife American-born woman with Eastern European ancestry. Since the research study was from the perspective of the individual and involved an interpretive approach, knowledge about how the researcher related to the study is important (Piantanida & Garman, 1999). The researcher was drawn to this particular research study and approach to inquiry from several dimensions of personal biography.

The initial interest for this study grew out of the researcher’s work as a community-based family nurse practitioner with a special interest in caring for vulnerable populations in the United States. The researcher has clinical experience working with a local hospital organization for women’s health care with outreach to new Americans from the Former Soviet Union. In addition to interacting with local émigrés from the FSU about health issues surrounding women’s health, especially menopause, the researcher completed preliminary fieldwork in the culture of origin and the culture of destination. Field experience in both these cultures provided the researcher with knowledge about transcultural links connecting immigrants to their homeland that is often lacking in research of immigrant populations concentrating only on the culture of destination (Foner, 1995).

Preliminary fieldwork in the culture of origin included travel for 2-week periods to the FSU in 1998 and 2000. During these trips, the researcher spent extended periods of time in both urban and rural communities and visited hospitals, clinics, and academic institutions responsible for preparing health care professionals to practice in the FSU. While the researcher maintained extensive field notes of interviews with FSU citizens
and FSU health care providers about the Russian culture and health care (Resick, 2002),
the researcher experienced many communication challenges. For example, when the
researcher asked for further explanation in order better to understand a subject being
discussed, the Russian hosts often replied, “This is very complicated to explain if you are
not Russian,” or “It will be hard for you to understand this unless you are a Russian.”
Through these experiences, the researcher grew to value the importance of understanding
the meaning of interpretation within the context of culture and history.

Preliminary fieldwork in the culture of destination included living in a Western
Pennsylvania community with a large Russian immigrant population where the researcher
has maintained personal contact with several Russian-speaking families. Interactions with
the Russian-speaking families have included participating informally and formally in
family and community social activities.

Through participation in community health-related activities, in Russia and the
United States with Russian-speaking women, the researcher became interested in learning
about the health care needs of menopausal and postmenopausal women in Eastern Europe
and the United States, and, especially, the health-related needs of the increasing numbers
of older women who are immigrants and refugees in Western nations. The researcher’s
interest in researching health beliefs, values, and practices of midlife women from the
FSU grew out of the limited Western literature on this topic, the limited consistent
documentation about the health of émigrés from the FSU before leaving the country of
origin, and the perceived views of health disparities experienced by midlife and older
women expressed informally to the researcher by women from the FSU.
The researcher’s prior experiences of exploring health beliefs, values, and practices of women in a small Appalachian community (Hansen & Resick, 1990) and in an urban African American community (Resick, Taylor, Carroll, D’Antonio, & de Chesnay, 1997) have greatly influenced the researcher to value the need for understanding the human experience from the perspective of the client in order to implement culturally appropriate and competent health care services.

H. Significance to Nursing

The American health care system continues to struggle with conflicting demands (USDHHS, 1991; USDHHS, 2000). The phenomenon of health is central to nursing practice and nursing research (Payne, 1986; Reynolds, 1988). As health priorities change, nurses, too, will be focusing on these areas of disease prevention and health promotion as a central concern of the discipline of nursing (Turton, 1997). At the same time, the percentage of older adults and the total number of elderly in the population will be increasing (US Census Bureau, 1999). Moreover, immigrants and refugees from the FSU are growing in numbers and tend to be older women (Brod & Heurtin-Roberts, 1992; Fitzpatrick & Freed, 2000; Gelfand, 1986). Older adults, especially post-menopausal, have more chronic conditions that will require more nursing interventions for their long-term management (Speroff, 1999).

The evolution of the advanced practice nurse (APN) role has presented continuing challenges and prospective opportunities for APNs to develop innovative practice models in population-based community health (Meleis, Lipson, Muecke, & Smith, 1998). Knowledge about the health beliefs of groups such as midlife women immigrants from
the FSU will enable the APN to develop population-based, culturally competent community health services (Meleis, Lipson, Muecke, & Smith, 1998). This kind of knowledge will result in strategies to meet national health objectives by increasing the years of healthy living and decreasing health disparities (USDHHS, 1991; USDHHS, 2000).

No one study addresses the health beliefs, values, and practices of midlife immigrant women from the FSU. Studies about immigrant populations in Western cultures tend to report health beliefs, values, and practices as a fused entity (Strand & Jones, 1983; Van der Stuyft, De Muynck, Schillemans, & Timmerman, 1989). Other empirical studies (Aroian, Khatutsky, Tran, & Balsam, 2001; Wei & Spigner, 1994) offer conflicting reports of over-utilization and under-utilization of health-related services by immigrants during the first 10 years in the country of destination. Most studies are not designed to explore these issues from the perspective of the immigrant and within the context of the immigration experience. Migration is affected by changing migration legislation, public opinion, and historical events (Rogler, 1994). In addition, migration is impacted by voluntary and involuntary conditions, personal decisions to move, and the person’s degree of control in making the decision (Rogler, 1994). The results, findings, or conclusions from existing studies tend not to add to this information. Until the last decade, most of the knowledge about midlife and menopause was based on research conducted with native-born middle-class European Americans (Berg, 1999; Im & Meleis, 1999a). Few studies have explored the health-related problems identified by midlife immigrant women or the challenges these women perceive that they are facing when interacting with the health community providing services to them.
In the discipline of nursing, one type of knowledge that is important is the understanding of human experiences (Allen & Jensen, 1990). This kind of understanding requires research methods enabling the exploration of the breadth and depth of the human experience. Hermeneutics is a method of inquiry that provides an interpretive strategy for this understanding of the human experience of the meaning of health (Cohen, Kahn, & Steeves, 2000).

The findings of this study will, therefore, contribute to the body of knowledge of nursing by exploring the health experiences of midlife women from the FSU within the context of immigration in ways that may not be obtainable through other means. The knowledge generated will add to the groundwork for the design of culturally competent health promotion and wellness interventions in midlife that can result in the modification of morbidity and mortality of chronic diseases associated with aging. In other words, this kind of intervention can enhance quality of life and decrease health care costs associated with the debilitating diseases of aging (USDHHS, 2000).

Quality health care depends on the health care providers’ ability to understand the lived experience of the client and the framework used by the client to make health decisions. Health care providers are challenged to deliver health-related services that meet the needs of a diverse society through culturally appropriate interventions (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995).

In order to offer such interventions, the health care provider must understand the complexity of the life experiences of the midlife immigrant woman (Meleis, Lipson, Muecke, & Smith, 1998), something that may not be readily apparent when health care interventions are made based on a priori assumptions about immigrant populations.
Moreover, midlife immigrant and refugee women represent ethnic minority populations within the United States (Meleis, Lipson, Muecke, & Smith, 1998). Although the diversity of the population is one of America’s greatest assets, the older immigrants from the FSU represent a population that is at risk for the onset of chronic diseases associated with aging (Brod & Heurtin-Roberts, 1992; Fitzpatrick & Freed, 2000). Recent studies indicate conflicting findings regarding the utilization of health care services by new immigrants to the United States, a situation with the potential to result in culturally inappropriate care and to add to the health needs of aging new Americans. This study will add to the knowledge of research on health disparities by seeking to understand health values, beliefs, and behaviors from the perspective of midlife women from the FSU within the context of immigration. This knowledge is vital in order to achieve the health promotion and disease-prevention objectives of Healthy People 2010 (USDHHS, 2000) for this population.
II. REVIEW OF LITERATURE

A. Introduction

This chapter presents an overview of the literature written in English and related to Russian-speaking émigrés living in Western cultures. First, an historical overview of the Eastern European migration to Western cultures is presented as a background to the current immigration experience. Next, background regarding the challenges of obtaining census data is discussed along with a review of the studies of the “Third Wave” migration to the United States. Specific literature addressed in this chapter includes health care utilization among émigrés, acculturation and Russian-speaking émigrés, and health within the context of immigration. The international literature relating to Russian-speaking émigrés in other Western cultures including Israel and Australia is reviewed, in addition to the literature related to immigration and women at midlife. Also included in this chapter is a discussion of the literature related to health as a concept central to nursing science, elucidation of the challenges of maintaining cultural competence in research, and provision of examples of related research using phenomenology and hermeneutics as methods to study phenomena of concern to nursing. This chapter closes with a summary synthesis of the review of literature.
B. Historical Background of Eastern European Migration to the West

People have migrated since the beginning of time. Thus the East-West migration is not a new phenomenon. Historically, migration has occurred for both economic and political reasons. With the blossoming of the Industrial Revolution during the nineteenth century, over 30 million people migrated from Eastern Europe to North and South America seeking paid work (Fassmann & Munz, 1994). A second deciding factor that influenced migration was the variation in political systems and the desire for freedom and equality in the West as compared to the feudal structures that remained in the East (Fassmann & Munz, 1994). These two factors led to a “pulling” of immigrants due to economic and political reasons. In contrast, a third reason for the increase in migration was the rise in nationalism, which resulted in a “pushing” or forced migration due to religious and political persecution in Eastern Europe (Fassmann & Munz, 1994).

Immigrants of Jewish descent have left Russia and Eastern Europe for the West in great numbers since the 1880s, a period marked by a series of pogroms and the beginning of official anti-Semitism (Jacobs, 1981). When the Bolsheviks rose to power and eliminated all other political entities, synagogues were closed and Jewish religious instruction forbidden. Although anti-Semitism was regarded as anti-Bolshevism, it continued in the workplace, in the army, and among bureaucrats (Jacobs, 1981). This “first wave” of immigrants from Russia and Eastern European nations ended in the early 1920s.

Although the USSR was supposedly closed to emigration after the 1920s, some movement continued over the next four decades, with a second wave of immigration occurring during 1945 to 1950 that was directly related to World War II. The Cold War
and the Iron Curtain resulted in a marked decrease in European East-West migration, but a third wave of migration occurred between 1950 and 1993. This group of émigrés was made up of Jews who had experienced discrimination and chose to leave. According to Paul & Jacobs (1981), in 1968, 231 Jews migrated from the USSR to the West. Then, starting in 1969, this number began to increase dramatically, until nearly 13,000 Jews received permission to leave the USSR in 1971 (Paul & Jacobs, 1981). The reason for the sudden policy change by the Soviets was thought to be partially related to their hope that, by appearing to be more responsive to the human rights of the Jewish minority in the USSR, the United States and other Western nations would consider improved trade agreements with the Soviet Union (Paul & Jacobs, 1981).

While actual numbers are not available due to inaccurate and inconsistent record keeping, more than 75 percent of the European East-West migrants during this time period were considered ethnic migrants belonging to ethnic and religious minority groups such as ethnic German emigrants and individuals of Jewish ancestry who were supported by a Western nation or a political lobby. Over 50 percent of the immigrants in this group were Soviet Jews, who migrated to the United States or to Israel (Paul & Jacobs, 1981).

Although approximately 33,500 Soviet Jews migrated from the USSR (Paul & Jacobs, 1981) in 1973, the United States made no move to improve its trade agreements with the USSR. This decision resulted in a reduction of Russian Jews permitted to leave the USSR. Thus by 1976 only about 14,000 Jews were granted permission to leave the USSR (Paul & Jacobs, 1981), though this number increased again in 1979. In 1989, however, the annual immigration from the FSU was only 1,408 (Schmidley & Gibson, 1999; U.S. Census Bureau, 1999). In the 1990s, changing economic and political
conditions worldwide resulted in widespread global migration patterns. The disintegration of the Soviet bloc and the dissolution of the Soviet communist system, along with changes in the immigration policies of the United States, resulted in the former Soviet Union (FSU) becoming the leading source for refugees to the United States in that decade (Fassmann & Munz, 1994; Lewin-Epstein, Roi, & Ritterband, 1997; Miller & Chandler, 2002). In 1996, the number entering from the FSU rose to 62,800 (Schmidley & Gibson, 1999; U.S. Census Bureau, 1999).

C. Challenges of Obtaining Census Data

The data related to international migration are not standardized, are difficult to locate, and, if located, are difficult to interpret. Tyree and Donato (1986) summarize the frustration resulting from their efforts to locate precise numbers on international and local migration with regard to age, gender, occupation, etc., by observing that “the data are notable primarily for their spottiness, absence, and incomparability” (p. 22). Differences exist in definition and standardization of the unit of measure. Often information is determined by inference (Tyree & Donato, 1986).

In addition, exact census data with regard to newly arrived émigrés to a locality are extremely difficult to obtain. National databases do not distinguish how long a person has been living in the country or specify the arrival date of a person born outside of the United States. Secondary immigration patterns make it difficult to estimate accurately the number of émigrés in any given location (Brod & Heurtin-Roberts, 1992). As a result, the number of recently arriving immigrants may be difficult to find directly and is usually estimated by induction (Weitzman & Berry, 1992). Actual numbers of Russian-speaking
immigrants living in a given geographical area are difficult to determine through federal, state, and local census data (personal communication, M. McDonald, November 11, 2003).

An estimated 734,000 Russian-speaking immigrants from the FSU were living in the United States in 1997 (Schmidley & Gibson, 1999; U.S. Census Bureau, 1999). The ten states with the largest Russian-born population in 2000 included the following: New York (27.8%), California (16.1%), New Jersey (6.0%), Massachusetts (5.1%), Illinois (4.8%), Washington (4.6%), Pennsylvania (4.1%), Florida (4.0%), Maryland (2.6%), and Ohio (2.5%) (http://www/migrationinformation.org/USFocus/whosresults.cfm, retrieved 7/9/04).

Since family unification often provided the means for émigrés to enter the United States during times of restricted immigration opportunities, most often the end point of settlement was dependent on where family members who had emigrated earlier were living. Although no restrictions are in place with regard to gender and family reunification, most of those émigrés who take advantage of the family unification provision for emigration to the United States are women (Gabaccia, 1994). Approximately 25 percent of those immigrating from the FSU are women at midlife or older (Brod & Heurtin-Roberts, 1992). In general, Russian immigrants tend to be older than other groups of immigrants to the United States (Brod & Heurtin-Roberts, 1992).

Little is known about the health of the Russian-speaking émigrés living in the United States. Studies conducted in the 1970s and 1980s in the United States often consist of surveys and case studies from caseworkers and social workers in various cities
that describe the émigrés of the “third wave.” More recent studies focus on issues related to health care and service utilization, and acculturation.

D. The “Third Wave” Migration to the United States

Overview

Earliest studies of Russian immigrants in the literature include descriptive surveys by social workers and caseworkers of Soviet immigrants who migrated in the “third wave” (Jacobs, 1981, p. 1), which began in 1971 and peaked in 1979. These demographic studies included surveys conducted with the purpose of describing the population of Soviet Jews who migrated to the United States; they concentrated on Detroit (Gitelman, 1977), Baltimore (Gilison, 1981), Minneapolis and St. Paul (Feinstein, 1981) and Cincinnati (Paul & Jacobs, 1981). The focus of the research included absorption efforts (Gitelman, 1977), resettlement issues (Gilison, 1981), and attitudes and reactions to life in America (Feinstein, 1981; Paul & Jacobs, 1981). Other studies about the “third wave” included case studies of émigrés (Dranov, 1981; Drew, 1981; Paul, 1981).

Survey studies of Soviet Jewish immigrants who migrated to the United States in the third wave (Feinstein, 1981; Gilison, 1981; Gitelman, 1977; Paul & Jacobs, 1981) concluded that these émigrés differed from earlier Soviet émigrés due to higher levels of education and less identification with the Jewish religion. Although the newcomers who arrived in the United States in the 1970s had experienced anti-Semitism at home, the major reason voiced by most of the émigrés for leaving the USSR was to seek more professional opportunities and a better standard of living. Both professionals and intellectuals in this group identified the desire for freedom as a reason for leaving the
USSR (Feinstein, 1981; Gilison, 1981; Gitelman, 1977; Paul & Jacobs, 1981). Most of the émigrés in the third wave relocated in family units consisting of a father, a mother, and one child, and approximately a fifth came with one grandparent (Simon, 1983, p. 493).

According to Jacobs (1981), earlier Soviet Jewish émigrés, who arrived in the United States in the first and second waves, brought with them a greater identification with the Jewish religion than those émigrés who arrived in the third wave. In addition, these earlier émigrés had experienced the pogroms of organized persecution, which contributed to their view of America as a refuge and a land of opportunity to a greater degree than later émigrés, who had done reasonably well in the Soviet system and did not personally experience pogroms in their lifetimes. The émigrés of the third wave, at the same time, tended to be strongly motivated and to have expectations for success in America (Jacobs, 1981).

The studies of the third wave suggest that the newcomers often “complained and pushed” (Jacobs, 1981, p. 9) in the United States, just as they had done in the Soviet system. Although these studies illustrate the challenges encountered by the émigrés in seeking acceptance by different communities throughout the United States during this period, no explanation with regard to the cultural competence of the research method or research tools was offered by the authors.

The authors did speak to some of the methodological challenges encountered in the research process. While émigrés were often reluctant to participate in studies due to suspicion of “some hidden, deceptive governmental agency behind the academic cloak” (Jacobs, 1981, p. 10), the authors of these studies did not mention any deliberate efforts
on their part to meet these challenges. These studies do, however, add to our knowledge base with regard to understanding the background of the émigrés, something that was found to be absent from American or international literature on the subject prior to these descriptive works.

Gitelman (1977) asserts that some Soviet immigrants may view others with suspicion and avoid interactions; these differences may be more intense in America. According to Gitelman (1977), “Soviet immigrants may demand and shout, rather than request; but this is normal, accepted, and even expected behavior for those coming from a culture where the relationship between official and citizen, between salesperson and buyer, is automatically assumed to be an adversary one” (p. 15).

**Russian Immigrants in Detroit, Michigan**

In a random sample survey (in Russian) of 132 Soviet immigrants in Detroit, in the summer of 1976, Gitelman (1977) investigated their expectations of America and the degree of fulfillment of those expectations. Questions were asked about expectations and fulfillment, work, income, housing, perceived standard of living, social class, identification as Jews, Jewish Family Services, and attitudes toward and assessment of life in the United States. The study suggested that approximately half of those surveyed reported that their expectations had been fulfilled, 31 percent reported expectations partially fulfilled, 11 percent were not able to say, and only 9 percent felt they had not been fulfilled.

In this study, the reasons given for immigration included political dissatisfaction, anti-Semitism, family concerns, and desire for economic opportunities. The greatest variance in fulfillment of expectations was observed in those who emigrated due to
family reasons. This group was also the highest in reporting that they were unable to judge if their expectations were fulfilled. Although this study was also conducted with an Israeli population, using the same questions (in Russian), it was difficult to make a meaningful comparison due to the high percentage of “Don’t know” responses among the immigrants in Detroit. This survey suggested that a large percentage of the immigrants are either unemployed, not sure about their satisfaction, or not willing to “complain” to the interviewer (Gitelman, 1977, p. 17). In both Detroit and Israel, the more educated émigrés such as physicians had the most difficulty finding employment. In this study, among working males and females, women tended to be more satisfied. The reason is felt to be related to women having lower expectations, on the one hand, and to the fact that work was more available in less skilled and specialized fields, on the other. In this study, some of the women reported that they were content to remain in the home in the United States, since their work in the Soviet Union had been a necessity rather than a means of self-fulfillment (p. 18).

In Gitelman’s study, immigrants were found mainly in the lower income groups. As experienced in the USSR, in America, also, the women tended to earn less than the men. Fifty percent of the immigrants in this study perceived their standard of living as higher in the United States than in Russia, but lower than that of most of those born in the United States. Men and highly educated immigrants reported the highest perception of experiencing a lower standard of living than that of those born in the United States. Immigrants, especially those with higher degrees of education, viewed themselves as having lost social status and having experienced a change in social class. With regard to attendance at synagogue, this survey suggests that the majority of immigrants attended
synagogue out of curiosity and because of invitations or perceived pressure from the local Jewish community.

Unlike the experience of Russian émigrés in Israel, immigrant absorption in the United States was found by Gitelman (1977) to be nearly entirely a nongovernmental process. In the United States, those dealing directly with émigrés are social workers and guidance and occupational counselors, who have little knowledge of the Russian culture and language. However, in Israel, those dealing directly with émigrés tend to be civil servants, and social workers there make up only a small portion of those dealing directly with émigrés.

In Detroit, the charge of the Jewish Family Service (JFS) was to oversee the transition of the Soviet émigrés, and each family is assigned a caseworker. According to Gitelman (1977), interactions with the Jewish Family Service often lead to frustrated cultural expectations on both sides; thus, “the immigrants naturally transfer Soviet ways of dealing with bureaucracies and bureaucrats, and their confrontational style quickly alienates – or at least puzzles – the American social worker. The Jewish agencies are often perceived as government agencies and the attitude toward them develops accordingly” (p. 24).

Gitelman (1977) suggested that, in this study in Detroit, although the émigrés were informed by the Jewish Family Service (JFS) that they would be asked for interviews and assured by the JFS and the interviewers that the JFS did not sponsor the study, some of the study participants may have perceived that the study was carried out by the JFS. This may have influenced responses to the inquiry about satisfaction with the JFS. The less educated were more pleased.
With regard to attitudes and assessment of life in the United States, Gitelman (1977) asserted that, although 20 percent of the less educated émigrés in Detroit reported that nothing disturbed them in this area, several less educated émigrés identified the difficulty of learning English as a problem, while the more educated identified the lack of “culture” as disturbing. Other frequent complaints included the isolation of the families, lack of social contact, lack of public transportation, and the need to work harder in the US compared to the Soviet system. Others noted how pleased they were with political freedom and the higher standard of living they experienced in the United States.

Although 42 percent responded that there was nothing that the United States could learn from the Soviet system, those better educated reported that the US could benefit from the Soviet example of discipline and order, social services, and free higher education and medical care. These respondents also recommended the use of the death penalty and a tacit agreement not to discuss scandalous situations publicly.

Gitelman (1977) concludes that many essential questions remain unanswered. These include immigrant expectations of America, the immigrants’ socialization process, and the expectations and evaluations of the resettlement agencies.

*Russian Immigrants in Baltimore, Maryland*

In another community case study of “individuals in transition” (p. 29), Gilison (1981) studied the resettlement of Soviet Jewish émigrés in Baltimore. In 1978, Gilison (1981) conducted a survey of a random sample of ninety Soviet émigrés having resided in the metropolitan area of Baltimore for at least 4 months. This random sample ranged between the ages of 18 to more than 50, with 54 percent of the participants being male and 46 percent female; 56 percent of this group were between the ages of 30 and 49; 67
percent were married; and approximately a third had migrated from Ukraine. The rate of immigration of Soviet émigrés to Baltimore was in accordance with the Hebrew Immigration Aid Society (HIAS)’s national policy of placing émigrés in cities in approximate proportion to the number of native Jews in each metropolitan area (Gilison, 1981).

The variables measured in this survey included changing attitudes, patterns of behavior, and the development of relationships with those born in the United States. Its purpose was to provide information to those agencies responsible for resettlement of Russian-speaking Jewish émigrés (Gilison, 1981). As a result, the survey design was based on the information needs of the agency workers. Although the main focus of the survey was the resettlement program, the survey included questions that would reveal information about the acculturation process and conditions left behind in the Soviet Union (Gilison, 1981).

Pilot testing of the survey tool suggested that a system of indirect questions was more productive with this group than direct and evaluative questions (Gilison, 1981). In addition, often the same data were elicited in more than one question, for a check on the consistency of the responses. This survey tool was originally developed as a pilot for a larger scale multi-community study.

The surveys were completed through interviews in the participants’ homes conducted by bilingual interviewers unknown to the study participants. Although, according to the author, efforts were made by the interviewers “to set the respondents at ease by creating an atmosphere of informality” (Gilison, 1981, p. 32), no further description was given as to how this was accomplished or whether the efforts succeeded.
The author did state that the study participants were told by the interviewers that the research was sponsored by an academic institution and not by the agency being evaluated by the survey. In addition, the study participants were told that the purpose of the survey was an attempt to improve the resettlement process for future émigrés.

Findings indicate that a high percentage of the émigrés in this study were Jews from Ukraine; at the time of the study (1970s), this was the population of Jews who had experienced greater anti-Semitism at home; were less likely to assimilate into Russian culture than Jews living in Russia; and were twice as likely to emigrate to the United States (Gilison, 1981). Approximately 26 percent of this sample did not complete the standard education expected in the Soviet Union (Gilison, 1981).

The participants in this study noted that the experience of applying for an exit visa in the USSR in this “third wave” was not without harassment and inconsistency. The wait for exit visas could last anywhere from a few months to a few years. During this waiting period, several study participants reported experiencing deprivations such as loss of employment and avoidance from friends. The author interpreted this experience as adding to “the defensive reactions that can be so counterproductive when immigrants arrive here” (Gilison, 1981, p. 39).

Nearly 71 percent of the émigrés reported that they had no knowledge of English upon arrival. The author reported that taking English language classes was often not a priority for the newly arrived émigrés due to other issues being identified as having more immediate importance, since not all occupations required the same level of English skills and they were living in an ethnic community. Although English-speaking skills were directly related to earning power, the data did not suggest that increased skill in speaking
English was the cause of increased salaries (Gilison, 1981). The group least likely to seek English-speaking classes comprised émigrés older than 50 years of age, with a mean age of 66. This group was most likely to overrate their English-speaking abilities and continue to experience poor English communication skills four years after arriving in the United States. The author interpreted these findings as related to this group’s general lack of education, its age, its background, and its discomfort with engaging in a formal class setting.

According to Gilison (1981), if his interpretation of the analysis of the survey is correct, and the motivation for immigration was to get a better job, then finding suitable employment would be the first expectation for the newcomers. However, suitable employment is likely the greatest challenge facing the newly arrived émigré. Moreover, the likelihood of upward mobility is limited by age, mastery of the English language, the challenges of the American work place, and the educational and skill levels required.

Comparing American and Soviet life, covariant analysis suggests that American culture is considered superior with regard to standard of living and personal freedom. Although there appeared to be a reluctance to rate anything lower in American society, as evidenced by the increased frequency of the answer “Don’t know,” American society seemed to be considered inferior in cultural life, education, climate and personal safety and crime (Gilison, 1981, p. 44). The author interpreted this type of response as related not only to the fact that an American interviewer was asking the questions, but to the sense that “to acknowledge the superiority of Soviet society in any respect is, in effect, to call into question the wisdom of the emigrant’s decision to emigrate” (Gilison, 1981, p. 44). The data suggest that, for these respondents, a stark contrast or an inverse
A relationship existed between Soviet society and American society. That is, in each category in which the Soviet society received a high rating, the American society received a low rating, and in each category in which the Soviet society received a low rating, the American society received a high rating (Gilison, 1981). The correlation coefficient of the seven items of comparison was -0.92. These polar opposites, according to the author, could suggest that, by immigrating to the United States, the émigré believes he has left behind all the unfavorable aspects of Soviet life (Gilison, 1981).

The data in the Gilison (1981) study suggest the presence of two different groups in the émigré community. One group identifies with the Orthodox Jewish community and the other with a more secular view of Judaism in that, although they identify with being “Jewish,” they do not consider themselves “religious” (Gilison, 1981, p. 46). The author noted that responses to the questions about the immigrants’ desire to educate their children in the Jewish faith may have been biased, since the interviewer was from a Jewish organization.

Gilison (1981) suggested that being Jewish played a major rule in personal relationships, as the majority of respondents reported that the majority of their Soviet acquaintances were also Jews, even when they had no formal knowledge of the Jewish religion under the Soviet system. In addition, the author hypothesized that the pattern of intense friendships in Soviet culture may be a significant factor in the decision of those left behind in the Soviet Union to follow the emigration of friends and family.

It should be noted that the émigrés’ experience in Soviet culture had been influenced by anti-religious teachings under the Soviet system. This anti-religious propaganda depicted religious individuals as superstitious and absurd. According to
Gilison (1981), this might well have resulted in Soviet Jews who not only know nothing about organized religion but who may have strong feelings against religious beliefs.

In this study, approximately one-fifth of the respondents did not require medical treatment in Baltimore, and one-fifth visited a health care provider more than ten times. The study found that the émigrés arrived in the United States with more untreated medical and dental conditions than would have been expected in this age range. The author hypothesized that the émigrés in this sample tended to avoid Soviet physicians and dentists due to a lack of trust in the care they would receive and instead decided to wait for perceived better care in the United States. Nevertheless, the untreated medical and dental conditions added to the costs of the facilities providing care without charge to this group of émigrés (Gilison, 1981).

As for the responses concerning views on resettlement policies and procedures, the author wrote that, although the interviewers represented an unrelated organization (the Baltimore Hebrew College), it was not realistic to expect that the participants in this study would give candid answers; thus he concluded that the responses were somewhat overrated and subject to bias. The respondents, who appeared reluctant to discuss emotional and psychological issues related to resettlement and adjustment, changed the focus to more mechanical problems such as learning the language and finding employment. With regard to financial support given to them by the Jewish community, when asked what, if any, portion of the money should be repaid by the immigrants, the majority view was that the loans should be considered at least partially as gifts (Gilison, 1981, p. 50).
With regard to children and childrearing and immigration, although other sources have reported that some immigrant parents were experiencing difficulties related to the immigration process, the respondents were not willing to discuss any such difficulties. The majority of respondents expressed that they felt that the Soviet system provided more control over children and less permissiveness than the American system. In addition, although the sample size was small, the data seemed to suggest that the longer the length of stay in America, the more acculturated the children became and the more upsetting the acculturated behavior became to the émigré parents (Gilison, 1981).

According to the author, the typical family that immigrated in this third wave was made up of a married couple in their 30s or 40s with one or two children and, in about 18 percent of the cases, with one or more older parents (Gilison, 1981). The immigrant family usually joined other family members already living in the metropolitan area.

Most émigrés find friendships within the émigré community in the first years after arrival. Approximately 36 percent in this study had no American friends, and 80 percent reported that all their friends were Jewish. This suggests that the émigrés, especially those not long in this country, are living in a state of isolation from American culture. The author asserts that, although it may be helpful in the first year or so after arrival to live in close knit émigré communities, in the long term these isolated communities may become obstacles to the integration of their members into American society (Gilison, 1981).

Gilison (1981) was dependent on the émigrés for knowledge of Soviet life and culture. According to Gilison, the longer the émigrés lived in America, the more difficult it would be to learn from them about life in the Soviet Union. That is, with time and the
process of Americanization, important details would likely be forgotten. Gilison (1981) surmised that several challenges existed in attempting to obtain reliable information about the Soviet Union from émigrés of the third wave, including the émigrés’ probable negative view that led to immigration in the first place and the inaccuracy of information all Soviet citizens received from the Soviet news media and informal networks. In addition, the émigrés of the third wave were for the most part of Jewish descent. As a result, the experiences voiced by this group of émigrés would be reflective of only a small sample of the Soviet population. Interpretation of the data remains a challenge, and inferences from the data to the Soviet population as a whole are impossible.

Gilison (1981) summarizes his research by describing the Soviet émigré of the third wave “in motion between two cultures” (p. 54). He goes on to state that, although the survey was not meant “to tap the level where psychological stress shows itself” (Gilison, 1981, p. 54), it does provide a snapshot of the acculturation process taking place. Although the newcomer is provided a start in American society with housing, employment, and English language classes, this is only the surface. Under the surface, the immigrants are not experiencing integration into American society. Their friends tend to be other immigrants, and they do not identify with the American or the Jewish culture around them. In addition, they have experienced occupational setbacks compared to their level of employment in the USSR. Still, the émigrés do not appear to regret the decision to leave their homeland (Gilison, 1981).

The author concludes that the sample did not experience adverse feelings toward the interviewers. In addition, the responses were generally positive with regard to the resettlement agencies and the policies of the local Jewish community center. Criticisms
about American society were focused on issues that native-born Americans also criticize (Gilison, 1981).

In the study by Gilison (1981) of the Russian émigrés of the third wave in Baltimore, the author gave no indication that the survey tool was culturally appropriate or that his interpretation of the findings was verified with the study participants. Also, he did not clearly state what process was followed by the interviewers to create a trusting environment during the interview process. Although the interviewers were described as bilingual, the ethnic and cultural background of the interviewers was not given; thus the reader cannot determine if the respondents might have felt ill at ease with the interviewers despite attempts to create a comfortable interview environment (Gilison, 1981).

**Russian Immigrants in Minneapolis-St. Paul, Minnesota**

In the summer of 1977, Feinstein (1981) studied attitudes and reactions to life in America of a representative sample of sixty-six out of approximately one hundred and two Soviet-Jewish émigrés over the age of eighteen who had arrived in Minneapolis and St. Paul in the 1970s. The major purpose of this study was to document the background of this group and provide statistical information on the challenges and attitudes they developed as they experienced life in America. In this region, the Jewish community comprised approximately two percent of the total population, had a low level of industry, and was geographically isolated (Feinstein, 1981). The first Jewish émigrés to this area came from Germany in the nineteenth century, many of them preferring the cold winters of Midwestern US to the hotter climate of Israel (Feinstein, 1981). The relationship between the newly arrived émigrés and the resettlement services of Minneapolis and St.
Paul was a strained one, with both sides perceiving the other as not meeting preconceived expectations (Feinstein, 1981). In order to understand the situation better and to maintain the objectivity that an uninvolved third party would provide, the University of Wisconsin sponsored a research study to create a statistical profile of the community.

Interviews were carried out in Russian by four students with a background in travel or study in the USSR. Although it was clear that the émigrés would not readily talk to the resettlement representatives due to their dependent relationship, it turned out that they were very willing to talk to the university students. Out of the sample, only two families declined to be interviewed. One family stated that the interview would be “useless” (Feinstein, 1981, p. 59), and the other expressed concern over possible retribution toward family members who remained in the homeland.

The survey questionnaire comprised four general areas: everyday life in the Soviet Union, the experience of being Jewish in the homeland, the process of emigration, and absorption into the American culture. No mention was made as to how the tool was developed or pilot-tested for relevance and cultural competence. Although Feinstein discovered that several of the survey questions were “superfluous or perhaps naïve” (Feinstein, 1981, p. 60), and that some could have been worded differently, the author asserted that the project team felt that enough information had been collected to provide the desired results of the survey. The author emphasized that the interests of the project team focused on subjective rather than objective data. It is notable that, despite efforts to record the interviews, only six out of the sixty-six study participants agreed to be audiotaped.
The data revealed that, demographically, nearly 45 percent of those interviewed were émigrés from Moscow or Leningrad, that is, “heartlanders.” Approximately 24 percent came from Ukraine, six percent from Byelorussia, and the remaining 25 percent from various cities throughout the Soviet Union (Feinstein, 1981). More than 60 percent of the fathers and 53 percent of the mothers of the émigrés interviewed had been professionals, many of them involved in medical care or other white-collar employment (Feinstein, 1981).

The author surmised that the high rate of professional occupations of the parents of those interviewed could possibly explain the strong work ethic of the current émigrés (Feinstein, 1981). Thus 18.7 percent of these émigrés identified themselves as working in the medical field; 48 percent described themselves as professionals or engineers; and approximately nine percent listed other vocations. It is of interest that 89 percent of those interviewed considered themselves “intelligentsia,” a term described by the author as “nebulous” (Feinstein, 1981, p. 61), with a variety of meanings from “a graduate of a professional or technical school” to someone who thinks on his or her own. Although this self-reported high percentage is in contrast to the normally accepted percentage of 7-8 percent in the Soviet Union at the time of the study, the author noted that, in other reports, Soviet Jewish immigrants have also tended to describe themselves as “intelligentsia” (Feinstein, 1981). This finding is of great significance, according to Feinstein, in understanding the immigrants’ reaction to acculturation. That is, having self-identified with the highest social class in the culture of origin, the émigré tends to experience a loss of status and cultural identity in the culture of destination.
When questioned about wages, the émigrés in this sample experienced a higher standard of living than had been expected by the interviewers. Other responses reflected a high degree of religious and national alienation, indicating that the émigrés had found it difficult to get into certain schools and occupations because of their Jewishness. Anti-Semitism was described as having worsened after World War II and improved slightly after the death of Stalin; however, 26 percent of those surveyed felt that the time from 1967 to the time of this interview in the late 1970s was the worst period for Soviet Jews. A little less than a quarter of those interviewed stated that they were involved in groups concerned with Jewish issues or emigration. The respondents expressed that the decision to immigrate was individualized among families and associated with uncertainties, anxiety, and a general lack of information about what to expect in the transitional process to life in the United States. Forty-six percent of the émigrés in the sample expressed pride in their Jewish identification in the Soviet Union, while 53 percent expressed “feeling at home in the USSR” (Feinstein, 1981, p.63). According to Feinstein (1981), since over half of the émigrés felt at home in the USSR, these data may be helpful in measuring levels of success and resistance to occupational pressures experienced in the United States.

With regard to the emigration process, this study suggested that the émigrés surveyed experienced time periods of delays and anxiety that were tolerable. Nearly all the respondents indicated that the decision to migrate took place over an extended period of time. Approximately three-fourths of émigrés identified anti-Semitism as the major impetus that began the process. Other reasons included desires for a better life for the children, and “freedom” (Feinstein, 1981, p. 63). With regard to the time period before
permission to leave was granted, 44 percent stated that they received permission to
migrate after waiting three to six months, 24 percent received permission to leave within
two months, and 12 percent of the émigrés reported that they waited one to three years.
With regard to the cost of beginning the immigration process, 32 percent of the
respondents indicated that they needed to receive financial assistance from friends or
people from outside the country.

Nearly all the respondents experienced some form of reprisal as a result of
applying for permission to leave the Soviet Union. Forty-six percent lost jobs or resigned
due to treatment in the work environment, 24 percent experienced harassment, and others
underwent the loss of friends, family pressures not to leave, and reprimands (Feinstein,

In this study, 60 percent of the respondents indicated that migration to the United
States was their first choice. The author added that, since this survey was completed in
the mid-1970s, anti-Semitism related to Jews’ choices of occupation and educational
opportunities had increased in the Soviet Union (Feinstein, 1981).

The reasons given for the decision to immigrate to this geographical area included
reunification of family (26 percent), suggestions by friends (15 percent), the cold climate
(21 percent), and the perception that they were offered no alternatives (21 percent). The
author noted that the relationship between the émigrés and the agencies responsible for
resettlement was an adversarial one. The two Jewish resettlement agencies in the
Minneapolis-St. Paul area had different structures to aid the émigrés in the resettlement
process. One agency provided a model in which the émigrés were given financial aid
based on a loan system; in addition, a host family was assigned to aid in the resettlement
process. The other agency also provided a loan model; however, no attempt was ever made to collect the money. The hope was that the émigrés would eventually contribute back to the community, but, according to the author, this did not occur. In the second model, university volunteers were used to help in the resettlement process. Since the number of émigrés to this geographical area was so small, no formal English language programs geared toward the special needs of Soviet émigrés existed, as was the case in larger metropolitan areas receiving newcomers. This situation resulted in frustration on both sides, since, without the ability to speak the language of the host culture, the émigrés continued their dependency on the resettlement agencies (Feinstein, 1981).

In this study, the émigrés expressed varied reactions to the resettlement process they experienced. Fifty-two percent of the sample indicated that they were satisfied with the way the agency assisted with resettlement, and 44 percent indicated that they were not satisfied. Seventy-five percent indicated that the personnel aiding in the resettlement process did not understand them, whereas 15 percent indicated that they felt understood. According to the author, the major challenge suggested by the respondents was that of the relationship between the professionals and the émigrés (Feinstein, 1981).

The area that seemed to be of most concern to the émigrés was employment. During 1977, when this study was done, nearly a quarter of the émigrés were unemployed. A high percentage of these were women, who, for the most part, had held highly technical occupations prior to immigration. The author noted that, although the role of housewife in America was a relief from the hectic pace prior to immigration, it was also boring, if the family experienced difficulty establishing social networks in America (Feinstein, 1981).
Approximately 56 percent of the respondents indicated that they were satisfied with their current employment situation. The author noted that, regarding the question about work satisfaction, only nine percent responded “No” and 35 percent “rejected the question” (Feinstein, 1981, p. 67). Upon further analysis, the data suggested that job satisfaction was highest in those émigrés who had been in America longest.

The émigrés were critical of how the resettlement agencies focused on “work” rather than “profession” or “employment” (Feinstein, 1981, p. 67). Nearly 40 percent reported that they felt that their work values and lifestyles had been compromised, because the resettlement agencies had not adequately understood them. The émigrés usually spoke highly of their host families and tended to develop close social ties with them. However, many host families reported becoming frustrated with their guests’ “pushiness” or their failure to consider employment at a level lower than that experienced in the Soviet Union (Feinstein, 1981, p. 70).

With regard to the question about major fears before immigration to the United States, the respondents listed unemployment, crime, and lack of knowledge of the language. Thirty percent of those surveyed indicated that they did experience these, just as they had anticipated. As for responses to a question about the greatest disappointment experienced in the culture of destination, job-related issues were named first, followed by lack of mastery of the English language. When asked how the current resettlement agency could be improved, the respondents suggested reducing the bureaucracy and replacing the current staff with Russian-speaking personnel (Feinstein, 1981).

With regard to responses about social integration, 62 percent of the émigrés responded positively that they felt they had made the right choice to come to America
and Minneapolis-St Paul. Seventy percent responded that they were more content in the United States than in the Soviet Union. Approximately 75 percent felt that their standard of living and diet were better than in the Soviet Union. This group of émigrés was found to have a higher familiarity with the Jewish religion and culture than other émigrés (Feinstein, 1981).

Data analysis of responses related to social integration suggested that social contacts between émigrés and Americans left a lot to be desired. Americans were described as insincere, living isolated lives in single-family units, having no books in the home, and lacking knowledge of historical culture. Generally, the émigrés described Americans as materialistic, self-centered, and individualistic. American Jews were termed “shallow,” without a solid family structure, and condescending to émigrés (Feinstein, 1981).

The researcher surmised that the émigrés were experiencing many contradictions. That is, negative feelings toward Soviet culture and the discrimination they experienced as Jews conflicted with their embrace of Russian and Soviet culture. The author suggests that, although these émigrés had experienced anti-Semitic persecution in the Soviet Union, they maintained a strong romanticized attachment to the Soviet Union. At the time of the survey, the émigrés were participating in a survival process in which employment and language skills were paramount. The need on the part of the émigrés to establish themselves in the new community often led to behaviors interpreted as theatrical and viewed in a negative light by professionals and community leaders. When the newcomers perceived their interactions with resettlement workers as akin to those with Soviet bureaucrats, a hostile exchange might well result (Feinstein, 1981).
The author concludes that the data suggest that most of the émigrés were becoming integrated into American culture, as exemplified by the fact that many had become homeowners. The author describes this group of émigrés as the “desert generation” (Feinstein, 1981, p. 73), by which she means that “they may never reach a point where they will become totally free of their past.” One could argue that this may be interpreted as an unrealistic expectation and a somewhat ethnocentric statement on the part of the author of this study. That is, this statement was made without establishing that an attempt was made to understand the meaning of the events surrounding the immigration process from the perspective of the émigrés themselves. The author went on to suggest that, although the émigrés have found employment, the social and religious aspects of adaptation had not occurred at the time of this study.

The author raises a philosophical question with regard to how “being Jewish in America” is defined (Feinstein, 1981, p. 74). That is, what rights do American Jews have to define acceptable Jewish behaviors? In the Minneapolis-St. Paul area, enrollment of émigrés in synagogues and Jewish schools drops, once the free enrollment period ends.

The results of the study suggest that the third wave of Russian-speaking émigrés is very different compared to émigrés who migrated in the first wave and second wave. The author recommends that further studies be done to evaluate perceptions, attitudes and responses of émigrés themselves and of the American Jewish community. Another area of research that the author recommends is on the variations in the absorption process of immigrants from other lands who have migrated to the United States.
**Russian Immigrants in Cincinnati, Ohio**

In the fall of 1978, the Soviet Jewish immigrant experience in Cincinnati, Ohio, was studied in two phases (Paul & Jacobs, 1981). The researchers asked questions of resettlement caseworkers, Jewish community members, and volunteers who worked closely with the émigrés, including the following: How did these émigrés react to life in an American community? What were the expectations and experiences of the émigrés? How did they experience “cultural disorientation”? What was their experience in finding employment? What was their feeling about the Soviet and the American systems? How did the community absorb these émigrés? (Paul & Jacobs, 1981)

In another phase of this study that took place in the winter of 1978-1979, out of the 246 Soviet Jews who had settled in the Cincinnati area between 1973 and 1978, approximately 135 individuals over the age of 16 received questionnaires. From this number, only 37 responses were received, with four more requested by volunteers working with Russian families. Of these, 21 respondents submitted anonymously, with expressions of concern over ramifications that might hurt family still in Russia. These responses were supplemented by data from personal interviews with Russians who were open to discussion of opinions, tended to be outspoken, and were mostly professionals. They were not representative of the entire group of émigrés. The authors do not mention the gender and age demographics of the sample in the study. Development and testing of the tool were not mentioned nor were data collection and analysis (Paul & Jacobs, 1981).

Cincinnati is the oldest Jewish city west of the Allegheny Mountains, and the third largest Jewish city in the United States. The German Jewish émigrés who came to settle in the 1850s felt that this area reminded them of Germany and the Rhine River.
These German Jews resented the influx of Eastern European Orthodox Jews following the 1881 pogrom, to the point where a barrier existed between the two groups of Jews in Cincinnati. The authors point out that, although the Cincinnati Jewish community is now well established and prosperous, the community was slow to respond to appeals from the Jewish Federation to support Jewish immigrants (Paul & Jacobs, 1981). However, when the first group of Soviet émigrés arrived in 1973, an excellent resettlement program was in place. The authors point out that the group of émigrés under study was unique compared to other Soviet citizens. That is, this group of émigrés had experienced discrimination not experienced by non-Jewish Soviet citizens and had decided to leave the Soviet Union, while other Jews stayed (Paul & Jacobs, 1981).

Once the émigrés arrived in the United States, they were met by a Hebrew Immigration Aid Society (HIAS) representative, who made arrangements for an overnight stay in New York City. The following day, the émigrés traveled to the city of destination, where they were met by a Jewish Family Service caseworker who had already received information about their backgrounds. Also at the airport at the city of destination were the relatives of the family waiting to meet the newcomers (Paul & Jacobs, 1981).

The next step usually consisted of a briefing of what to expect, a tour of the area, and a visit to the shopping district. A furnished apartment was made available. In a few days, the caseworker began to help the newcomers adapt. If applicable, the caseworker registered the new arrivals for benefits and arranged for any needed health and dental care (Paul & Jacobs, 1981).
After about 2-3 weeks, efforts were begun to assist the émigrés in seeking employment through the Jewish Vocational Service. Often émigrés had already gotten jobs through relatives. At the time of this study, newly arrived émigrés were aided by support, services, and housing provided by the Jewish community and the Federal government through JFS (Paul & Jacobs, 1981). These included a weekly sum of money, free medical and dental care for one year, membership in the Jewish Community Center for one year, English classes, and tuition at a local Hebrew school for one year for the children (Paul & Jacobs, 1981).

The purpose of this survey was to show how the American Jewish community of Cincinnati perceived the motivations of the émigrés and how they evaluated the needs and success of the resettlement program. The American Jewish groups included the JFS and JVS caseworkers; major funders of the resettlement program; and volunteers who worked with the families during the initial months of immigration (Paul & Jacobs, 1981).

The authors indicated that they encountered great difficulties in arriving at valid generalizations in this study (Paul & Jacobs, 1981). They ran into reluctance on the part of the Russian émigrés to consent to the study and to answer questionnaires. Information was, nevertheless, collected from caseworkers, contributors and volunteers.

Results of the study suggested that the caseworkers perceived the newcomers as “émigrés” and not “refugees” (Paul & Jacobs, 1981, p. 83). They believed that the émigrés, although having experienced prejudice, were not victims of extreme oppression like that of earlier émigrés, but were, rather, motivated by the desire to seek better economic opportunities. The author interpreted this perception by the caseworkers as having resulted from the ambivalent attitudes of the émigrés themselves to the social
workers. That is, according to Paul and Jacobs (1981), the early émigrés of the third wave often reacted to the caseworkers with demanding behavior, since they could not comprehend that the caseworkers were not part of the government. Thus the émigrés reacted to the caseworkers as they had been accustomed to reacting to Soviet bureaucrats. In addition, the early émigrés often refused to take jobs at a level lower than that at which they had worked in the Soviet Union. The authors attributed this to the lack of understanding about job mobility in the United States, since under the Soviet system the worker was locked into a job category indefinitely (Paul & Jacobs, 1981).

In response to the question of how the caseworkers perceived the reactions of émigrés to American culture, the caseworkers indicated that the émigrés felt that Americans were superficial, lacked strong support networks, and were preoccupied with television. The caseworkers’ analysis did not match what the interviewers in the study heard from the émigrés themselves when they were asked the same question. The émigrés responded that they perceived greater freedom and independence in American culture (Paul & Jacobs, 1981).

The study suggested that the isolation experienced by those émigrés in the early 1970s was not felt by later newcomers, since the population of émigrés had grown over time. The findings of this study also suggested that the immigration process and resettlement were most stressful for adolescents and older adults. That is, adolescents had no personal reasons for leaving the homeland; like the older adults who left to follow their adult children, the children migrated to be with their parents (Paul & Jacobs, 1981).

It is interesting that the caseworkers did not stress the difficult adjustment needs of the older adults that were identified by all the Russians who were interviewed (Paul &
The caseworkers, rather, identified the elderly as experiencing the fewest problems related to adjustment. They tended, instead, to identify the middle-aged émigrés as experiencing the most immediate adjustment difficulties in learning a new language and finding employment (Paul & Jacobs, 1981). The authors attributed the reason for the discrepancy in identification of the group with the most difficult adjustment experience as a result of the caseworkers’ consistent interaction on a daily basis with the most vocal age group of the émigrés (Paul & Jacobs, 1981). Members of the Jewish community had relatively little personal contact with the émigrés and did not seem to know where the donations to the resettlement program were allocated (Paul & Jacobs, 1981).

The responses of the Americans interviewed about their perception of the reason why the émigrés left the Soviet Union suggested a great difference in opinion based on the amount of contact the Americans had had with the émigrés. In this study the more intense the contact the Americans experienced with the émigrés, the less they were viewed as freedom seekers and victims of oppression and the more as ordinary people with ordinary motivations (Paul & Jacobs, 1981).

The researchers describe challenges in collecting data from the Soviet émigrés (Paul & Jacobs, 1981). Since mailed questionnaires were not routinely returned, volunteers were sent out to interview the study participants. Many of the émigrés were described by the volunteers as exhibiting resentment and even anger, and reluctance to respond to questions. The researchers postulated that this was because of the émigrés’ fear of repercussions to family and friends who remained in the Soviet Union and suspicion that interviewers were really government informants (Paul & Jacobs, 1981).
The volunteers who interacted closely with the émigrés during their first several months in the United States were also interviewed in this study to gather information about their perceptions of the émigrés. Most often the volunteers voiced the perception that the émigrés expected to return to their previous lifestyle or better in one year. Professional families, who appeared to have a more realistic view, often said that their working class compatriots were adding to the bad reputation of other émigrés because of their self-seeking behaviors (Paul & Jacobs, 1981).

Of interest is that many respondents appear to be identified solely by their work. They have very few hobbies or outside interests. Women in this group, who often take longer to be employed, tend to become very depressed (Paul & Jacobs, 1981). Since the émigrés seek to fit into American culture and yet to maintain their Russian background, they tend to be modest and conservative in attitudes about sex and sex education. Men and women traditionally do not discuss this subject in mixed company (Paul & Jacobs, 1981).

The caseworkers and volunteers identified the acquisitiveness of the Russian émigrés as their most overt attribute. The remainder of the study, which focused on the émigrés’ perceptions of life in the United States, was implemented in the winter of 1978-1979 through a questionnaire sent out to the Soviet Jewish émigrés who had arrived in Cincinnati between 1973 and 1978 (Paul & Jacobs, 1981). The purpose of the questionnaire was to elicit their responses to the following questions: What were their sources of information about the United States and what expectations did they nurture?; Why did they leave the USSR and choose to settle in the United States rather than Israel?; How did they assess the present condition of Jews in the Soviet Union and their future prospects?;
How have their political attitudes changed since they arrived? How do they evaluate American society? and What is their present assessment of the Soviet Union? (Paul & Jacobs, 1981)

The respondents identified foreign broadcasters as playing a significant role in providing Soviet citizens with information about the United States. Approximately 75 percent listed the BBC, Radio Liberty, or Radio Israel as information sources. Some listed family and friends. Few respondents had individual contact with Americans or other foreigners. Most respondents were willing to leave their homeland for the United States without a clear vision of what to expect. The researchers concluded that leaving was more important than knowing what to expect at the other side (Paul & Jacobs, 1981).

When asked to state the primary reason for leaving, 48 percent cited the hope for a better life for their children, while 38 percent cited personal or political freedom or hope for better economic opportunities. Some came as a result of a highly motivated family member (Paul & Jacobs, 1981). The researchers compared the perceptions of the American caseworkers, Jewish community members, and volunteers with the responses of the émigrés and drew the following conclusions: Although the Americans interviewed did not consider Russians motivated by the quest for freedom, the Russians perceived that they were more motivated by the search for freedom than the Americans in the Jewish community realized. In addition, what the Americans interpreted as “crass materialism” (Paul & Jacobs, 1981, p. 105) was described by Russians as a desire to obtain a better life for their children.

On the other hand, the Jewish community in Cincinnati accurately described the émigrés as having little knowledge or experience of Jewish religion. For the émigrés,
being Jewish meant that “Jew” was stamped on their official internal passports (Paul & Jacobs, 1981; personal communication, S. McGivern, November 22, 1998). The émigrés noted that being Jewish in Russia had a negative connotation, although about 38 percent stated they were proud to be Jewish. A smaller number reported ambivalence re feeling pride versus alienation or inferiority (Paul & Jacobs, 1981).

In response to the question asking the respondents to describe conditions of Jews in the Soviet Union, nearly 80 percent reported that the situation had gotten worse and that they expected it would worsen still. The émigrés responded that, although there are many mixed marriages, Jews and Russians rarely socialize, and Russians openly express hostility toward Jews within their circle of Russian friends, though not in public. Discrimination against Jews was more blatantly experienced by émigrés seeking admission to universities and certain technical schools. Often Jews picked fields where there was a need and they would not be held back from succeeding (Paul & Jacobs, 1981).

The responses to why the émigrés chose to come to the United States instead of Israel varied. This group of émigrés was not exposed to Jewish education or customs. Twenty-five percent chose not to live in another socialistic state. Twelve percent cited that there was better economic opportunity in the United States than in Israel. When asked if they would still leave the Soviet Union if the only choice was Israel, all answered affirmatively. The authors interpreted this response as meaning that the emigration from the Soviet Union was a “flight from the Soviet Union rather than ... a pursuit of a definable ideal” (Paul & Jacobs, 1981, p. 107).
The authors found that uncovering political attitudes of the émigrés was challenging. Of interest was that most of the émigrés interviewed had not given politics deep thought in the USSR. They pointed out that it was useless to discuss politics, since nothing could be done to change the situation. The authors observed a tendency for this group of émigrés to describe the Soviet system as “monolithic, immutable, and impervious to analysis” (Paul & Jacobs, 1981, p. 107).

In addition, the authors observed the following in 1979: “The Russians exhibited an all-or-nothing attitude towards the system: either it would last forever unchanged, or it would fall (which no one thought of as a real possibility), but it would not be altered by piecemeal reform” (Paul & Jacobs, 1981, p. 107).

With regard to their evaluation of American culture and values, this group of émigrés, raised under communism in the USSR, felt that life in the United States was better than or the same as expected. Some of the émigrés listed several concerns from personal economic difficulties to social problems such as crime, race relations, permissiveness, and inflation (Paul & Jacobs, 1981, p.108).

Over 65 percent of the respondents listed two aspects of American culture with approval, namely: freedom and economic opportunities (Paul & Jacobs, 1981). With regard to disapproval of American culture, more variation was reported. Twenty percent listed personal economic difficulties, the low level of culture exhibited by most Americans, health care costs, or overly liberal social mores. At the same time, the majority of the émigrés reported that they did not want to return to the USSR. Seventy-two percent indicated that they would not return for any reason, while 21 percent reported they possibly would return if communism were overthrown. It should be noted that this
study reported the responses but did not analyze the data; thus, “The middle-age generation had all sensed sometime in early adulthood that something was very wrong with the Soviet system” (Paul & Jacobs, 1981, p. 112).

**Summary**

Summary of the results of the demographic studies of Soviet émigrés of Jewish descent in the United States conducted in the 1970s suggests that this population as a whole experienced good economic adjustment, since the majority of adults were highly educated with many skills (Feinstein, 1981; Gilison, 1981; Gitelman, 1977). These studies were conducted for the most part by American political scientists, with few exceptions, from the American viewpoint. The results were reports from surveys developed by the researchers. No information was given as to method of testing for cultural appropriateness and relevance of the survey questions, nor as to the method, if any, used to analyze the data. Information about the study participants related to age and gender, but length of time in the United States was not provided.

**E. Health Care and Social Service Utilization among Émigrés in the United States**

*Health Care and Social Service Utilization among Immigrant Populations in the United States*

Across all immigrant groups, new arrivals tend not to have a regular source of health care in the first 10 years following entry into the United States (US) (Frisbie, Cho, & Hummer, 2001; LeClere, Jensen, & Biddlecom, 1994). Barriers to health care are often related to language, the lack of understanding by US health personnel about the health
beliefs, values, and practices that the new arrivals bring with them from the country of origin (Meleis, Lipson, Muecke, & Smith, 1998).

In a cross-sectional survey using secondary data from the 1990 National Interview, a multivariate analysis based on adults living in family households suggested that the utilization patterns of health services by immigrants were related to gender, health insurance, immigrant status, and time in country of destination. In addition, the analysis revealed that cognitive and cultural barriers were as influential to health care utilization patterns as barriers related to financial constraints and lack of insurance. This study was based on the Western conceptual models of Anderson and Newman (1973) and Portes, Kyles, and Eaton (1992), and did not differentiate the country of origin of the immigrants; nor did it differentiate immigrant status from refugee status (LeClere, Jensen, & Biddlecom, 1994). These differentiations, however, are important. A refugee’s entrance into the United States is governed by the Refugee Act and not by quotas, as is the case with immigrants. A refugee differs from an immigrant in that refugees are defined as people having left their culture of origin due to fear of persecution because of religious or political beliefs or ethnicity. Refugees are required to undergo a medical examination one year before immigrating to the United States (Ackerman, 1997).

Studies of other foreign-born populations in the United States have suggested that immigrant status affects insurance coverage and utilization of medical, dental, and mental health services (Ku & Matani, 2001); thus, the health of Asian and Pacific Islanders was found to be better than their US counterparts upon arrival in the US, but their health advantages consistently decreased with length of time in this country (Frisbie, Cho, & Hummer, 2001). Problems related to utilization of health care do not occur during the
period of initial resettlement, because newly arrived refugees are screened and treated for acute problems; however, when the burden of utilization is transferred to the refugee, at least in the case of Indochinese refugees, utilization of medical services tends to decrease and untreated health problems increase (Strand & Jones, 1983). It has been found that programs addressing service utilization by older Taiwanese immigrants should be culturally sensitive and treat the family as a unit of intervention (Kuo & Torres-Gil, 2001). Finally, cultural considerations, income, language, and citizenship status are significant barriers to the use of health care services by Chinese Americans (Jang, Lee, & Woo, 1998).

**Health Care Utilization and Health Care Status among Immigrant Women**

In a longitudinal descriptive study of the impact of insurance on health status and health care utilization, Weitzman and Berry (1992) studied 387 immigrant women. The immigrant women were found to be less likely than other national samples of poor or uninsured Americans to utilize basic health services, although they were more likely to describe themselves as having fair to poor health status compared to Americans of the same age.

The immigrant women were less likely to use ambulatory health care than their American-born counterparts. The women with health insurance had a much higher utilization rate than those who were uninsured (4.2 compared to 2.1 visits, p < .01), although, in comparison with the national data, the immigrant women paid fewer visits to their primary care providers. According to the study, the uninsured immigrant women reported lower levels of health care utilization than other uninsured men and women. This finding was especially important, since, typically, women use ambulatory health
services more than men do, and men were included in the national statistics used in this study; moreover, the number of visits reported by the immigrant woman included the mandatory pre-employment physical examination.

This study suggests that low-income immigrant women face barriers to health care that exceed those encountered by native-born uninsured and poor women. The sample group in this study comprised newly hired home attendants who were mailed invitations by their union to attend a brief, one-on-one, benefits orientation during work hours. For a small sum of money, they were asked to participate in this study. The sample included only 25-30% of the women who were mailed invitations. According to the authors, the 70-75% who chose not to participate included those who did not speak English, those who may be less assertive, and those who may have more ability to access health care services than the 25-30% of the group who were represented. Therefore, the findings in this study are likely to be a conservative estimate for the entire group. The countries of origin of the participants in this study included Haiti, Jamaica, the Dominican Republic, and the Former Soviet Union (FSU). Nearly 94% of the sample arrived in the United States as adults, and approximately one-third had been in the country less than five years. Although the sample does not represent a homogeneous group, the authors assert that it enabled them to identify needs common to immigrant women. Questions used in the interview were adapted from the National Health Interview Survey. The researchers did not address the cultural appropriateness of the tool’s content. Interviews were conducted in union headquarters for the majority of the participants. Data collected were compared with the published indicators of two national samples (Weitzman & Berry, 1992).
According to the authors, the finding that the health care utilization patterns of immigrant women in this study were similar to those of the poor and uninsured born in the United States suggests that structural barriers to care are major factors in determining patterns of immigrant health needs and health care utilization. The authors also point out that, when the variables of income and insurance status were controlled, the findings of this study indicated that the immigrant women demonstrated lower levels of health care utilization than non-immigrant counterparts, suggesting that structural barriers for immigrants such as language or discrimination are much greater than for those already known to be restricted. Although the authors point out that the study cannot identify responsible factors, they imply that insurance and socioeconomic factors may not be sufficient explanations for the differences among these groups. The authors suggest that another explanation to explore is that factors related to the cultural belief system of the immigrant women may differ from counterparts born in the United States (Weitzman & Berry, 1992).

In addition, the authors point out that the low rates of health care utilization for the immigrant women would not be so crucial if the self-reported health needs of the immigrant women were not so apparent in this study. On the other hand, the older immigrant women in this study were less likely to report themselves as having poor or fair health and specify a chronic medical condition, although an argument could be raised that only healthy midlife women would be choosing to work in a physically demanding job such as that of the home attendants in this sample. Also, the low reports of chronic health problems from the women could be a result of the lack of care and medical diagnosis for an existing but undiagnosed condition such as hypertension. The authors
point out that this could explain the lack of relationship between self-reports of health status and the failure to report a chronic medical condition. The study suggests that the likelihood of poor, working immigrant women to utilize the American health care system is low. In addition, the researchers emphasize the desirability of recognizing that immigrant women have different needs and experiences from those of their counterparts who are born in the United States (Weitzman & Berry, 1992).

**Health Care and Social Service Utilization among Russian-Speaking Émigrés in the United States**

In contrast to studies of immigrant populations relating to utilization of health care and social services, a qualitative study of Russian émigrés using health care services (Wheat, Brownstein, & Kvitash, 1983) described their utilization of services as “particularly challenging” (p. 300). That is, the pattern of health care utilization for this population of émigrés was often perceived by health care providers as “difficult or maladaptive” (Wheat, Brownstein, & Kvitash, 1983, p. 300). Using five case studies from the San Francisco area, these researchers described a conflict in medical role expectations with regard to health care utilization between medical personnel and older émigrés from the FSU. The authors explained the reasons from their knowledge of the culture of origin and offered no apparent verification of their findings from the êmigrés who participated in this study.

In a later study conducted in Oregon, using descriptive and inferential statistics to analyze secondary data from medical records, health status and clinical utilization by Russian, Laotian, Mien, Cantonese, Cambodian, and Vietnamese refugees, Wei and Spigner (1994) reported that gender and age were important indicators of health care utilization. That is, Russian-speaking women had a higher prevalence of cardiovascular
disease than the Russian-speaking men in the study. The Russians were younger than the study participants from Southeast Asia. In comparison to the Wheat, Brownstein, and Kvitash, (1983) study, Wei and Spigner (1994) reported that Russian immigrants used health services less than immigrants from Southeast Asia. It is important to note that, in contrast to the study by Wheat, Brownstein, and Kvitash (1983) that focused on Russian Jewish refugees in San Francisco, the majority of Russian participants in the Wei and Spigner (1994) study were described by the authors as Pentecostal, less-educated, and living in rural areas.

Fitzpatrick and Freed (2000) used a qualitative design with case-oriented vignettes to explore the psychological, social and cultural factors affecting health care utilization by older persons from the FSU. The authors suggested that depression was a major mental health issue for Russian-born Jews, and also stressed the importance of understanding the patient’s views and beliefs about health and illness, in addition to somatizations, traumas, and the need for service providers to develop trust. The authors suggested that future research efforts should address specific cultural values, health beliefs, values, and experiences that address physical and mental health needs.

In a qualitative, case-oriented study from the nursing literature, Aroian, Khatutsky, Tran, and Balsan (2001) researched health and social service utilization among older Russian immigrants living in Boston from the perspective of the older Russians (n=17), their caregiving children (n=8), and health and social service professionals (n=15). The authors reported that use of health-related services by older Russian émigrés was perceived as extensive and related to reasons for immigration, cultural beliefs and values, and characteristics of the community. Aroian et al. (2001)
concluded that older Russian émigrés would benefit from the provision of support for depression and loneliness. In addition, educating immigrants about realistic expectations of American health care, and managing care to avoid inappropriate use of the health care system, would facilitate appropriate use of services among elderly Russian immigrants.

This research was based on an adaptation of the Anderson behavioral model (1968), a case-oriented approach, to enable a “holistic perspective that allowed causal analysis of complex interactions and contingencies” (Aroian et al., 2001, p. 269). The authors explained that, rather than use this model in the traditional way “to determine the best predictors of service use …” (Aroian et al., p. 266), they used the model as a framework for a qualitative case study approach to explore inductively the use of services by older Russian émigrés.

Some of the earlier studies in the literature conducted by caseworkers and social workers researched service needs from either the perspective of the émigrés (Gelfand, 1986) or that of both the émigrés and their health care providers (Brod & Heurtin-Roberts, 1992). Gelfand (1986) surveyed 259 elderly Soviet Jews, whose sample median age was 67 years old; they had migrated to New York during the 1970s, after the age of sixty, on the average of nine years prior to the study. The purpose of the study was to gather data on the social service delivery issues facing older Russian émigrés. A self-administered tool was developed for use by the older émigrés with limited English-language skills. The questionnaire was developed first in English, and then translated into Russian and retranslated back into English by a third person, as a reliability check. The questionnaire was administered at nine sites run by the Jewish Association for Services for the Aging in four of the five boroughs of New York City (Gelfand, 1986).
At each of the nine sites, a Russian resettlement worker explained the study before the questionnaire was distributed. Since group sites were utilized, a random sample of elderly émigrés was not obtained. In addition, those older Russian émigrés who lived alone in isolation, and who might not feel comfortable attending these sites or who might have greater need for services than those attending the sites, were not in the sample. The author pointed out that, based on interviews with caseworkers and Russian-born workers assisting in the resettlement of émigrés, the results of the questionnaires were not unrepresentative of the general situation of elderly Russian Jewish émigrés (Gelfand, 1986).

The author reported that the sample of older émigrés expressed a strong interest in completing the questionnaire (Gelfand, 1986). However, many had difficulties with the closed-ended sentences predominately used on the tool. This type of question structure was new to many of the older émigrés. Many of the questionnaires were returned with incomplete responses to those questions that asked about personal feelings regarding satisfaction with life in general and satisfaction with their current living conditions. The average educational background was at the technical school level. Only 12 percent of those surveyed lived with their children, although more than half of those surveyed lived within walking distance of their children (Gelfand, 1986).

In this sample, the adult children were older than thirty years of age and the grandchildren were mostly in their teens. Ninety percent of the women were widows. The older Russian women relied primarily on children and other relatives and friends for support, although older children may not have as much time to spend with elderly parents as they did in the Soviet Union (Gelfand, 1986).
The results of the questionnaire included a 62 percent self-rating of satisfactory health status, although 22 percent felt their health status was worse now than in the Soviet Union. Although this could be related to the stress of immigration, the author felt it was more likely related to aging over the nine years in the United States (Gelfand, 1986).

Service delivery-related issues included the strong concern expressed by older émigrés about their ability to adapt to the demands of a new culture. Many issues of acculturation difficulties relating to command of the language, housing, medical services, supplemental security income, and food stamps were mentioned. Although the expectation was that the use of formal social agencies would diminish over time, this was not what the survey results suggested. Instead, the older émigrés continued to rely on service agency assistance for two to three years after arrival (Gelfand, 1986).

The author points out that it is reasonable to expect that Russian émigrés who arrived in the United States in the 1970s would be very different from those Russian émigrés who arrived at other times in history (Gelfand, 1986). Arriving in a new land does not mean that cultural values and beliefs from the homeland are forgotten. For older Russian émigrés who have lived the majority of their lives under the Soviet regime, social support is important to meet daily challenges. The need to negotiate with governmental bureaucrats for all requests had been a familiar and expected way of life. The author uses the term “manipulate” (Gelfand, 1986, p. 447) to refer to the approach exhibited by the émigrés vis-à-vis their social workers. These workers, who had been used to developing a relationship of trust with their clients, certainly did not have this experience with the Russian émigrés. This study pointed out the cultural clash between the expectations of the American social workers for a professional relationship with
clients and the interpretations of the Russian émigrés regarding their relationship with the social workers (Gelfand, 1986).

The study generated two conclusions. First, intergenerational support for elderly émigré parents may be difficult for adult children trying to make a new life and survive in a new culture (Gelfand, 1986). As a result, older émigrés may need to turn to social agencies for support. For older Russians in this research study, assistance from these agencies was neither stigmatized nor rejected (Gelfand, 1986). This study inferred that the émigrés’ adult children, many of whom were in midlife, experienced multiple roles (Gelfand, 1986).

Secondly, an understanding of the cultural experience of older Russian Jewish émigrés is essential for the practitioner to be effective. The practitioner may not be able to use the same approach that works for younger adult Russian émigrés with older Russians, since these generations have had different life experiences in the culture of origin (Gelfand, 1986).

In addition, as the length of stay in the culture of destination increases, new problems may arise, as younger adult children become more successful and move to more suburbanized areas. Due to this type of move, and the fact that the tradition of self-help has not been part of the Russian culture, the possibility exists that the Russian-Jewish older adult will become more dependent on assistance agencies (Gelfand, 1986).

In a qualitative exploratory study using case studies, Brod and Heurtin-Roberts (1992) interviewed Russian émigrés 60 years old and older who had been in the United States for one year or less. The émigrés from Ukraine (n=8), interpreters (n=3), physicians (n=3), and nurses (n=2) were interviewed in an ambulatory medical clinic in
San Francisco, California, where they were asked to describe the influences of culture and aging on older émigrés’ health and interactions with the health care community. Although the authors do not describe how the case studies were analyzed or verified for themes, they concluded that, for older émigrés, the health system in the United States was a place where the stressors of immigration were expressed and treatment was sought (Brod & Heurtin-Roberts, 1992).

The findings suggest that cultural expectations and health beliefs, adaptive behaviors learned for survival in the FSU, the stressors of immigration, and aging can pose serious challenges in the health care management of older Russian-speaking émigrés. Used to depending on the government for basic survival, and having experienced a paternalistic and authoritative style of health care, Russian émigrés may find themselves facing “cultural disequilibrium” (Brod & Heurtin-Roberts, 1992, p. 334). Few older émigrés are prepared to function in a political and social system that values and stresses personal initiative and responsibility for one’s own health. In addition, cultural attitudes in the FSU toward mental illness meant that a loss of social status could result if the utilization of mental health services were made known. Based on an emphasis on the social focus of health and illness, rather than the biological causes (except for starvation), the Russian primary health model emphasizes social and environmental influences on health (Brod & Heurtin-Roberts, 1992).

According to these authors, it is not unusual for older émigrés to have unrealistic expectations of the American health care system. The authors suggest that solutions include educating Russian émigrés and health professionals about cultural expectations, integrating mental health services into the primary care area, and expanding services such
as adult day health care (Brod & Heurtin-Roberts, 1992). The authors report, moreover, that, although greater numbers of immigrants are migrating into the larger American cities, the implications of immigration and the onset of illness behavior and the need for medical care in this population have not been fully explored and are referred to only tangentially (Brod & Heurtin-Roberts, 1992).

In a descriptive study of Cambodian, Vietnamese, Soviet Jewish, and Ukrainian refugee caregivers and older adults, dealing with life experiences, health status, and knowledge of services available to them, 105 female caregivers ranging in age from 20 to 70 years of age (30 each Cambodian, Vietnamese, and Soviet Jews, and 15 Ukrainians) and 52 older adults ranging in age from 55 to 94 (15 Cambodians, 15 Vietnamese, 14 Soviet Jews, and 8 Ukrainians) were interviewed between 1993 and 1995 (Strumpf, Glicksman, Goldberg-Glen, Fox, & Logue, 2001). In this study, the émigrés had come to the United States between 1980 and 1995. Included were Ukrainian refugees who were persecuted in their homeland due to their Baptist faith. The participants were paid $40 for taking part in the study. Data were collected by face-to-face tape-recorded interviews that required two to three hours to complete.

In addition to standardized instruments that incorporated domains of life experience, acculturation, socioeconomic factors, functional status, and knowledge of social services available, the interviews included open-ended questions by native-speaking interviewers as well as participant observation and recorded field notes that, according to the authors, enhanced data collection and data analysis (Strumpf et al., 2001). Data analysis involved quantitative data that were coded and entered into SPSS, and frequencies and chi-squares were calculated. Qualitative data were analyzed by
identification of patterns and themes by the authors, a research team of gerontology, sociology, ethnography, and nursing experts, who reported that similar patterns emerged with regard to obligations, lack of knowledge of services, impact of immigration, and ties to the culture of origin (Strumpf et al., 2001).

These patterns included the need to learn the language and a sense of marginalization from the American culture. Caregivers expressed an obligation to care for older adult family members, along with limited knowledge of the services available to them. Older adults expressed the desire to retain ties to the culture of their homeland (Strumpf et al., 2001). The findings suggest that common experiences among these groups included the need to learn the language, coping with financial strains, adaptation to the American culture, and, for the older adult, facing loss, dislocation and isolation as well as aging and decreasing health. The researchers conclude that the findings speak to the underutilization of services by some immigrant groups (Strumpf et al., 2001).

In a qualitative study using an adapted version of the Conceptual Model for the Study of Access to Health Services (Aday & Anderson, 1974), Ivanov and Buck (2002) studied health care utilization patterns of women’s health services among a sample of Russian-speaking women aged 20 to 75 years who had lived in the United States from nine months to eight years, arbitrarily selected from one Russian-speaking church in central Virginia. The participants, who spoke little English, were divided into three focus groups (led by Russian-speaking moderators). These groups included nine women aged 20-30 (“childbearing age”), six women aged 37-46 (“middle-aged”) and sixteen women aged 60 and beyond (“elderly”) (Ivanov & Buck, 2002, p. 19). The authors reported eight major themes, namely, “access behavior, provider gender, trust/professionalism,
continuity of care, cost, health beliefs, locus of control, and lack of culturally congruent care” (Ivanov & Buck, 2002, p. 21).

According to the researchers, the findings mirror other reports that health behaviors are related to culture and reflect prior patterns of use in the country of origin. For example, none of the women reported doing breast self-exams, and nearly all depended on the health care provider for referrals to stay healthy. The women reported use of home remedies, which was consistent with the practice in the country of origin, use of health services mostly for episodic care, and a general lack of understanding about the value of preventive care (Ivanov & Buck, 2002). Most of the women depended on each other for health information. Although the authors express the need for cultural competence in health care service, the limitations of this study include the sample selection and lack of discussion about cultural competence issues related to the research design and methodology of the study itself.

F. Acculturation and Russian-Speaking Émigrés in the United States

In a study by Birman and Tyler (1994) of Soviet Jewish émigrés aged 28 to 65 (with a mean age of 45), who had emigrated to the United States after 1972 and had lived in the United States for 22 months to 14 years (with an average of 7 years), 80 married couples were telephoned by club leaders and asked to participate in an anonymous academic research study about immigration. The researcher, who was a member of the refugee community, called each of the homes of the people willing to participate for permission to mail questionnaires to each adult member of the household. Although 80 couples were queried, only 49 questionnaires could be used in this study.
The authors compared the demographic data of the sample in this study with the samples described by past demographic studies (Feinstein, 1981; Gilison, 1981; Gitelman, 1981). Based on these comparisons, the authors considered this sample to be representative of the Soviet Jewish population in the United States (Birman & Tyler, 1994).

In this study, acculturation was defined as identity and behavior that resulted in an accommodation to a host culture and involved changes in the individual related to values, customs, and language. Adjustment was defined as the “absence of alienation from the American culture” (Birman & Tyler, 1994, p. 105). Using a multifaceted and multicultural approach to the process of acculturation, and examining the relationship of acculturation to adjustment, all the paper and pencil measurement tools were reviewed and modified for validity by four key informants from the Soviet refugee community, who were familiar with mental health and resettlement issues. These measurement tools were translated into Russian and back into English, and administered in Russian with questions in the English language also included.

Subjects were asked to what extent they enjoyed or felt comfortable with aspects of Russian, Jewish, or American culture such as movies, books, music and customs. The measurement tools for the independent variables included the Identity Acculturation Scale, which was based on the Bicultural Involvement Questionnaire (Szapocznik, Kurtinez, & Fernandez, 1980), with Cronbach alpha reliability scores of .82 for the American subscale, .91 for the Russian, and .90 for the Jewish; and the Behavioral Acculturation Scale (Szapocznik & Kurtinez, 1980), with Cronbach alpha reliability scores of .84 for the American subscale, .80 for the Russian, and .83 for the Jewish. The
dependent variable was measured by an adaptation of the Alienation Scale (Nicassio, 1983).

Based on the difficulty that Gitelman (1981) experienced interpreting questionnaire results because of the tendency of Russian Jewish émigrés to frequently choose the option “Don’t know,” when this was one of the choices, Birman and Tyler (1994) adapted the Alienation Scale (Nicassio, 1983) with a Cronbach alpha reliability coefficient of .82 by eliminating the “Don’t know” choice and using the scale to measure the dependent variable.

To assess gender role in acculturation, correlational analysis was used between gender and all dependent and independent variables. In this study, women were found to be significantly more alienated than their male counterparts (Birman & Tyler, 1994).

The authors report that a negative relationship was found between acculturation and the American and Russian cultures. In the study, the likelihood of women identifying as Americans was related to length of residence in the United States. For women, retaining Russian identity in addition to behavioral acculturation was associated with alienation. Men, however, appeared to experience a multicultural process with regard to behavioral acculturation; in short, men were able to maintain participation in Russian culture-related activities without experiencing alienation, and the degree of this participation increased with the increase of length of residence in the United States (Birman & Tyler, 1994).

Although the length of residence in the United States was associated with an increase in American identity and behaviors in women and an increase in Russian identity and behaviors in men, the results suggest that the Soviet Jewish émigré women
were significantly more alienated than the men in this study. Acculturation for women appeared to be a unilevel process involving the choice between Russian and American identity and behaviors, with the choice over time being more often the American identity. For the women in this study, alienation was reduced when they assimilated by taking on American identity and behaviors (Birman & Tyler, 1994).

This study further suggested, in contrast, that neither identity nor behavioral acculturation was a unilevel process for men; moreover, men with longer residence in the United States were more active in the Russian culture in the United States than new arrivals. Although men could identify with and behave in both the American and the Russian cultures, Russian identity for the men was also related to alienation. This finding suggests that both men and women émigrés paid a price for continuing to identify with the Russian culture (Birman & Tyler, 1994).

However, since alienation was not a factor, men did not have to stop participating in Russian culture-related activities to lessen alienation. The researchers explain the different findings for women and men from the perspective of Gilligan’s work (1982) on the relational theories of the development of women (Birman & Tyler, 1994). According to Gilligan (1982), women are socialized more than men to respond to the environment and the expectations of the people around them. The authors assert that it is for this reason that the women in this study would feel more alienation than the men when living in a different environment (Birman & Tyler, 1994). The researchers used the work of an American author (Gilligan, 1982), whose study is based on research in Western culture.

The finding that the Russian émigré women were more assimilated into the American culture than the men in this study does not support other studies of assimilation
and acculturation in other groups of émigrés (Szapocznik, Scopetta, & Kurtinez, 1978), which suggest that women are the ones who continue and maintain the traditions and behaviors of the culture of origin. Birman and Tyler (1994) propose that, due to the interpersonal orientation of women, becoming involved in the American culture becomes more of a priority for them than for the men. For the latter, unaffected by the new cultural environment of the United States, upholding their identity as Russian Jews is important. Birman and Tyler (1994) assert that different relationships between cultures result in different acculturation patterns and that gender is an important variable in research about acculturation. The authors recommend the need to transcend the present study and to research further the sources of these differences. They claim that such research is necessary in order to make it possible to consider ways of preventing the negative consequences of the acculturation of Russian Jewish émigré women.

In an empirical study (Vinokurov, Birman, & Trickett, 2000) of 206 Russian-speaking émigrés (110 from New York City and 96 from Washington, DC), mostly women (55.8%), between the ages of 25 and 64 (average age of 43), who had been in the United States for an average of 3.7 years, the relationship of work status to acculturation was assessed. Life satisfaction and alienation were used to measure psychological adaptation. The authors reported that those émigrés working in the same field in the United States as in the FSU reported higher life satisfaction and less alienation than those émigrés who were underemployed or unemployed. Implications of this study, according to the researchers, are that the role of work and the importance of attending to community differences are essential considerations in acculturation. Other findings suggested by the researchers were that Russian-speaking émigrés continue to maintain their Russian
identity even as they become more acculturated to the American culture; they also found that the context of the community was related to the acculturation process, and, unlike previous studies (Birman & Tyler, 1994), that the women in this group did not differ from the men with regard to acculturation or work status (Vinokurov et al., 2000). The researchers suggest that future research include attention to the context of the community, assessment of acculturation to both the country of origin and the country of destination, and further exploration of gender-related issues with regard to acculturation and adaptation (Vinokurov et al., 2000).

G. Health within the Context of Immigration

*Health within the Context of Immigration among Russian-Speaking Émigrés in the United States*

The literature contains limited empirical studies related to the health of refugees after arrival in the United States (Ackerman, 1997). As part of a larger three-part study of refugees that combined both quantitative and qualitative methods to study health services experiences, Lipson, Weinstein, Gladstone, and Sarnoff (2002) used a qualitative approach to examine health and health-care utilization patterns of Bosnian and Soviet refugees living in Northern California.

In regard to the Soviet refugees, ethnographic methods, including participant observation, semi-structured interviews, and focus groups were used to study experiences with health care, self-care, and health risk behaviors of 35 adults (63% women), with a mean age of 60. The authors noted that only 9 participants were under the age of 40, since older émigrés in this group had more time to participate in the research study than the younger émigrés.
The study suggested that the psychological health of new refugees is affected by the social disorganization experienced in the country of origin. In addition, care was sought based on insurance coverage and recommendations from other refugees. Health was highly valued and the majority of émigrés from the FSU knew about and practiced health promotion and self-care activities, although there was low use of health screening. The health care system in the United States was confusing due to cultural variations and language differences. Half of the study participants reported that they took medications as prescribed, and the others admitted that they did not follow the prescribed treatment plan. The researchers noted that, in the process of conducting the study, they found that the study participants were more comfortable with a personal and informal approach to data collection that resulted in discussion of issues of importance to the study participants but were not elicited through the original interview questions proposed by the researchers (Lipson, Weinstein, Gladstone, & Sarnoff, 2002).

In a qualitative descriptive study of 42 Russian-speaking immigrants from the Boston area who were in the United States from 1 to 19 years, Aroian, Spitzer, and Bell (1998) investigated types of family support and stress. Participants were interviewed about immigration experiences that included relationships with their families and their resettlement experience. Content analysis of data suggested that families can be a valuable source of support, or the stress of immigration can lead to feelings of being overwhelmed, thereby adding to the stress. The study suggested that the types of stressors experienced by families included conflict of values, unmet expectations, unsatisfactory living arrangements in the United States, emotional distress involving the immigration experience, and changes in the composition of the household. The researchers
recommend that future research continue to use qualitative methods to discover support and stressors experienced by other immigrants from the FSU.

In an empirical study of 1,647 émigrés living in Boston, Aroian, Norris, Patsdaughter, and Tran (1998) found that predictors of distress in émigrés from the FSU included gender, age, education, and feelings of alienation related to language, discrimination, or loss. That is, women, older émigrés, émigrés with less than a college education, those with limited language skills, and those undergoing loss or discrimination experienced the most distress. Attempts were made not to bias the sample toward particular demographic characteristics. Data collectors were of both genders and from various age groups and cultures of origin, and had lived for varying amounts of time in the United States.

Instruments comprised a demographic scale, the Demands of Immigration (Aroian, 1995), and the Symptom Checklist 90-R (Derogatis, 1992). Both instruments had been checked for reliability and validity. The Demands of Immigration Scale was internally consistent with alpha ranges of .72-.92, with test/retest reliability over a three-week time period (r = .75-.84). The Cronbach’s alpha for the Russian-language version of the Symptom Checklist 90-R was .98.

Data were collected in the homes of the participants, who were paid ten dollars apiece. Data collection forms were developed through translation and back translation (Werner & Campbell, 1970). Data analysis included multiple regression analysis of predictors of psychological stress, and univariate analysis consisting of correction, t-test, and ANOVA to identify predictor variables.
The authors suggest that this study provides direction for assessing and treating émigrés from the FSU. Rather than assuming that the passage of time will result in lessening of psychological distress, interventions aimed at increasing language skills, facilitating the grieving process, alleviating feelings of discrimination, and increasing a sense of feeling “at home” may contribute to lessening psychological distress. Further research is recommended to understand more about the complexity of the immigration experience by studies of immigration demands related to gender and age.

Similar findings were reported by Gutkovich, Rosenthal, Galynker, Muran, Batchelder, and Itskhoki (1999). These researchers used the Hamilton Depression Scale (Ham-D) and self-rating scales, including the Beck Depression Inventory (BDI), Life Orientation Test, Beck Hopelessness Scale, Attributional Style Questionnaire, and Snaith-Hamilton Pleasure Scale, to examine the levels and nature of depression and psychological distress among 57 Russian-Jewish émigré patients (27 men and 30 women), who had lived the United States less than 6 years, ranged in age between 34 and 54 years old, and sought care in a primary care setting in New York. The primary care physician provided information with regard to the medical diagnosis, primary problems, psychiatric diagnosis, and treatment.

All instruments were translated into Russian and then translated back by a translator who had not seen the original instrument. According to the authors, this was done to “ensure cross-cultural validity” (Gutkovich et al., 1999, p. 120). Pearson correlations were used to correlate the Ham-D with the self-rated instruments, physical complaints, and demographics. Means and standard deviations were computed for variables, and differences were analyzed by one-way analysis of variance. Based on the
Ham-D, a high rate of depression was found; moreover, BDI and Ham-D scores correlated significantly with the number of psychosomatic complaints, lack of optimism, hopelessness, anhedonia, and dysfunctional attributional style (Gutkovich et al., 1999). The authors reported that 82.7 percent of the participants were found to be experiencing psychological distress, and 43.9 percent were found to be expressing symptoms of significant depression. Although a high proportion of Russian Jewish immigrants in primary care may require psychiatric care, mental hospitals in the Russian culture historically have a different meaning from what they have in the American culture. The authors hypothesize that the these rates of depression among Russian-Jewish émigrés are high due to the high rates of distress among Russian-Jewish émigrés in the community, “a tendency to express distress through somatic symptoms, culturally specific negative attitudes toward mental health systems and, perhaps, a high degree of neuroticism” (Gutkovich et al., 1999, p. 118).

According to the authors, the distress described in the research was similar to the phenomenon of demoralization and learned helplessness associated with an external locus of control or the belief that the control over one’s life came from an external source and that one’s life was not under one’s own internal control. Of interest, the sample of émigrés who participated in this study contained an over-representation of older émigrés and unemployed professionals with university degrees who had been in the United States for less than six years. Although the authors reported that the high rate of depression was attributed to the cultural tendency of the group to use somatic terms as an expression of depression, they did not indicate how cultural competence with regard to cultural and contextual meaning was addressed in the design of the study or the collection and
analysis of data. Although the authors noted that the instruments were translated into Russian and back into English, and bilingual physicians were used in the study, cultural appropriateness with regard to the actual contents of the instruments was not addressed.

*Impact of Immigration and Resettlement during Midlife among Russian-Speaking Women in the United States*

In a cross-sectional, descriptive study that examined the impact of immigration and resettlement during midlife on the health and well being of 200 Russian-speaking émigré volunteer women aged 45-65 years old, living in the United States for at least six years, Miller and Chandler (2002) reported that midlife women from the FSU exhibited very high scores on scales of depression compared to the norms in the United States. The higher scores were noted in older women and in women who reported greater demands of migration, whereas the lower depression scores were reported for women with greater command of English and more resilience.

Miller and Chandler (2002) suggest that these results, like those of previous studies, indicate high levels of depression in immigrant women, although more studies need to be done to distinguish symptoms of depressed mood from those of clinical depression. In addition, the authors suggest that interventions that increase English-language skills and enhance resilience may decrease depressive symptoms in midlife Russian-speaking women from the FSU who have migrated to the United States. Although the Center for Epidemiological Studies–Depression (CES-D) scale used in this study was translated into Russian, the researchers advised that additional research was needed to validate the concept of symptoms, the willingness to report symptoms, and the cross-cultural differentiation of depressed mood from true clinical depression.
H. Israeli Literature and Russian-Speaking Émigrés
(written in the English Language)

Overview of the Literature Related to Russian-Speaking Émigrés in Israel

Several Israeli studies of Russian immigrants have focused on specific issues related to mental and physical health. Recent studies have addressed women’s health issues across the lifespan such as family planning (Remennick, 1993), breast cancer awareness and detection (Remennick, 1999a), preventive health practices, and the role of midlife women as caregivers (Remennick, 1999b, 1999c, 2001).

Health Care Utilization among Russian-Speaking Émigrés in Israel

In an Israeli cross-sectional community survey of 966 Jewish immigrants with the mean age of 39.3 years, of those who had arrived from the FSU within the previous 30 months, women, older, and divorced individuals reported significantly more somatic problems and symptoms of distress than men (Ritsner, Ponizovsky, Kurs, & Modai, 2000). In this study, somatization was positively correlated to the intensity of psychological distress, gender, age, marital status, migration experience, self-reported health-related problems, and help-seeking behavior. The researchers noted that one of the limitations of this study was that it did not include a way to verify if the participants considered to be somatizing did or did not actually have an associated disease.

Mirsky, Baron-Draiman, and Kedem (2002) conducted an empirical study of social support and psychological distress among young people born in the FSU who had immigrated to Israel. The study, carried out in two-year stages, dealt with 893 university students, sampled from the national registry of immigrant students or contacted through advertisements, who had immigrated to Israel during late adolescence or early adulthood.
The researchers suggested that, although concepts of acculturation, adjustment, and naturalization involve a process that occurs over time, a trait culturally specific to Russian immigrants from the FSU in Israel was a higher and longer lasting degree of psychological distress, the persistence of which did not diminish over time. The authors speculated that this culturally specific finding might be related to a low tolerance for distressful psychological stress, limited introspection skills, or lack of autonomy, and suggested the necessity for further research to determine the reasons.

In multiethnic societies, health experiences, beliefs, and values vary among women of different cultural groups. These differences stem from social, economic, and cultural variations that are related to life events such as immigration (Ferran, Tracy, Gany, & Kramer, 1999). In addition, these variations may result in different health needs and present different barriers to seeking care; thus, they are important to consider when designing appropriate health services (Ferran, Tracy, Gany, & Kramer, 1999).

In an Israeli cross-sectional survey study of 793 Israeli men and women, ages ranging from 45 to 75 years, of whom 124 were immigrants from the FSU who had lived in Israel since 1989, the immigrants reported higher rates of disease and less desirable health status than those born in Israel (Baron-Epel & Kaplan, 2001). The researchers did not find a tendency for excessive use of the health care system, although the reporting of health problems was related to time spent in Israel. That is, those immigrants who arrived before 1970 reported health patterns very similar to those study participants who were Israeli-born, compared to those immigrants who arrived after 1994, who reported more incidence of chronic disease. Although acculturation could have played a major effect on the immigrants’ health, another explanation could be that the health of those individuals
who migrated after 1994 was initially not as good as that of those who migrated prior to that time.

_Health Care Utilization among Russian-Speaking Women in Israel_

Gross, Brammlti-Greenberg, and Remennick (2001) studied immigrant women from the FSU who had lived in Israel ten years or less, and compared them to other Israeli Jewish women – both those born in Israel and those who had immigrated more than ten years before. In a telephone survey of a random sample of women aged 22 and above, comparative data from a subset of 760 immigrants from the FSU and non-immigrant Jewish women revealed that immigrants were more likely to self-report that they had been diagnosed with a chronic disease in the past five years.

A multivariate analysis suggested that, although the variable "immigrant" had an independent effect on self-reports of chronic disease and health, it did not have an independent effect on self-reported disability. In addition, when controlling for background variables, multivariate analysis revealed that immigrant women were more likely to experience depression than the non-immigrant women (P <0.01). Although both immigrant and non-immigrant women reported having a primary care provider, after controlling for background variables in regression analysis, the immigrant women were less likely to report visiting a gynecologist regularly.

The study found no statistical difference between the two groups of women with regard to satisfaction with the primary care provider. Lastly, the multivariate analysis revealed that, except for smoking, the variable "immigrant" had an independent negative effect on health counseling. The study suggested that the specific health needs of immigrant women were not totally met by the health system of the country of destination.
Specific health needs included mental health, disease prevention and health promotion. This Israeli study suggested that, even when full access to all types and levels of health care was available, utilization might be limited by cultural barriers and lack of communication between health care providers and the immigrant population. The researchers concluded that, in order to meet the health needs of immigrant women, barriers related to communication and cultural competence must be overcome.

In an interview-based qualitative study of the reaction of 45 new Soviet immigrants (two-thirds women and 70% aged 45 and older) to Israeli primary care services, Remennick and Ottenstein-Eisen (1998) found that, although aspects of clinical management were perceived as better than Soviet standards, a serious deficit existed in communication between health care providers and Soviet patients with regard to language barriers and health-related beliefs and values about illness and management of illnesses.

The researchers point out that, although this study began with the goal of providing Israeli health care providers with information about perceptions of the Israeli health care system by Russian immigrants, deeper insights about the integration of immigrants from a socialist system into a Western system of health care emerged from the data. The implication of this study, according to the researchers, may have important relevance to other Western cultures into which immigrants from the FSU and Eastern Europe have migrated. Such immigrants tend to have a high incidence of chronic medical conditions as a result of the higher morbidity of the Soviet population compared to Western populations and the tendency for those with pre-existing chronic diseases to
migrate to Western nations in search of better health care (Remennick & Ottenstein-Eisen, 1998).

The qualitative approach of Remennick and Ottenstein-Eisen (1998) brought to light several factors related to life under communism that have impacted immigrant life in Israel. That is, the participants perceived the biotechnical model of the Israel health care system as impersonal and “technical” (Remennick & Ottenstein-Eisen, 1998, p. 555) and without regard for holistic values. In addition, study participants expressed feelings of deprivation because of the lack of paternalism to which they had become accustomed while living under the Soviet health care system model, interpreting this as Israeli health care providers having abandoned responsibility for the health of their patients. Russian immigrants were not used to consumerism in health care and the expectation that they should be informed and assertive health care consumers. The study suggested that women appeared to adjust to the Western health care system more easily than did the Russian immigrant men.

Preventive Behaviors among Russian-Speaking Women in Israel

In a two-phase study comprising a survey of immigrant women and in-depth interviews based on the Health Belief Model (Rosenstock, Stretcher, & Becker, 1988) as a theoretical framework, Remennick (1999a) studied preventive behavior among Russian-speaking immigrant women who had migrated to Israel from the FSU after 1989. This study included a national sample of 620 women aged 35 years and older, with 64 percent of the sample in the age bracket of 40-60 years, having migrated within the past ten years.
This study suggested that similar problems are encountered in health care interactions in Western societies, when Eastern European immigrants migrate to cultures featuring a Western-type health care system. That is, even though people have universal access to disease prevention and health promotion, health care, and cognition about the importance of preventive action, the presence of these factors alone may not result in recommended health care utilization by the immigrant group. Remennick (1999a) suggests three explanations for the discrepancy between the lack of health actions by immigrants and cognition: (1) low motivation for health-related activities due to downward social mobility and the need to focus energy on issues related to resettlement; (2) an external locus of control along with beliefs of low self-efficacy prevalent under the Soviet belief system; and (3) cultural and communication barriers to Western health services (p. 1669).

According to Remennick (1999a), although the immigrant experience for Russian women may be different from the experiences of immigrant women from less developed cultures with regard to gender roles, expectations, and experiences before immigration, the impact related to workload and time suggested by this study may have universal relevance across other immigrant ethnic groups. Self-care and health issues have low priority for midlife women, who are focused on more immediate challenges associated with resettlement (Remennick, 1999a, 1999c). This finding was also suggested in a later study related to the multiple roles of women as caregivers (Remennick, 2001).

Midlife Russian-Speaking Women in Israel

In a qualitative study of 20 midlife immigrant women from the FSU, aged 40-60, who had arrived after 1989 and had been in the country of destination 5-7 years,
Remennick (2001) explored their experiences of multiple roles. These women were responsible as informal caregivers to their elderly parents, husbands and children, in addition to working outside the home in a job that had been downgraded from their professional status prior to immigration. The researcher asserts that, although the Russian-Soviet system posits an egalitarian gender system, women often find themselves giving up life goals in order to carry out other multiple roles and to function as principal caregiver. In addition to the experience of resettlement, the women underwent caregiver stress due to caring for the older generation of parents and younger generation of children. This caring for the older and younger generations resulted in physical and emotional symptoms and poor self-care for the women caregiver.

*Gender and Immigration in Israeli Literature*

Few studies have addressed the needs of women from the FSU and Eastern Europe immigrating to Western cultures. Although the literature reports studies of women from Third World nations, the experiences of women from the FSU and Eastern Europe prior to migration are not the same, given the higher levels of education and participation in the job market expected of these women. However, the immigration experience itself may turn out to be similar, given the downward social and occupational mobility that goes along with immigration (Raijman & Semyonov, 1997).

In an Israeli case study that included an aggregate analysis of several surveys, in addition to studies and articles from the secular Israeli press on gender-related challenges encountered by Russian-speaking women from the FSU, Remennick (1999b) explored the areas of cultural conflict encountered as a result of immigration; these involved the tensions between Israeli society and women from the FSU with regard to issues of
employment, family life, and sexuality. Of interest is that the historical background of Israel has focused on complete assimilation into the culture of Israel, with the expectation that the newcomer will comply with national norms of commitment to the Jewish national cause and adherence to the Hebrew language (Remennick, 1999b). Failure to comply with this “absorption” (Remennick, 1999b, p. 445) is considered a form of treason, with resultant discrimination and social isolation. This review revealed an occupational downgrading, with women who had been in occupations such as education, law, medicine, and the humanities experiencing the greatest downward mobility upon immigration. Women who were in their late 40s and older had less chance of finding qualified work and faced significant occupational, social, and economic downgrading.

Common to most women immigrants, regardless of country of origin, is the experience of the responsibility of working both outside the home and inside. For women immigrants, age plays an important role as a predictor of occupational success. Remennick (1999b) suggests the age of 45 as a pivotal point, with younger women seemingly adapting better to the host culture and older women remaining within the ethnic community. With regard to sexuality and family life issues, roles of women, and family life, immigrant women often find themselves at odds with Israeli cultural norms, as they are more familiar with a high divorce rate, abortion as the main method of birth control, the rarity of single motherhood, and a limited number of children as compared to the Israeli norm (Remennick, 1999b).

In Israel, the response to the influx of immigrants has been to assimilate the newcomers into the Israeli culture without making any attempt to understand the immigrants’ cultural values and beliefs; the end result has been the creation of a less than
positive moral image of Russian immigrant women in the Israeli press and in the public
media (Remennick, 1997). Remennick’s review has also suggested that immigrant
women from the FSU in Israel were likely to experience sexual harassment in the work
place and in the street, changes in sexual conduct including the use of more reliable birth
control methods, cohabitation, premarital sex, marital distress, and single parenthood. In
short, the cultural differences with regard to single parenthood and divorce create a
source of stress in the life of the immigrant woman from the FSU who has migrated to
Israel. Remennick (1999b) hypothesizes that the promotion of negative stereotypes of
immigrant women from the FSU in Israeli culture may be a way to keep women in an
inferior status, and that future research should include exploration of this possibility.

I. Australian Literature and Russian-Speaking Émigrés

In an Australian study (Taft & Steinkalk, 1985) of the adjustment of recently
arrived immigrants from the FSU, 101 adolescents with the median age of 16, and 154
adults with the median age of 44, participated in structured interviews about family
background and attitudes concerning migration, a list of concerns connected with
adaptation, and feelings of nostalgia. Also used were a tool to measure their satisfaction
with life in Australia and several standardized questionnaires concerning self-esteem and
trust in others. The results correlated with those of a group of Australian-born adults and
adolescents (Taft & Steinkalk, 1985). The tools were translated into Russian, but no
mention was made in regard to the tools being culturally appropriate. While nearly half of
the participants expressed satisfaction with living in Australia, they noted major sources
of dissatisfaction such as work, leisure time, and friends. The low satisfaction with work
was felt by the authors to be related to loss of occupational status (Taft & Steinkalk, 1985). Those adults who reported having lived in Australia more than two years reported greater satisfaction than those having lived in Australia less than two years. The adolescent children reported a higher level of satisfaction with regard to friends, leisure, and accommodations than the older adults in the study, but less than a comparison group of Australian-born adolescents (Taft & Steinkalk, 1985).

J. Women and Migration

Although women make up a significant number of a migrating group regardless of the culture of origin (Tyree & Donato, 1986), the literature concerning immigration and health issues related to immigrant women’s health is limited (Anderson, 1987; Gross, Brammli-Greenberg, & Remennick, 2001; Remennick, 1999a, 1999b). Gross, Brammli-Greenberg, and Remennick (2001) suggest that a reason for the lack of research studies in this area may be “due to the scarcity of an interdisciplinary approach and the cross-cultural skills it requires” (p. 67).

Socio-cultural and economic implications of current-day migrations are present in the literature, but only recently have migration and health implications related to gender and cultures of destination been addressed (Anderson, 1985, 1987; Meleis, Lipson, Muecke, & Smith, 1998; Remennick & Ottenstein, 1998; Simon & Brettell, 1986). Most studies have combined immigrants without attention to differences in gender or cultures within cultures (Brettell & Simon, 1986). Studies conducted in receiving cultures often neglect to give attention to the manner in which the culture of origin defines the roles and status of women. That is, the level of ideology of a culture, and the status and roles of
women in reality may not be the same (Brettell & Simon, 1986, p. 16). According to Brettell and Simon (1986), authors must be cautious as to whose explanations are emphasized.

Upon taking on immigrant status, both men and women experience a challenging process of both psychosocial and physical accommodation with resultant outcomes related to both physical and mental health (Aroian, Khatutsky, Tran, & Balsam, 2001; Aroian, Norris, Patsdaughter, & Tran, 1998; Aroian, Spitzer, & Bell, 1996; Remennick, 1999b). In addition to these shared challenges, women face additional challenges with regard to issues related to gender (Remennick, 1999b), sexuality, and reproductive health care (Anderson, 1985; Meleis, Lipson, Muecke, & Smith, 1998; Remennick, 1999b).

In an analysis of the literature on immigrant life in America, Gabaccia (1994) describes the “centrality of gender” – that is, “in a world divided between powerful and less powerful regions” (p. i), gender cannot be easily removed from other aspects of the life of an immigrant woman. In other words, immigrant women carry with them not only the culture from which they come, but also the dimension of gender-related traditions unique to their culture of origin (Gabaccia, 1994).

The author asserts that life for immigrant women differs from the life of immigrant men. “Associated symbolically with cultural identity – indeed, the very ‘heart’ of a culture – immigrant women and their daughters became markers of the line dividing Americans from outsiders; as a result, they found their lives subjected to intensive scrutiny both from other immigrants and from Americans” (Gabaccia, 1994, p. i).

Few studies conducted in the United States have explored the experiences of Russian-speaking immigrant women with regard to gender and immigration to Western
cultures (Remennick, 1999). Unlike women immigrants from Third World cultures, women immigrants from the FSU tend to be well-educated professionals, equal to their partners in financial support of the family in the culture of origin (Posadskaya, 1994). However, immigrant women from all cultures may undergo similar experiences due to downward social and occupational mobility (Remennick, 1999).

By comparison, women immigrants from Third World and developing cultures may be coming to the culture of destination as dependents of their husbands or other male relatives (Weitzman & Berry, 1992). Many of these women from developing countries may never have had the experience of working outside the home prior to arrival in the country of destination (Weitzman & Berry, 1992). These women often find work in service-related jobs that require limited educational and licensure qualifications and are usually characterized by low wages, long hours, and few benefits (Weitzman & Berry, 1992). In addition, these women are often responsible for caring for young children and are very likely to face circumstances and challenges different from those of immigrant men (Weitzman & Berry, 1992). The compounded stressors of migration, limited support systems, and financial and cultural barriers may result in both physical and psychological health conditions (Anderson, 1985, 1987).

According to Gabaccia (1994), it is not unusual for immigrant women to respond to the stress of immigration through illness. Such stress-related illnesses may be difficult for health care providers from other cultures to understand, especially if the concept of health and illness understood by the immigrant woman differs significantly from that of the health care provider (Gabaccia, 1994; Kendall, 1987).
Remennick (1999a) summarizes concerns common to receiving cultures related to immigrant health: “Despite their cultural diversity, ethnic diasporas in the late 20th century may have common health-related problems in various national contexts. These problems are shaped by the very nature of the migration experience and the immigrants’ marginal status in the host societies, with the resulting limited access to health services, or cultural barriers to their utilization, lower health motivation, and a higher prevalence of risk behaviors” (p. 1669).

K. Immigration and Women at Midlife

*Overview*

Most émigrés from the FSU are midlife and older women (Brod & Heurtin-Roberts, 1992). Both immigration and midlife are times of transition associated with changes in life patterns (Schumacher & Meleis, 1994). Just as immigration has been associated with vulnerabilities in health status (Wei & Spigner, 1994; Weitzman & Berry, 1992), midlife is associated with the onset of modifiable chronic illnesses (Eaker, Chesebro, Sacks, Wenger, Whisnant, & Winston, 1992; US Department of Health and Human Services [USDHHS], 1995; World Health Organization [WHO], 1994) related to culturally mediated lifestyles as women age (Lock, 1998).

These conditions can be mediated with health promotion and wellness interventions at midlife (Speroff, 1999). Since menopause is the primary midlife marker in women (McKinlay, 1996), often associated with a combination of physical changes, cultural influences, and individual perceptions (Robinson, 1996), this period is pivotal for intervention (Speroff, 1999) to modify the onset of chronic disease. Moreover, for health-
related interventions to be acceptable, they must be culturally congruent, accessible, and appropriate to the needs of the population being served (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995).

Health and Midlife Immigrant Women in the United States

Few studies address health-related issues among midlife immigrant women from their point of view. The perceptions of women themselves are most valuable to determine if the concepts of health and illness (Brettell & Simon, 1986) understood by immigrant women differ significantly from those of health care providers in the receiving culture (Gabaccia, 1994, Kendall, 1987).

Culture influences many aspects of people’s existence, including beliefs about wellness, health, and illness (Helman, 1994). Understanding culture involves grasping the meaning to an individual or group of a phenomenon such as health within the context of history, economic status, and social, political, and geographic elements such as immigration (Helman, 1994; Meleis, 1996).

Studies focusing on health values, beliefs, and behaviors among midlife immigrant women include the following:

In an ethnographic study of 20 women ages 40 to 70 years of age who immigrated to Canada from India, Choudhry (1998) used open-ended questions to describe health-promoting practices and the ways in which cultural norms, knowledge and values influence behavior. Choudhry (1998) found that the women consistently reported the belief that, in order to remain healthy, diet, exercise, and weight control were important in addition to spiritual activities, prayer and good family relationships. The range of length of residence in Canada for this sample was less than two years to 22 years.
Im and Meleis (1999a) used the Situation-Specific Theory to study the menopausal transition of first-generation low-income Korean immigrant women in the United States. The study used findings from a report of menopausal transition among Korean immigrant women in a cross-sectional design with methodological triangulation. Quantitative analysis was based on data from 119 first-generation Korean women aged 40-60, and a qualitative study used 21 participants (19 of them having lived ten years or less in the United States) chosen by theoretical sampling. Data analysis included descriptive and inferential statistics and analysis of three major themes: The immigrant women focused more attention on the transition processes related to immigration and work than on menopause; menopause was culturally a silent experience; and menopausal symptoms were not considered abnormal (Im & Meleis, 1999a, p. 333).

Kim (2002) used a cross-sectional survey to study factors affecting health promotion behaviors among 120 midlife Korean immigrant women between the ages of 45 to 63 living in Los Angeles County. All the women answered structured questionnaires, while another subset of 26 women participated in a qualitative interview. Kim concluded that, in order to encourage health promotion in this age group, interventions must facilitate role integration and access to services.

Using a community-based sample, Berg (1999) studied the biopsychosocio-cultural dimensions of 165 midlife Filipino immigrants aged 35-56, who had lived in the United States an average of 18.4 years. The study suggested that calcium intake was low, that nearly a fourth of the sample was depressed according to the Center for Epidemiological Studies Depression Scale, and that physical health problems were minimal.
Little is known about the health status and health practices of midlife Russian-speaking women in the United States. Although a few studies address the meaning and knowledge of health among older adult immigrants (Benisovich & King, 2003), health problems, practices, and values in adults (Duncan & Simmons, 1996; Lipson, Weinstein, Gladstone, & Sarnoff, 2002; Smith, 1996), health care and social service utilization of older émigrés (Aroian, Khatutsky, Tran, & Balsan, 2001), utilization patterns of immigrant women across age groups (Ivanov & Buck, 2002), and depression in midlife Russian-speaking women (Miller & Chandler, 2002), the literature lacks studies that explore the perception of health among midlife Russian-speaking women from the perspective of the women themselves.

In these studies of Russian-speaking participants carried out by American researchers, little was said about cultural variations in the degree of comfort felt when sharing personal views in a public setting. That is, in the studies that addressed personal views of the Russian-speaking groups related to the meaning of health (Benisovich & King, 2003) and health problems, practices, and values (Smith, 1996), the researchers used a focus group for data collection. Two studies in the literature addressed the cultural issue brought out by the use of focus groups as a method of data collection in Russian-speaking populations (Aroian, Khatutsky, Tran, & Balsam, 2001; Lipson, Weinstein, Gladstone, & Sarnoff, 2002). The literature surveyed was lacking in studies that included in their design attention to cultural differences involving data collection, such as using private interviews in place of focus groups in situations that involved disclosing personal views on health.
Although the FSU provided universal health care, there was little attention to health promotion. In an analysis of current health lifestyles in Russia, Cockerham (2000) reported diets high in fat, lack of exercise, excessive use of alcohol, and smoking as contributing to the high rates of heart disease and early morbidity for middle-aged Russian men. Cockerham (2000) also asserted that the poor health lifestyle was related to “the outcome of structural conditions (life chances)” (p. 1313) “rather than agency (life choices)” (p. 1313). That is, the unhealthy lifestyle practices could be viewed as a reflection of life experiences, socialization, interpersonal dynamics, group norms, and class in society that have resulted in a routine of unhealthy habits of behavior that continue over time.

These behaviors occurred within a larger context of socialism in which control and planning were centralized, controlled the quality of life, and limited opportunities for individual choice. According to Cockerham (2002), “In the case of Russia, life chances (structure) were dominant over life choices (agency) in health lifestyle participation and these chances had negative consequences for health” (p. 1322). These findings are consistent with an earlier cross-sectional study of 1599 Russians, which concluded that poor health was related to “dysfunction of social structures, socioeconomic deprivation, and lack of perceived control” (Bobak, Pikhart, Hertzman, Rose, & Marmot, 1998, p. 269). Cockerham’s study was based on a randomly selected nationally representative survey of 8,402 participants of health and economic well being conducted in a collaborative effort between the University of North Carolina at Chapel Hill and several Russian academic institutions. Data were collected through personal face-to-face interviews in 1995.
L. Health as a Concept Central to Nursing Science

Models of Health from the Nursing Literature in the United States

According to Smith (1983), “fundamental to any development of community health policy and practice is the idea of health itself. What is a healthy person? The answer varies according to the perspective of the respondent” (p. 1). Based on a literature search of contemporary authors, Smith (1981) proposed four models of health, namely, eudaemonistic or “general wellbeing” (p. 44), adaptive or “flexible adaptation to the environment” (p. 45), role performance or “performance of social roles” (p. 460), and clinical or “absence of signs or symptoms of disease or disability as identified by medical science” (p. 46).

Challenges of Measuring the Concept of Health

In an article reviewing the nursing research literature measuring the concept of health, Reynolds (1988) noted that nurse researchers most often characterized the concept of health using a clinical model without regard to psychosocial aspects or reliability and validity of the measurement tools. Smith (1996) suggested that nursing needs to be engaged in scientific investigations that include cultural relevance in the study design as a critical component in determining the scientific merit of research conducted with culturally diverse groups. Referring to the classic article by Carper (1978) that discussed the meaning of health for nursing, Smith (1996) also points out that indicators of health and illness are culturally defined and occur over a continuum. The implication is that the four models, although not mutually exclusive, lead to different goals and different types of health care. Smith describes health care as oriented toward the clinical model, even though the issues affecting quality of life raised by the other three models are
distinctively within the role of nursing and require as much attention. According to Smith (1996), “Nursing’s challenge is to, through the process of a culturally sensitive assessment, identify health/illness behaviors as they are defined by the culture and intervene only when those behaviors are deemed dysfunctional” (p. 68).

In a later article by Silva, Sorrell, and Sorrell (1995), Carper’s work (1978) was challenged. That is, these later authors asserted that the epistemological focus on patterns of knowing in nursing as described by Carper (1978) was giving way to an “emerging philosophical shift in nursing ... to ontological reflections on ways of being” (p. 1). One difference is in the type of research questions formulated by the epistemological and the ontological approaches. That is, the epistemological approach leads to questions about knowing, whereas the ontological approach leads to questions about being. According to Silva, Sorrell, and Sorrell (1995), expert knowledge in clinical skills is as important as the nurse’s understanding of the meaning, reality, and experience of an event to a client and the nurse’s ability to assist the client in finding meaning in health-related experiences. The authors give the following example: “How the nurse uses expert knowledge to administer complex chemotherapy treatments is as important as how the nurse uses artistry of being to help a young mother find meaning in her impending death. Often the two converge” (Silva, Sorrell, & Sorrell, 1995, p. 11).

In a concept analysis of health, Keller (1981) spoke to the challenges of defining “so nebulous a concept” (p. 47). Smith (1981) described the use of philosophical inquiry to learn more about concepts of the nature of health, asserting that “the conclusion of who is healthy will differ depending on the standard, that is, the model of health used” (p. 44).
Reynolds (1988) suggested that future research should include qualitative approaches to “examine the characteristics of health in a particular setting or group of subjects” (p. 30).

Researching the Meaning of Health Cross-Culturally

Although the concept of health is central to nursing science, few studies address the meaning of health for immigrant populations. Cultural background may affect how an individual defines health and practices health-related activities (Rodin & Salovey, 1989). According to Geertz’s (1973) definition of culture, “Culture, here, is not cults and customs, but the structure of meaning through which men give shape to their experience, and politics is not coups and constitutions, but one of the principal areas in which such structures publicly unfold” (p. 312).

These differences can influence how recent immigrants understand and respond to health-related information and take part in recommended health-related activities. Misunderstanding can result in lack of adherence to health advice and medical treatment and non-participation in health promotion activities (Rajaman & Rashidi, 1998). Understanding health beliefs or the personal and social meanings that one attributes to health, and how these meanings influence health behavior, is essential in order to administer culturally appropriate and acceptable health care to recent émigrés. The importance of understanding cultural values and beliefs prior to planning health service delivery for specific groups has been stressed in the literature (Gelfand, 1986, 1982; Gelfand & Kutzik, 1979; Jackson, 1980).

Two cross-cultural qualitative studies from the American nursing literature (Turton, 1997; Woods, Laffrey, Lentz, Taylor, & Cowan, 1988) and one cross-cultural study from the American health education literature (Benisovich & King, 2003) illustrate
varying approaches used to explore the concept of health. These studies feature a multiethnic group of women in the Pacific Northwest (Woods, Laffrey, Lentz, Taylor, & Cowan, 1988), the Ojibwe people of the Great Lakes (Turton, 1997), and older Russian émigrés living in the San Francisco Bay area (Benisovich & King, 2003).

Woods et al. (1988) used an ontological approach, asking 528 women from a cross-section of a community who had participated in a women’s health study, “What does being healthy mean to you?” The researchers found that, although the respondents’ view of health was consistent with the four dimensions identified by Smith (1981), the eudaemonistic category contained several dimensions that crossed over all demographics of age, ethnicity, education, employment and income status. Turton (1997) used an ethnographic, epistemological approach of in-depth interviews and participant observation to explore culturally specific “ways of knowing about health” (p. 28) with over 100 Ojibwe consultants in the Great Lakes region. The author found stories from oral tradition, authoritative knowledge from respected elders, and “common sense” models related to health and illness, knowing oneself, and spiritual knowledge. Turton (1997) stressed the importance of culturally congruent inquiry into cultural beliefs and ways of knowing about health, asserting that current health models may not be applicable to all cultures.

In the health education literature, Benisovich and King (2003) reported a phenomenological study that methodologically seemed to blend the epistemological approach with an ontological approach, exploring the meaning and knowledge of health among older Russian émigrés in the San Francisco Bay area. The goal of this study was to understand the health experiences of older adult Russian émigrés from the perspective
of the individual. The primary researcher was Russian-born and had lived in the United States over 25 years. The authors described the bracketing of beliefs prior to the study in order to add objectivity to the study design.

Focus groups were used, and 12 participants (eight women and four men) over the age of 65, who had migrated within the past five years from Ukraine or Russia, were recruited. Open-ended questions were pilot-tested prior to use. Transportation was provided, and the participants received no compensation. The interviews were tape-recorded. Although the themes were verified by two physicians described as “experts” in the cultural beliefs of the participants, they were not verified with the study participants themselves.

Moreover, while the participants were of the same age, the émigrés from Ukraine may not have had the same cultural background and life experiences as the émigrés from Russia. The researchers reported themes of distrust and alienation toward the media about health-related information, alienation from the current health system, a medical-model definition of health as being the absence of disease, and stress related to the language barrier and lack of understanding of the American health care system. The authors recommended replication of this study in a larger population with gender diversity.

Although the study discussed both meaning and knowledge, the ontological versus the epistemological approach was not treated in the study design, nor did this study address such aspects of culturally appropriate research as participants’ comfort level with expressing thoughts publicly in a focus group. That is, the participants were encouraged to join the focus groups by their teachers, who could be viewed as authority figures by the older émigrés, since they were recruited through English and citizenship
classes. Although one of the researchers was Russian-born and had lived in the United States for 25 years, themes were not noted to be verified with the study participants who had arrived in the United States within the past five years.

M. Challenges of Maintaining Cultural Competence in Research

Few of the studies in the review of literature discussed the researchers’ attempts to validate responses with the study participants in order to seek clarification or confirmation of their interpretations throughout the research process. That is, the authors of the studies did not report that they had validated the responses of the study participants in order to seek clarification or confirmation of their interpretations throughout the research process.

N. Understanding the Meaning of Health: Examples of Phenomenological Studies

*About the Meaning of Health across Cultures*

Little is known about health from the perspective of midlife Russian-speaking women in the United States. Few studies address the roles of women or the meaning of health within the context of immigration. Phenomena of concern to nurses are human perceptions and experiences encountered in day-to-day life. From a phenomenological perspective, understanding the meaning of health that people apply to experiences in day-to-day life provides nurses with information to improve the delivery of care and to add to the knowledge base of the discipline (Silva, Sorrell, & Sorrell, 1995).
Geetz (1973) describes the concept of culture thus:

... man is an animal suspended in webs of significance he himself has spun. I take culture to be those webs, and the analysis of it to be, therefore, not an experimental science in search of law but an interpretive one in search of meaning. It is explication I am after, construing social expressions on their surface enigmatical. But this pronouncement, a doctrine in a clause, demands itself some explication (p. 5).

Models of Health from the Canadian Nursing Literature

In the Canadian nursing literature, Payne (1986) affirms the need to describe health and health behavior from the client’s point of view and language by asking the ontological questions, “What is it like to be healthy?” and “What is the experience of being healthy like for you?” (p. 32). Payne identifies the following observations of health as a valued possession in time (p. 33), a balanced pendulum with spatial harmony (p. 34), a feeling of unity (p. 35), a “belonging to life” (p. 35), a process of becoming (p. 35), and a transcendence (p. 37). Payne (1986) encourages a phenomenological hermeneutic approach to the study of the meaning of health, asserting that it is individual and that “health interacts in all realms of life” (p.32).

O. Summary Synthesis of the Review of Literature

Historically, migration to the West from Eastern Europe has been related to economic reasons, or religious and political persecution (Fassmann & Munz, 1994; Jacobs, 1981). Early studies of Russian-speaking émigrés consisted of surveys and case
study reports designed from questionnaires developed by caseworkers to study absorption efforts (Gitelman, 1977; Jacobs, 1981).

Since the collapse of the FSU in 1991, migration of people from that area has increased dramatically. This group is one of the oldest groups migrating to the United States, with approximately 25 percent consisting of women at midlife and older (Brod & Heurtin-Robers, 1992; Fitzpatrick & Freed, 2000). Although midlife women make up a significant portion of recent émigrés from the FSU, few studies focus on the implications of gender, health, culture of destination, past exposures, social roles and health-related activities of this group (Posadskaya, 1994).

Midlife is associated with the onset of modifiable chronic illnesses (Eaker, Cheseboro, Sacks, Wenger, Whisnat, & Winston, 1999). The literature suggests that immigrant women have different needs and experiences from their American-born counterparts (Weitzman & Berry, 1992). Although gender and age have been identified as important indicators of health care utilization (Wei & Spigner, 1994), little is known about the health of midlife Russian-speaking women in the United States.

Recent studies of immigrant populations, which have focused on issues related to health care and service utilization (Aroian, Khatutsky, Tran, & Balsan, 2001; Frisbie, Cho, & Hummer, 2001; LeClere, Jensen, & Biddlecom, 1994; Wheat, Brownstein, & Kvitash, 1983), report conflicting findings. Studies of health care and social service utilization among émigrés are often based on national surveys (LeClere, Jensen, & Biddlecom, 1994). These studies often do not differentiate country of origin or immigrant status and base their findings on inferential statistical analysis that may not address reasons for seeking or not seeking care from the perspective of the groups studied.
Other studies have focused on acculturation of Russian-speaking émigrés and have led to conflicting findings (Birman & Tyler, 1994; Vinokurov, Birman, & Tricket, 2000) related to gender and acculturation. Russian-speaking midlife women have been studied relative to immigration and stress responses (Miller & Chandler, 2002; Aroian, Norris, Patsdaughter, & Tran, 1998; Aroian, Spitzer, & Bell, 1996). Depression has been identified as a major health issue for Russian-speaking émigrés (Aroian, Khatutsky, Tran, & Balsan, 2001; Fitzpatrick & Freed, 2000; Gutkovich, Rosenthal, Galynker, Muran, Batchelder, & Itskhoki, 1999). Aroian, Norris, Patsdaughter, and Tran (1998) suggested that predictors of distress in émigrés from the FSU included gender, age, education, feelings of alienation related to language, discrimination and loss.

Review of the literature suggests that health behaviors are culturally determined and reflect prior patterns of use in the country of origin (Ivanov & Buck, 2002). Although Russian-speaking émigrés know about and practice health promotion activities, they tend not to participate in routine health screening or to follow prescribed treatments (Lipson, Weinstein, Gladstone, & Sarnoff, 2002).

The Israeli literature suggests that immigrants from the FSU reported higher rates of disease and less desirable health status than their Israeli-born counterparts (Baron-Epel & Kaplan, 2001) and health needs of immigrant women were not being met (Gross, Brammli-Greenberg, & Remennick, 2001). In addition, serious communication deficits existed among the émigrés from the FSU and the Israeli health care providers (Remennick & Ottenstein-Eisen, 1998).

With the increase in the number of Russian-speaking émigrés to the United States (US Census Bureau, 1999), Pennsylvania is noted as being among the top ten states in the
United States to receive Russian-speaking émigrés. However, the literature is lacking in regard to émigrés who have settled in Pennsylvania.

Although studies have utilized focus groups in the study design (Duncan & Simmons, 1996; Ivanov & Buck, 2002; Smith, 1996), Aroian, Khatutsky, Tran, and Balsan (2001) and Lipson, Weinstein, Gladstone, and Sarnoff (2002) reported that the use of formal focus groups with the Russian-speaking participants in their studies was found not to be the best data collection method to learn about health due to cultural considerations and the hesitancy of the study participants to discuss private issues in a public format.

Most studies of Russian émigrés were conducted with older immigrants (Aroian, Khatutsky, Tran, & Balsam, 2001; Gelfand, 1986; Wei & Spigner, 1994). The tendency to use older émigrés as study participants was attributed to the limited availability of midlife women who are likely to be working outside the home in addition to caring for the needs of the family (Aroian, Khatutsky, Tran, & Balsam, 2001; Gelfand, 1986; Wei & Spigner, 1994).

Understanding human experiences and the concept of health are central to nursing. The North American nursing literature defines health from a Western perspective (Smith, 1981, 1983; Payne, 1986) and contains studies about the meaning of health with an interpretive design (Maddox, M, 1999; Woods, Laffrey, Duffy, Lentz, Mitchell, Taylor, & Cowan, 1988). However, not one study addresses the meaning of health among midlife Russian-speaking women using an interpretive approach. Little is known about the health status and practices of midlife Russian-speaking women from the
perspective of the women themselves. As a result, this group is relatively silent and invisible in the United States.

In summary, the literature is lacking the voices of midlife Russian-speaking women expressing their own perspectives about the meaning of health and how they manage multiple roles within the context of immigration. Listening to the voices of the émigrés, and seeking verification of the interpretation by health care providers in the receiving culture of the meaning of health and health experiences from the perspective of the individual clients, are essential tasks to understanding the components necessary for the creation of culturally-competent health care services and the delivery of these services to this group of women.
III. METHODS

A. Introduction

This chapter covers the hermeneutic phenomenological research method that was used to guide this study. The discussion will begin with an overview of phenomenology as a philosophical perspective as well as a research method. Included in this overview will be definitions related to hermeneutic phenomenology, followed by a description of the research design, the setting, the sample, the recruitment process, the means for protection of human subjects, the procedure for data collection and data analysis, and application of cultural competence.

B. Hermeneutics as a Method to Study Phenomena of Concern to the Discipline of Nursing

Definitions

Hermeneutic is defined as “interpretive, explanatory” (The American Heritage® Dictionary of the English Language, 2000a) and “unfolding the significance…” (Webster’s Revised Unabridged Dictionary, 1996, 1998). In the literature, hermeneutics is referred to as a modern philosophy that focuses on the experiences of interpretation and understanding, so that “… something foreign, strange, separated in time, space, or experience is made familiar, present, comprehensible…” (Palmer, 1969, p. 14).

The word hermeneutics originated from the messenger-god Hermes, who was said
to be able to transfer messages from the gods to mortals (Bleicher, 1980). Hermes both announced the messages from the gods and interpreted them by turning the unknowable, through the spoken and written word, into that which human beings could understand (Thompson, 1990). Hermeneutics has been used in situations where phenomena are encountered that are not immediately understood but require some degree of interpretation to reveal otherwise hidden meanings.

*Phenomenology* is defined as “a philosophy or method of inquiry based on the premise that reality consists of objects and events as they are perceived or understood in human consciousness and not of anything independent of human consciousness” (*The American Heritage® Dictionary of the English Language*, 2000b). Phenomenological research involves the study of the lived experience and the study of essences (van Manen, 1990). An *essence* is defined by the phenomenological historian Spiegelberg (1982) as “the whatness of things, as opposed to their thatness, i.e., their existence” (p. 743).

Spiegelberg (1975) defines *phenomenology* as “… the name for a philosophical movement whose primary objective is the direct investigation and description of phenomena as consciously experienced, without theories about their causal explanation and as free as possible from unexamined preconceptions and presuppositions” (p. 3).

Taylor (1993) describes *phenomenology* as “a methodology which acknowledges and values the meanings people ascribe to their own existence” (p. 173). Phenomenology involves discovering concepts and understanding meaning by going to the source of the phenomena, namely, individuals and their lived experiences (Cohen, 1987; Keen, 1975; Reeder, 1988).
Max Scheler (1874-1928) has described the phenomenological frame of reference in his work *Phenomenology and the Theory of Cognition* (1913) as follows:

... phenomenology is neither the name of a new science nor a substitute for the word “philosophy”; it is the name of an attitude of spiritual seeing in which one can see (*er-schauen*) or experience (*er-leben*) something which otherwise remains hidden, namely, a realm of facts of a particular kind. I say “attitude,” not “method.” A “method” is a goal-directed procedure of thinking about facts, for example, by induction or deduction. In phenomenology, however, it is a matter, first, of new facts themselves, before they have been fixed by logic, and second, of a procedure of seeing...

(Stecher, 1973, p. 137).

[Moreover,] a philosophy based on phenomenology must be characterized first of all by the most intensely vital and most immediate contact with the world itself, that is, with those things in the world with which it is concerned, and with these things as they are immediately given in experience.... The phenomenological philosopher, thirsting for the lived experience of being, will above all seek to drink at the very sources in which the contents of the world reveal themselves (Stecher, 1973, p. 138).

[And] as wide a gulf separates the radical empiricism of phenomenology from any and every kind of rationalism, insofar as phenomenology ... rejects the notion of giving priority to the problem of *criteria* when it deals with any question. A philosophy which does give criteria priority is rightly called “criticism.” In contrast, the
phenomenologist is convinced that a deep and living familiarity with the
content and meaning of the facts in question must precede all questions of
criteria concerning a particular domain ... (Scheler, 1973, p. 139).

Historical Overview of Hermeneutics

Historically, six different categories of hermeneutics are described in the
literature (Palmer, 1969). Originally, hermeneutics, which grew out of the interpretation
of obscure religious texts, involved connecting the familiar with the unfamiliar by
providing interpretation to make the latter understandable. Other categories that followed
included hermeneutics as a general philosophical methodology, a science of
understanding linguistics, a foundation for a methodological approach to human science
research, a phenomenological existential understanding, and a method of interpretation
(Palmer, 1969).

The last two categories of hermeneutics – as a phenomenology of existential
understanding and as a method of interpretation – are characteristic of the present-day use
of hermeneutics (Allen & Jensen, 1990). It was during the twentieth century that
hermeneutic philosophy expanded from an interpretive method to a way of understanding
human life.

Current hermeneutic philosophy has historical roots in the work of Edmund
Husserl, often referred to as “the father of phenomenology”; his approach has been
termed Husserlian, or transcendental, phenomenology. Several phenomenological
methods use Husserlian principles (Thompson, 1990). Hermeneutics as a type of
phenomenology, however, differs from transcendental phenomenology as described by
Husserl (Thompson, 1990). Much of the current use of hermeneutic methods has its
origins in the work of Martin Heidegger, who was a student of Husserl.

According to Heidegger, understanding was not so much a way of knowing as it was a way of being (Spiegelberg, 1984). With regard to Heidegger, Palmer (1969) wrote, “He went beyond previous conceptions in seeing understanding not as a mental but as an ontological process, not as a study of conscious and unconscious process but as a disclosure of what is real for man” (p. 140). This shift from epistemology (knowing) to ontology (being) has implications both for formulating the research question and for choosing the research method to answer the question (Leonard, 1989). Using the ontological approach, one cannot assume a prior definition of what is real; instead, the researcher probes for understanding of the experiences and the concept of reality of the individual who is living or has lived the experiences. The “disclosure of being” (Palmer, 1969, p. 141) was the hermeneutic theme embraced by Heidegger, who has been referred to as “the most ‘hermeneutical’ of Western philosophers” (Palmer, 1969, p. 141).

Over time, transcendental phenomenology transitioned to hermeneutic philosophy, which focuses on day-to-day lived experience and assumes that knowledge is a tacit part of most experiences (Cohen, 2000; Thompson, 1990). Because many interpretations of hermeneutic philosophy exist today, the researcher must consider several implications with regard to research design and method. According to Cohen (2000), “What sets hermeneutic phenomenology apart from these other hermeneutic approaches is the tradition of looking at a phenomenon, a single kind of human experience, rather than a social process or structure of a culture” (p. 8). The hermeneutic phenomenological research question focuses on how people interpret experience and transmit this interpretation through language. According to Linge (1977), “It is vitally
important to recognize that the hermeneutic phenomenon encompasses both the alien that we strive to understand and the familiar world that we already understand” (p. xii). An important aspect of the hermeneutic approach is to look “with” the other at what is being communicated rather than “at” the person who is communicating, in order to bring into light assumptions and awareness of cultural beliefs and values that may impede interpretation (Linge, 1977). At the same time, although culture and social issues are part of the experiences, they are not the focus of the question in hermeneutic phenomenological research.

Palmer (1969) describes language as the most powerful communication tool: “Language shapes man’s seeing and his thought – both his conception of himself and his world (the two are not so separate as they may seem)” (p. 9). In commenting on the works of Heidegger and Gadamer (a student of Heidegger), Palmer further notes, “… it becomes apparent that language is the ‘medium’ in which we live, and move, and have our being” (p. 9).

As a qualitative method in research, hermeneutic phenomenology differs from other qualitative methods in that it has evolved from a philosophical origin (Cohen, 1987). This evolution has been described in the literature as the “phenomenological movement” (Spiegelberg, 1975, 1982).

Hermeneutics as a research design provides understanding; empirical methods, in contrast, provide explanations. Although the same objects are studied, the context of relationships is different. According to Thompson (1990), the experience of understanding can be compared to three analogies: “the hermeneutic circle, the fusion of horizons, and the act of dialogue” (Thompson, 1990, p. 242). The hermeneutic circle
refers to shared language and history of meaning, including the experience of moving between commonly shared backgrounds of experience to a specific focus. Thus the hermeneutic circle is a metaphor that describes what occurs when one understands or moves between the common shared background of experience (the whole) and the focus (the parts) and vice versa (Bleicher, 1980). Gadamer offered another description of understanding as the “fusion of horizons,” or ‘the range of vision that includes everything that can be seen from a particular vantage point” (1975, p. 269). Bleicher (1980) described this as occurring when “the concepts of a historical past are regained in such a way that they include, at the same time, our own” (p. 267).

Although Husserl supported the notion of “bracketing” as a way for the researcher to separate his or her beliefs from those of the study participants, Gadamer did not believe that researchers could bracket themselves entirely from preconceived ideas (Thompson, 1990). In addition, Gadamer pointed out the importance of the distinction between knowledge and wisdom – that is, science may provide researchers with the former, but not the latter. For Gadamer, the researcher becomes aware of his or her preconceptions when coming to an understanding of what had previously been foreign (Thompson, 1990). In his classic work, *Truth and Method* (1975), Gadamer asserts that truth is what occurs in the experience of understanding, much like a dialogue between two individuals.

The literature describes three major theoretical interpretations of hermeneutic philosophy that impact research methodology (Thompson, 1990), namely: objective hermeneutics, also referred to as hermeneutic theory (Bleicher, 1980); Gadamerian hermeneutics, or hermeneutic philosophy (Bleicher, 1980); and critical hermeneutics.
Those who follow the objective hermeneutic approach adhere to the more objective assumptions associated with the classical hermeneutic tradition – that is, the belief that a common standard is important to assure objectivity and validity of interpretation and to avoid “passion, self-interest, or prejudice of the scholar” (Thompson, 1990, p. 252). This hermeneutic interpretation supports objectivity and a neutral position for the researcher. In order to follow this approach and remove researcher bias, the researcher must acknowledge any such bias and “bracket” pre-existing biases or presuppositions in order to focus on the phenomenon of interest and emic perspective. Another important point is how the interpretive process is understood by the researcher – that is, how the researcher understands the meanings expressed by the participants. According to Thompson (1990), “seeing things through the native’s eyes” (p. 253) is not consistent with hermeneutic tradition, which asserts that one is not capable of direct access to the thoughts of another. Instead, the accepted belief is that one has access to thoughts or the way thoughts are expressed only through language and through action or behavior. In line with this assertion, the interpretive process in research maintains a focus on (a) what the participant expresses within a context, and (b) the meaning of these expressions and actions within a context.

Another major theory of hermeneutic interpretation is the one that supports the revisions suggested by Heidegger and Gadamer. In this theory, interpretation is described as a fusion of horizons and dialogue. This approach suggests that the interpretation would reveal the “fusion” of the researcher and the research participants. Bracketing is not done; rather, the focus is on explaining how the interpretation of the researcher has led to the research question and the research process.
The dilemma is to identify the approach that addresses the differences in the etic and emic perspectives. According to Thompson (1990), much depends on the researcher, who can address the issue by journaling and taking field notes that document differences in etic and emic views. Similarly, Lincoln and Guba (1985) suggest that the researcher maintain an audit trail of methodological and theoretical decision-making.

The third type of hermeneutic theory is referred to as “critical” hermeneutics. It differs from objective hermeneutics in its assumptions. Unlike objective hermeneutics, critical hermeneutics asserts that interpretations cannot be objective; rather, the interpreters may not realize their bias (Thompson, 1990). Critical hermeneutics operates under the assumptions that not all participants in the social interaction have a voice and that social oppression exists and may go unnoticed by the participants (Ricoeur, 1981). The role of critical hermeneutics is, thus, to raise consciousness and the awareness of hidden meanings (Thompson, 1990).

With regard to gender in the post-Soviet states, Buckley (1997) asserts:

An ongoing lesson for Westerners, particularly for feminists unfamiliar with the states of the former USSR, is never to assume a priori the meanings of particular actions nor to attempt to graft Western values onto post-Soviet behaviours. Invariably, they do not fit. Even though some communalities and overlap may obtain, much remains significantly different and only first-hand investigation can establish the subtleties of these differences (p. 15).

C. Research Design

In this study, the hermeneutic design was followed, using the Dutch
phenomenology of the “Utrecht School,” which has been translated and applied to research in the social sciences (Barritt, Beekman, Bleeker, & Mulderij, 1983, 1984, 1985). This approach has been applied with meaningful results in a variety of studies in order to critically examine phenomena and to understand and interpret meaning (Cohen & Omery, 1994).

Using the Dutch approach, features of descriptive and interpretive phenomenology guided this research. That is, the research process focused on what participants expressed within a context and the meaning of these expressions and actions within the context of immigration.

Before beginning the interviews with the study participants, the researcher bracketed her presuppositions by writing her own answers to the interview questions. This written text was analyzed to be sure that preconceptions of the researcher did not influence the participants during the study (Cohen, 1995). The interpretive process in this study included time for the researcher and participants to dialogue, a process that permitted the researcher to discuss interpretations with the study participants, verify interpretations, and document the outcomes of the discussion.

D. Setting

Interviews took place in the city limits of an urban setting in Southwestern Pennsylvania. The majority of the interviews took place in the homes of the participants; three women were interviewed in the work place; and one interview took place in a private dining area. This setting was chosen because this area had experienced a large influx of Russian-speaking immigrants from Eastern Europe and is located in one of the
top ten states in the United States with the largest foreign-born population from Russia (http://www/migrationinformation.org/USFocus/whosresults.cfm, retrieved 7/9/04). No research could be found in the literature about this group in this location.

E. Sample

Purposive sampling and snowballing were used (Polit & Hungler, 1999) to select the sample for this study. That is, the researcher, who had been actively involved in the Russian community for the past five years, purposely selected study participants who were self-identified as Russian-speaking immigrant women who also spoke English and were willing, able, and open to discuss elements of their health experiences and health beliefs. Early sample members were asked to identify and refer women who met the criteria for the study.

The age range of 40–60 was originally set as inclusion ages for participation in this study. Although other studies of midlife Russian-speaking women that have used the range of 45-65 in the United States (Miller & Chandler, 2002) and 40-60 in Israel have produced meaningful findings, expanding the age beyond 60 to 61 is appropriate, since the 40-60 age range was used merely as a guide (Remennick, 2001; E-mail communication, L. Remennick, July 31, 2003). Expanding the age range in this study to 61 did not change the findings.

Originally, a period of no more than ten years of living in the United States was to be the limit, since the literature reports that, after ten years, immigrants tend to be acculturated to the culture of destination (LeClere, Jensen, & Biddlecom, 1994). However, as the interviews progressed, the important element identified by the Russian-
speaking study participants in regard to acculturation was migration after 1991, that is, after the fall of the FSU, rather than the ten-year period identified in the literature.

Twelve women were recruited to participate in the study from a potential pool of approximately 40 women. In a phenomenological study, 10 is an acceptable number of participants in order to produce meaningful findings (Benisovich & King, 2003; Creswell, 1998; McCracken, 1998; Moustakas, 1994; & Riemen, 1986). According to Drew (1989), “The number of interviews done in a study is less important than the extent to which the phenomenon is explored in each interview” (p. 431). Data continued to be collected after the tenth interview until no new themes were determined – that is, until saturation (Denzin & Lincoln, 1994; Glaser & Strauss, 1967) was reached.

F. Recruitment

Recruitment took place through written advertisements in English (Appendix A) and in Russian (Appendix B). These dual language advertisements were placed in public libraries, the Jewish Community Center and related organizations, health care providers’ offices, city newspapers, synagogues, churches, hospitals, universities, and the local supermarket. Recruitment continued through word of mouth and key informants. Early study participants were asked to identify and refer other women who met the study’s inclusion criteria.

Potential participants were given a telephone number at which to call the researcher. During the initial telephone contact, the researcher discussed the study with the potential participant, determined her eligibility, and scheduled a time and meeting place at the woman’s convenience. Although the researcher had access to the community
through two liaisons, both of them midlife Russian-speaking immigrant women who also spoke English, a potential difficulty in gaining access to participants who met the study inclusion criteria existed. Due to work schedules outside the home and possible family responsibilities of caring for children and older adults in the home, midlife immigrant women often had little free time (personal communication, F. Linkov, August 6, 2003).

Since the setting for this study was the homes of the participants or other private places of their choice, a token of appreciation for participation in the study was given to each participant before each interview. In addition to being a gesture of appreciation to the study participants for volunteering their time, bringing a small gift when visiting people in their homes is a common Eastern European custom (personal communication, F. Linkov, August 6, 2003). At the beginning of each interview, therefore, each study participant received a gift bag containing a small box of tea, a healthy snack, and a $10 gift certificate redeemable at a local grocery store chain.

G. Reimbursement

According to Sears (2001), “Balancing the principles of respect of persons and justice in our society, even considering only the issue of monetary payments, will not be entirely possible because of the inequities inherent in our system” (p. 661). In this study, the gesture by the researcher of making a small gift was provided on three assumptions that were interpreted by the researcher to be in line with the ethical concern in regard to the requirement of voluntary participation and justice (Sears, 2001). The first is that this “gift” was given as a token of appreciation for the time the interview would take; second, the tea and snack were consistent with the Eastern European custom of bringing a gift
when one comes into the home of another; and third, this gift by the researcher did not violate the ethical principles of respect for all people, since it was low enough in value that it did not unduly persuade a low-income person to participate. Nor was it high enough in value to encourage a high-salaried person to participate (Sears, 2001).

H. Procedures for Protection of Human Subjects

Permission from the Duquesne University Internal Review Board for protection of human subjects was obtained (Appendices C and D). To protect human subjects, a consent form was printed in English (Appendix C) and in Russian (Appendix D), since potential participants might have been able to speak English but not read it. Potential participants were given the choice of reading the consent form in English or in Russian, but the form was explained in English, as they were all Russian-speaking women who also spoke and understood English. All information was kept confidential, and participants were guaranteed anonymity. All data were kept in a locked file in a locked room until the study was completed. Since immigrants from the FSU might not have felt comfortable using a tape recorder, due to former experiences under communism in the country of origin (personal communication, F. Linkov, August 6, 2003), the consent form included the option of the interview not being recorded. All study participants agreed to be audiotaped. Participants were given the choice of continuing with the interview or stopping at any time. Since the recollection of previous experiences might have created unpleasant thoughts or emotions for some interviewees, the study participants were told before taping began that if they experienced unpleasant thoughts or emotions, the researcher would stop the interview process and talk with them and, if needed, refer them
to a community resource. One study participant asked to have the tape stopped when she 
began to talk about her previous occupation and began to cry. She did not wish to be 
referred to a community resource. Once she wiped her eyes and regained her composure, 
she requested that the taping continue. The consent form included a number to call if 
unpleasant thoughts or emotions occurred after the completion of the interview sessions. 
The participants were assured that tapes would be stored in a locked file cabinet in a 
locked office and would have no identifying information on them. At the completion of 
the study, only tapes and transcripts with identifying information removed were kept. All 
other tapes and transcripts were destroyed by shredding.

Included in the explanation of protection for human subjects were the following 
points:

1) Title and name of investigator and advisor
2) Source of support of the study
3) Purpose of the study
4) Risks and benefits
5) Compensation
6) Confidentiality
7) Right to withdraw at any time
8) Voluntary consent
9) Offer to share findings of the study
10) Phone contact information for further questions
11) How participants gave consent
I. Procedure for Data Collection

Collection of data included two separate interviews per study participant. To ensure consistency with all interviews, the researcher conducted all the interviews herself. Interviews were completed within a six-month period between January and July 2005. A six-month time period for data collection was set in order to limit variations in the interview style that might have occurred if the interviews were spread over a more extended period of time (Tripp-Reimer, 1985).

Before interviewing, the researcher bracketed assumptions and preconceived knowledge related to the interview questions and analysis of data. This was done by the researcher writing down her responses, based on her assumptions and preconceived knowledge, to each of the questions before interviewing the study participants (LeVasseur, 2003). “Bracketing” ensured that the researcher did not introduce her presuppositions into the interview or analysis.

During the first interview, once consent had been granted, participants were asked to complete a demographic questionnaire followed by a semi-structured interview, both administered verbally by the investigator. Before the study began, both the demographic questionnaire and the semi-structured interview tools were piloted for use of language and cultural appropriateness by the administration of both tools to a representative of the study population.

The interview focused on three open-ended questions about the meaning of health, health within the context of immigration, and health currently (Appendix F). These questions sought to answer the following research questions: 1) What is the meaning of health among midlife Russian-speaking immigrant women in the United
States? 2) How has immigration influenced the experiences, values, and practices concerning the health of midlife Russian-speaking women in the United States? And 3) What are the health experiences of midlife Russian-speaking immigrant women in the United States?

The Demographic Questionnaire

The Demographic Questionnaire (DQ) was a 3-item questionnaire (Appendix E) designed by the investigator to collect demographic data about the study participants in order to describe their age, place of birth, and time of arrival in the United States. At the beginning of the first interview, this form was read to the study participants by the researcher, who also explained that they had the right not to answer any questions they chose not to answer. The researcher recorded the participants’ responses on the form and verified each response with the study participants. The completion of the DQ took 10 minutes or less.

The Semi-Structured Interview Questionnaire

The 3-item Semi-Structured Interview Questionnaire (SSIQ) (Appendix F) was the guide used by the investigator during the first audiotaped interview with each study participant. The goal of the SSIQ was to elicit the meaning of health and the lived experience of health within the context of immigration. The questions making up the SSIQ focused on the meaning of health, health promotion, and health-restoring and health-seeking experiences within that context. Probe questions were included to initiate responses and to assist in clarifying meanings. Two final questions were used to debrief the participant and close the interview. Although it was anticipated that it would take 60–90 minutes to complete the SSIQ, no time limit was imposed. Most interviews took 90
minutes to complete. A second follow-up interview to clarify responses was scheduled approximately 2–3 weeks following the initial interview. The second interview also lasted approximately 60–90 minutes.

Once approval was granted by the Institutional Review Board (IRB) of Duquesne University, recruitment for this study began. The researcher individually contacted the potential participants who had indicated interest in participating in the study, explained the study, and determined eligibility. Once eligibility was established, the potential participant was invited to participate in the study. A time was scheduled for the initial meeting at the convenience of the participant. The preferred place of the interview was in the participant’s home or in another private place of the participant’s choosing. Before the interview was scheduled, the researcher asked the study participant if anybody else was likely to be present during the interview; if so, efforts would be made to choose a more private place. Ideally, the interview would take place in a home with just the participant present, in order for the participant to feel comfortable in responding freely to the interview questions. In the Eastern European culture many women are reluctant to talk about women’s health or their own reproductive health in the presence of men, even their own husbands (personal communication, F. Linkov, February 10, 2003).

In the participant’s home, the investigator repeated the explanation of the study and asked the participant to read the informed consent document in English (Appendix C) or in Russian (Appendix D), whichever the participant preferred. The participant received a copy of the English or the Russian consent document, as appropriate.

After all questions about the research study were answered and the consent form was signed, collection of demographic data began. These demographic questionnaires,
which were numbered and later assigned a pseudonym in order to maintain the confidentiality of the study participants, were administered verbally by the investigator, who read the items in English to the study participants and recorded the responses directly on the questionnaire forms.

The audiotaped interview directly followed the completion of the demographic questionnaire. The goal of the questions was to elicit exemplars of the lived experience of the midlife immigrant women and the meaning of health to them during this time (Benner, 1985). The interview questions were as open-ended as possible to ensure that the interviewee, rather than the interviewer, guided the interview (Kahn, 2000). The aim was for the interview to resemble a conversation (Kahn, 2000). According to the traditions of hermeneutic phenomenology, “the informants have already interpreted the meaning of their lives … in the very act of turning their experiences into stories or narrative texts that can be told” (p. 61).

The interview ended with some debriefing questions such as, “Is there anything else about health and immigration that you think I should know?” and “I will be interviewing other women from the FSU about their immigration experience and health. What has this interview been like for you?” The personal and informal approach to data collection often resulted in a discussion of issues of importance to the study participants that were not elicited through the original interview questions proposed in the study. Field notes were written to describe the environment in which the interviews took place and the content of informal conversations that occurred spontaneously after the taped sessions were completed.

Either the investigator or an experienced transcriber transcribed the audiotape
interviews verbatim. The transcriber accessing the transcripts was required to sign a confidentiality statement (Appendix G). The investigator listened to each taped interview and verified the corresponding typed transcription for detail and accuracy. When the transcribed text was checked by the investigator, all identifying material was removed. For example, “city” was substituted for the actual name of the city.

After the typed transcription had been compared for accuracy of transcription with the audiotaped interview, the transcript was analyzed and coded for themes. Data were managed both manually and by using the software NVivo (© 2002, QRS International). Next, the investigator called study participants to schedule a second audiotaped interview, which took place approximately 3–4 weeks after the initial interview, lasted about 60–90 minutes, and occurred, like the first interview, in the participants’ homes or at another private place designated by them. This second interview was scheduled in order to verify interpretation of identified themes, clarify meanings, answer any remaining questions, and permit the participants to confirm that the conclusions of the initial interview had been accurately interpreted by the researcher. Again, like the first interview, the second was audiotaped and transcribed for analysis. The investigator listened to the audiotaped second interview to verify verbatim transcription.

At the second interview, a verbal summary of the transcript of their first interview was discussed with the participants. Participants were specifically asked if they had anything to add to the points discussed and if there was anything they would like to have omitted from the analysis (Kahn, 2000). Whatever the participants wanted to have changed, added, or clarified in regard to the researcher’s interpretation was discussed.
The participants were asked if the tentative themes identified by the researcher described the meaning they attempted to convey during the first interview. Agreement occurred approximately ninety-five percent of the time. The second interview continued until the informants agreed that the description of their experience had been interpreted as they had intended. Before the start of the second interview, the researcher again presented the study participants with a gift bag of a box of tea, a health snack, and a $10 gift voucher redeemable at a local grocery store.

J. Procedure for Data Analysis

A demographic profile was created based on the responses to the demographic questionnaire. Descriptive data were used to compute ranges of the demographic data.

Using the method of phenomenological analysis described by Barritt, Beekman, Bleeker, and Mulderij (1984), the investigator began data analysis by listening to the audiotapes and reading each transcription verbatim several times line by line, highlighting the whole and parts of sentences, and assigning tentative themes to these passages, using words as close as possible to those used by the participants themselves. Since the phenomenological approach is holistic, the researcher read through the entire transcript before starting any analysis, the goal of which was to recognize common themes from the transcripts (data) and to label these themes with words that adequately reflected the intended meaning (Barritt et al., 1984). The researcher identified common themes or substantive codes in all transcripts of the interviews. After each identified theme (or substantive code), the researcher wrote the supporting phrases from the transcription.
Transcripts, the extracted key phrases in the transcripts, and clusters of themes found in the first interviews with informants, as well as critical evaluation of the investigator’s interview process and technique evident in the transcripts, were discussed in the interpretive process with a nurse researcher with expertise in phenomenological hermeneutic research to ensure accuracy of coding and identification of themes, clustering, and analysis. Independent of each other, the investigator and the consultant reviewed and assigned themes and clustering for the first three interviews that were transcribed. Findings were compared. Agreement occurred approximately ninety percent of the time. Any disagreements were discussed in person, by e-mail, or on the telephone. The expert researcher was also contacted for comparison of independent coding in the final analysis. The nurse researcher with expertise in phenomenological hermeneutic research also critiqued the interview technique of the researcher to assure that the interview process was carried out without leading the study participants’ responses.

The identified themes (or substantive codes) served as topics for discussion at the second interview with study participants. A second meeting was arranged with each participant to confirm meaning, to clarify interpretations, and to ask additional questions in order to ensure that the clusters of themes from the first interview appropriately captured the meaning that the participant sought to convey. Initial interpretations guided the second interview with the participant to provide deeper, richer understanding. Conducting the second interview with each participant and asking each participant to verify the researcher’s initial interpretation of transcripts assisted in ensuring trustworthiness of the findings and initial analysis. The identified themes were read out loud and discussed with participants to check the degree of subject and investigator
Transcripts and audiotapes of the second interview with each participant were reviewed to compare groupings between the first and second interviews with the same participant. Samples of the completed transcripts of the first and second interviews were again critiqued for interview technique, analyzed for clusters and themes by the expert researcher, and compared to those clusters and themes identified by the researcher after the second interview. As individual participants’ central concerns became clear, the investigator and the expert researcher observed shared meanings among participants. The passages and themes were compared with passages and themes for all other participants for shared themes. This was done by comparing passages across themes and with other passages in the same theme. Common themes were identified as well as variations.

Due to work schedules outside the home and travel to care for family out of state, only nine of the twelve women could be interviewed twice. The content of the three interviews of the women who were interviewed only once was verified by Russian community liaisons who were midlife women who had migrated to the United States in the same time frame as the women who were interviewed once.

As more transcriptions were collected, the researcher clustered transcribed passages by themes and made comparisons within and between all transcribed data to refine and validate the identified themes. Based on this process, the themes were organized into a written account that described the essence of the meaning of health for midlife women within the context of immigration.
K. Application of Cultural Competence

Developing the Interview Tools and Consent Form

Recruitment for this study was through referrals by community liaisons and by word of mouth. Since the nature of the Demographic Questionnaire and the Semi-Structured Initial Interview Questionnaire might have required additional probes by the interviewer, data collection instruments were verbally administered to the study participants in English. Participants did not read the questionnaires on their own. Each of the items on the two instruments was verbally pilot-tested with a group of English-speaking Russian immigrants who had been in the United States for 10 years or less and who were invited to critique both tools for cultural relevance, structure, and language. Special attention was given to looking for concepts that did not have the same meaning in English and Russian to avoid any chance of inaccurate interpretation and false responses (Cox, 1987).

In this study, the consent form was read by the study participants and a copy given to each. In the event that a study participant could speak English but not read it, the consent form was available in both English and Russian. It was written first in English, next translated into Russian, and then translated back into English by another person. The consent form was piloted in both Russian and English translations for content, relevancy, structure, and complexity. Two study participants requested the Russian version of the consent form.

Credibility, Rigor, and Trustworthiness

The credibility of the findings was in the discovery of experiences as they were perceived and lived by the participants rather than as a priori conceptions based on the
use of a pre-existing theoretical framework (von Eckartsberg, 1998) or the personal experiences of the researcher. To address the possibility of researcher bias, the investigator bracketed personal responses to each of the questions prior to data collection (LeVasseur, 2003).

During the interview process, the interviewer was aware of the importance of reflecting responses back to the participants to clarify and elaborate their responses rather than suggesting views to them. Credibility was achieved when the participants could recognize the researcher’s descriptions as their own. To achieve credibility in this study, data were verified with the participants during a second interview with the researcher to determine if the data were typical or atypical and to verify the identified emerging themes.

Another threat to credibility was the relationship of the investigator to the subject matter and to the participants (Sandelowski, 1986). Since the investigator was a mid-life American woman of Eastern European descent, with social and professional ties to the Russian immigrant community, the investigator also kept a journal to describe how she was influenced by and influenced the participants. This step was taken to maintain a distance from the experiences of the participants in order to describe and interpret them correctly, and to minimize the threat to true value due to the investigator-subject relationship and identification. An example of an early journal entry was a reflection by the researcher of how she worked on her interview technique so as not to “lead” the interview by supplying “lost” words for the study participants when they tried to express themselves in English but needed time to find the word they wanted to use.

Assuring the consistency of findings involved the ability of another researcher to
follow the decision trail made in the methodology and arrive at the same conclusion as the principal investigator (Lincoln & Guba, 1985). A journal recording the decisions made was maintained throughout this study.

Since a semi-structured interview schedule was used to gather data, and probes had to be individualized based on study participant responses, issues related to reliability of data gathering were addressed in the following way. One interviewer, the principal investigator, who was also an experienced advanced practice nurse, collected all the data over a six-month period. Using the same interviewer over a limited amount of time added to the regularity of the interview process and limited variations in the interview style that might have occurred if the interviews had been spread over a more extended period of time (Tripp-Reimer, 1985).

According to the research design, the researcher validated responses with the study participants, sought clarification of interpretations throughout the research process, encouraged participants to speak to issues of self-concern without being led by preconceived ideas of the researcher, and met in a place chosen by each study participant. In addition, teaching was offered at the end of the interview sessions as issues arose. These considerations coincide with Meleis’s (1996) criteria to take into account in culturally competent research.

L. Summary

The purpose of this research study was to gain knowledge about the meaning of health and the health experiences of midlife Russian-speaking women in the context of immigration in order to design culturally appropriate disease prevention and health
promotion interventions to mediate the impact of chronic disease conditions associated with aging.

This study used a phenomenological hermeneutic design. The setting was in the study participants’ homes or in private settings of the participants’ choosing in an urban locale in Western Pennsylvania. Study participants were recruited from community locations and by word of mouth. To be eligible for this study, participants were self-identified Russian-speaking immigrant women who also spoke English, were between the ages of 40 and 61, and had migrated to the United States since 1991. The participants were asked to participate in two interviews lasting approximately 1 to 1½ hours. Data were collected, transcribed, and coded using the phenomenological method described by Barritt, Beekman, Bleeker, and Mulderij (1984). Themes were compared within and between transcripts. Identified themes were refined and verified with study participants. A final description, written by the investigator, unified themes and illustrated the essence of the meaning of health within the context of immigration for midlife Russian-speaking immigrant women. These findings will be used to design culturally-competent health promotion and wellness programs for this population in Western Pennsylvania.
IV. FINDINGS

A. Introduction

In this chapter, the description of the study participants and findings of the study are presented. The study participants are first described in terms of the demographic data that were collected at the beginning of the first interview.

B. Description of the Study Participants

The study participants comprised 12 self-identified Russian-speaking women between the ages of 40 and 61 (Table 1) who migrated to the United States from the Former Soviet Union (FSU) (Table 2) after 1991 (Table 3). In this study, the year of migration of the participants ranged from 1992 to 2001 (Table 3).

Participation in this study was limited to Russian-speaking women who could also speak and understand English. All of the study participants reported that they had completed higher levels of education beyond the basic and had held professional positions in the FSU (Table 4). Of the twelve women interviewed, eight were married and four were divorced, widowed, or single (Table 5). Eleven of the twelve study participants reported that they were Jewish, while one reported that she was Russian Orthodox. Ten of the twelve women lived in or near a predominately Russian Jewish neighborhood in Southwestern Pennsylvania. The two participants living outside the Russian Jewish
neighborhood reported that they maintained close ties with other Russian-speaking women.

Table 1
Age Ranges of Study Participants

<table>
<thead>
<tr>
<th>Age Ranges</th>
<th>Number Of Study Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 – 44 years old</td>
<td>N = 2</td>
</tr>
<tr>
<td>45 – 49 years old</td>
<td>N = 3</td>
</tr>
<tr>
<td>50 – 54 years old</td>
<td>N = 5</td>
</tr>
<tr>
<td>55 – 59 years old</td>
<td>N = 1</td>
</tr>
<tr>
<td>60 – 61 years old</td>
<td>N = 1</td>
</tr>
</tbody>
</table>

Table 2
Birth Place of Study Participants

<table>
<thead>
<tr>
<th>Birth Place</th>
<th>Number of Study Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russia (Near Moscow)</td>
<td>n = 6</td>
</tr>
<tr>
<td>Russia (Near Ural Mountains)</td>
<td>n = 1</td>
</tr>
<tr>
<td>Belarus</td>
<td>n = 1</td>
</tr>
<tr>
<td>Moldova</td>
<td>n = 2</td>
</tr>
<tr>
<td>Ukraine</td>
<td>n = 2</td>
</tr>
</tbody>
</table>
Table 3

Year of Migration Ranges of Study Participants

<table>
<thead>
<tr>
<th>Year of Migration to the United States</th>
<th>Number of Study Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992 – 1994</td>
<td>n = 4</td>
</tr>
<tr>
<td>1995 – 1997</td>
<td>n = 5</td>
</tr>
<tr>
<td>1998 – 2001</td>
<td>n = 3</td>
</tr>
</tbody>
</table>

Table 4

Professions of Study Participants Prior to Migration to United States

<table>
<thead>
<tr>
<th>Professions Prior to Migration</th>
<th>Number of Study Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engineer</td>
<td>n = 1</td>
</tr>
<tr>
<td>Research/Scientist/Health Related Field</td>
<td>n = 4</td>
</tr>
<tr>
<td>Teacher</td>
<td>n = 3</td>
</tr>
<tr>
<td>Librarian</td>
<td>n = 2</td>
</tr>
<tr>
<td>University Degree/Other</td>
<td>n = 2</td>
</tr>
</tbody>
</table>

Table 5

Marital Status of Study Participants

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Study Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>n = 8</td>
</tr>
<tr>
<td>Divorced/Widowed/Single</td>
<td>n = 4</td>
</tr>
</tbody>
</table>
C. Study Findings

Interviewing the study participants resulted in the identification of six major themes (Table 6) related to the meaning of health, health within the context of migration, and current health and health practices. These six major themes were the following: 1) Health as a highly valued possession, 2) Being a stranger/seeking the familiar, 3) Grieving and loss/building a new life, 4) Experiencing changes and transitions, 5) Trusting self, and 6) Importance of hope.

Table 6

Major Themes

1) Health as a Highly Valued Possession
2) Being a Stranger/Seeking the Familiar
3) Grieving and Loss/Building a New Life
4) Experiencing Changes and Transitions
5) Trusting Self
6) Importance of Hope
The conclusions that follow depict connections among meanings found within and across transcripts. Pseudonyms are used throughout this manuscript (Table 7).

Table 7
Pseudonyms of Study Participants

<table>
<thead>
<tr>
<th>Bella</th>
<th>Dasha</th>
<th>Fekla</th>
<th>Hanna</th>
<th>Nadya</th>
<th>Tatyana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caterina</td>
<td>Evgenia</td>
<td>Galena</td>
<td>Katya</td>
<td>Raisa</td>
<td>Vera</td>
</tr>
</tbody>
</table>

Theme 1 – Health as a Highly Valued Possession

All study participants emphasized the importance placed on health in the Russian-speaking culture. Nearly all of the women specified, “… health is everything, very important….” Fekla added that health was highly valued, and “… it is like something given to you.”

Both Fekla and Raisa noted that a traditional custom in the Russian-speaking culture during a celebration is to give one a wish for good health. As Fekla explained, “It is customary for those around the table to raise their glass to celebrate the guests of honor and say – ‘na zdorovye’ – ‘to health’....”

Raisa further explained, “… but I think … from the mouth of old people, more mature people, they say, ‘Be healthy.’ It’s the first wish for everybody in your family and for everybody you want to say something good. Be healthy. Not wealthy. Not beauty … but healthy....”

Health was described by other study participants in several dimensions, including health as physical and mental functioning; associated with youth; the absence of disease and pain; and balance and emotional well being associated with hope for the future. Other
dimensions included health as involving the health of others and the environment and health as a low priority within the context of immigration.

*Physical and Mental Functioning.*

The experience of being healthy was described by three of the study participants as having energy that enabled physical and mental activity and productivity. Bella stated, “When I’m healthy, I can do a lot of things at once…. I might have my job problems, but, first of all, I understand them; I can hide them, I can just work around them…. I can solve problems really well … think like chess player … five jumps in a row, so that’s what it means to me…."

Hanna described the experience thus: “You feel comfortable and … you feel well and you have enough energy for work, for your family… for your free times…. I was sure I could do everything I wanted to … it was when I was student. Ah, when I was 20 something I felt very healthy…."

According to Evgenia, “I did everything in house, in apartment. We have small apartment [in the Former Soviet Union], but it’s big job because we did not have so much devices like here in America…. Wash clothes by hand and more different things…. I feel myself good. I was energetic …when I was healthy…."

*Associated with Youth.*

The majority of the study participants reported that they felt the healthiest in their late teens and early twenties. Nearly all the women associated health with youth, and lack of health was associated with the normal process of aging.

Fekla stated, “Four years, 17-21 years old, I felt very healthy. I never was sitting at home.” For Evgenia, it was a little later: “Till age 35 I did not have problems with my
health and …I feel myself good…. It was everything good…. I think when I was young it
was more healthy than now, of course.”

For the majority of the study participants, the lack of health was considered a
normal and accepted part of the aging process. Bella sums up what other study
participants also conveyed:

… if you just lower your health expectations … at some point you can consider
this illness to be normal, just age-related … that’s my approach. You can’t return
your health as you were twenty-five, or even twenty. … you just can’t return it
back, it will not come back. … you need to understand it, you need to live with
the problems you have now…. There are age-related problems and if you keep
your health expectations rather high now, you would tell that you are sick now…. Because of the health problems such as headaches, whatever you have now. But if
you lower those expectations, you consider you are a healthy person…. There are
some minor issues, age-related issues…. If you disregard them, if you don’t have
real bad illness, you can tell that you are okay…. So, if you disregard your
vision’s getting worse, your problem-solving skills are getting worse … you can’t
run ten miles but now just two miles … it’s okay for your age….

Absence of Disease and Pain

Health was described by two of the women as the absence of disease and pain.
The seriousness and severity of illness and pain were related to the location of the pain in
the body rather than the actual degree of pain. The seriousness of pain was dependent on
the length of time the pain lasted, if the pain was “unusual,” and whether or not self-
treatment alleviated the pain. Pain was described as an expectation of aging. Muscular pain was not felt to be of a serious nature compared to pain near the region of the heart.

Dasha said, “… if I don’t feel any pain just like I feel, that must mean nothing wrong with me…,” later adding, “… which part is important … have pain here, like couple days, and I feel bad because I have this pain, but I never go to the doctor. And today I don’t have this pain and I forget about that I have it....”

Evgenia described when she would seek health care related to pain:

… if you have pain in the heart, you can go [to the physician]. If you have pain in the back, and many women go, can have this pain, like couple months, and just never go to the doctor. It depend which the part....

… You know, as an older person … I have pain…. Here and there, but actually I don’t really pay any attention and, ah, I try to keep myself moving. I try to walk. I try to work on it, my health. I, ah, thank God, I didn’t have any serious ... I have some lotion, some cream….

**Balance and Well Being**

Two of the study participants described health as both externally and internally experienced. For these women, health was described as involving a natural balance of all parts of one’s life and enjoyment that one is not aware of when it is experienced. Raisa said, “I see a person who is happy ... you feel happy when you’re healthy…. It is not possible to see your face and think how your health or not – most of the time, yes, you can see this, but not always....” Raisa later added, “Everything is important for health … it is a balance....” Nadya stated, “… my mind is free of worry....”
Emotional well being was described by one of the participants as not being noticed when experienced. Fekla observed, “… you don’t think of it when you have it – it is natural…. So it means … they want to enjoy every day … it’s difficult to say, you know, when person is healthy, person doesn’t think about it....”

For Others and the Future

Being healthy for others and for the future was of importance to Bella: “… I want to be healthy for them [family and children] and enjoy in my life…. I have two kids. I want see how their well-being in the future. I want to be healthy for them…. I want to be as more active as I can in the future because I have to work, like, for twenty years more…. I want to be healthy and I want to enjoy my life....”

Involving Others and Environment

Raisa and Hanna described health as meaning more than being limited to the individual. Health was depicted as having a more global meaning, including family health and all that is around the individual. According to Raisa, “Because some nationalities have more problems than another in some aspect of health … health is global … not just individual…. Everything around me is good. And I think so…. And people are good around me....” For Hanna, “…for me the main thing if my family would be healthy. It’s the most important thing for me. My husband, my kids and my parents. That they are taken care of....”

Not the Priority of Focus During the Migration Process

The majority of study participants described health as a low priority during the immigration process. Instead of focusing on health at that time, the majority of the women reported that they focused their energies on issues related to planning the
migration process and on attending to the needs of the family. All the study participants insisted that women were responsible for multiple roles in addition to establishing a new home and finding a job outside the home. Nadya expressed informally, during a conversation that was not taped, that it is not unusual for two or three generations to live in the same household in the FSU. All the women stated that it is common for Russian-speaking families to migrate as a unit.

All the women reported that planning to migrate from the homeland was associated with great stress. Reflecting on those stressors, Raisa summarized, “…they [women] think about everything else – especially if they have children and older parents … to stay alive … to fight everything to stay alive … and only when they have everything for leaving … they will think about health.”

Nadya reflected, “Looking back, now I realize I was really healthy because without this health, I wouldn’t be able to survive. I needed a lot of energy … needed a lot of, um, do you know, good mood?”

Evgenia said that she experienced such a high degree of stress related to the migration experience that she could not recall her experiences during the actual process of immigration: “… I don’t remember the time around migration – I was so stressed….”

Raisa described the woman who is the mother as the one responsible for the common good of the family unit and the one who is concerned with the health of the entire family, including the older generation: “… mother always think about her children, or adults who is more older to help … to help first your family… it’s human nature for mother to keep safe her children, her family, close family….”
Evgenia described how she had to care not only for two small children, but also for a chronically ill husband during the process of migration.

… I had two children and I took care of them and it was good with my health. But I had three children because my husband was sick everyday, all time…. When we came here it was important for us, because my husband was very sick in Russia, and we call emergency once a week because he has severe heart problems, and we hope that here doctors will help him because medicine in Russia for average people it’s, ah, wasn’t too good. Wasn’t good at all…. Here … doctor’s medicines help you….

Caterina described how she currently continued to care for her aging mother and her small children.

… I’m all time nervous about my mother, about my children. I’m very sensitive, very sensitive for everything, you know. And always afraid…. I am nervous when it is very cold outside, my son go play in the snow. Right now he is outside and will probably tomorrow … be a little sick…. But nobody listen to me…. Always nervous between my older, my parents, between my children....

All the women described the gender roles of women the same way. That is, that housework is traditionally the responsibility of women in Russian culture. Although men are reported to help more with the division of labor in the home after migrating to the United States, housework still remains the major responsibility of the woman. However, all the women agreed that the ability to complete housework was easier in the United States than in the FSU.

Raisa verbalized what all the women described in various ways:
… I think it's the same what was in Russia mentality. But if a woman works here, maybe a man will help a little bit more at home…. Women have a lot of responsibility like family and children, not man. In America I think man more in family. They work more with the home chores and with children. In Russia it’s women work. Like they have two works: homework … chores, home chores, family and children, and their work where they have money…. I think in Russia it’s more difficult than here because everything is more tough and everything the same … responsible for many things – and we stand this … if we can stand this in Russia … we can stand here because here, everything is easier. I … go store, shop for groceries, clean, wash…. When we came here in United States, something change. Because … it's easier to do home chores here.…

Caterina described her multiple roles: “… I am working, I have family. I have big family. I have my children and my mom I have to think about too. I have to clean, I have to wash … I have to, everything … store, shopping. You know, women, you have to….”

All the women except one reported working long hours, some with a full time and others with a part time job in the United States, with little time for themselves. One woman worked both full time and part time jobs. Only one woman was unemployed, but reported that she worked privately part time for cash. Although long hours were reported as affecting their health, in many cases, the women were grateful for the opportunity to have a job or jobs.

Katya described her life in the United States: “…You work, you work, you work…. I work too much in America. I work too much. I have two jobs…. One full time and one part time. … I need more time for making time for my health … more
time…. I sit at the computer, I sit with glasses…. When I came to America, I said I had 100% vision…. It’s computer…, no, just computer…. I said, thank you, that I have this, that I have jobs. It would be worse without jobs….”

In addition to working outside the home, ten of the twelve women were responsible for caring for one or two older parents or parents of their spouse; one of the women cared for a chronically ill husband, another had recently experienced the death of a mother-in-law, and one supported an aging family member in the FSU. All the women voiced that in the Russian-speaking culture it was not unusual for women to be responsible for the home and for care of the generations above and below. The women in the study described women as the family gatekeepers to the health care system. They also reported that they were highly educated, proficient at the computer, and sought information for their own health and the health of their family. Nearly all the study participants gained computer skills quickly after migrating to the United States. One study participant, Nadya, summed up her newly acquired skills using the Internet: “I wasn’t afraid to learn new stuff….”

In regard to acting as the gatekeeper to the health care system, Tatyana reflected: …I think maybe I thinking too much of myself … but I think that neither my mom or son thinking about their health … even my mom if she has a problem, I have to talk to her a week or more … why don’t you go to doctors … I’ll think about it … and my son … I don’t want to talk about this … he doesn’t like to go to doctor and he doesn’t like to take pills … feels it will go away – I read more and I am more knowledgeable than them … I get second opinion if possible … In Russia people go to other doctors to find the best one … I read more if my family
has a problem – like ear infections – my grandson has ear infections so I go to the
Internet and read about them…. 

Theme 2 – Being a Stranger/Seeking the Familiar

Even though the FSU continued to lift restrictions and Westernize rapidly after
the fall of communism, nearly all the women reported that they often viewed American-
made movies about life in America in preparation for migrating in order to become
familiar with American culture. However, first impressions were often reported by the
women to be quite different from the movies and the homeland the women had left. Two
of the women reported that family who had migrated years before to the United States
were often viewed as strangers. All the women reported that the environment, living
space, food, communication patterns, the health care system, and the quality of the school
systems were very different from the homeland they had left. Two of the women
described the challenges of parenting adolescent children. That is, although children
tended to adapt quickly to the new culture, adolescent children often found it a challenge
to establish themselves in the new land. Two of the women described the challenges
encountered by parents in regard to disciplining children. Dealing with parenting issues
was reported to add to marital stress as well. These differences were seen as resulting in
the experience of being a stranger in the new land. Since travel back to the homeland was
possible, several of the women who had gone back to the FSU to visit family and close
friends experienced the former environment from a new perspective. The homeland was
described by these women as not the same homeland that they had left. Nearly all the
women expressed that they felt more comfortable forming friendships with other
Russian-speaking women with similar backgrounds in their new environment.
Experiencing the Differences

The first impression of the women upon arrival in the United States was that the United States was very different from the homeland they had left. Oftentimes the women felt that they were seen as objects of interest by the Americans they encountered. Nadya stated, “… I couldn’t imagine what it would be like….”

According to Evgenia, “… it is a different world…. Life in Russia, life in Russia it’s, ah, different than here … before we left, the year before, we looked at American movies but these were an obstruction – I cannot compare I live in movie … and live in real life – for me, movie was movie – what is real life, I cannot imagine … movies weren’t real … Stallone, Schwarzenegger….”

Fekla said, “… when we first came here … Americans … looked at us like it some interesting subject…. it was just curiosity to find out ‘who they are; where they are from’ … just like people from another planet….”

Galena described her experience:
... It was restriction, restriction for any information about another life in another country. And when we went in here it was a surprise that people look like our people (laughs)…. We believe in other country, especially in America when we saw American movie, old people is very slim, woman especially, and when I came here … oh my God! I never saw so fat people like here. All my life, no one person like here so large in size….

Family as Strangers

The feeling of being a stranger was described by Raisa and Bella as a sense of estrangement from those family and friends who had migrated before them.
Raisa describes her feelings about an uncle and his family who had lived in the
United States for many years, who invited her and her family to come to the United
States but, after reuniting were perceived as “not being family any more”:

… My uncle, my mother’s brother, invited us to come to USA – I thought I had
family here … but when we came here after several days I understand this is not
family anymore … because we change, they change a lot ... they lived here 10
years before us. My gramma, her 3 children, my aunt, my mother, and uncle were
very close. It was very strong family before my uncle married another woman.
And this woman did amazing things to our family…when we came here we were,
I think, her enemies … I don’t know why … I cannot understand this … it was
different than we thought….  
Bella stated, “… people are forgetting … even if they want to help you, they don’t
know how. So, if you ask specific questions, they will answer you but they will not …
know … just give you the big picture because they forget that the struggle did exist…."

Unfamiliar Environment

The outside environment was strange to most of the women when they first
arrived in the United States. The women made comparisons to the environment of their
homeland. In regard to first impressions of the city streets near their new homes, Bella
stated, “I was shocked with how dirty the streets were and how friendly the dogs
were….” Hanna noted that the streets were free of intoxicated people: “… there were no
drunks in street....” Nadya was impressed with the accommodations for people with
disabilities:
… I was shocked by the buses – at the bus who was putting down stairs helping elderly people to enter bus … then more than this, there was a special road … a slide … and the person who was on a wheelchair was entering the bus…. This would never happen in Russia … never, never....

Settling into the new living space and the American way of life resulted in the impression by the majority of the study participants that the United States was a rich land with people who had a tendency toward excess. Americans were thought of as not appreciating the abundance in the United States.

Tatyana stated, “I always think Americans probably couldn’t appreciate everything because they don’t know…."

Nadya described her husband’s first impression: ”My husband – at the grocery store, just stood in front the glass wall, with ice cream … he couldn’t get this sight from his head … he couldn’t believe it … just ice cream … the whole wall … ice cream … just ice cream….”

Evgenia shared her first impressions: “I couldn’t believe the amount of paper in the mail…. I was thinking … there is a lot of paper in USA – it must be a rich country that can waste so much paper…. Everything works – there is lots of food, everything is so clean, there are no smells in apartment … lots of fat people…."

Unfamiliar Living Space

The women all stated that they were not used to the amount of living space for families in the United States. That is, according to the women, in the FSU, families tended to live close together in the same apartment or the same city. When they left the
FSU, the women noted that families who had lived close together there often migrated to different Westernized countries.

Tatyana best described this thus:

… in Russia we live near one another in city — here, my sister is in Chicago, my son in North Carolina, my mom in Pittsburgh near me … but we are lucky to be in one country…. In the FSU it is not uncommon for three generations, sometimes eight people, to live in a three-to-four-room apartment. Four-room apartments rare ... not four bedrooms, four rooms….

People get used to good things very quickly… for first fourteen years of my life the bathroom was one block away from where I lived – with fifty people sharing this common bathroom – can you imagine living with nine people in four rooms and standing in line for the bathroom – especially in the morning when we all have to go to work at the same time – but we didn’t know any better – we were okay – we enjoy our lives as much as we could – we were rich with four rooms – most people didn’t have four rooms….

Differences in Judging Edible Food

Discussions often continued after the taped interview over tea and food, as study participants invited the researcher to eat with them. The women all reported that adjusting to the food was difficult at first. Although food was seasonal in the FSU, it was described as better – tastier and fresher – by the study participants. These women felt that Americans tended to eat a lot of processed foods. Evgenia and Nadya stated that Russian people were accustomed to fresh meat and fish over the frozen, prepared foods found in supermarkets in the United States.
After taping an interview, Eugenia told the story of her husband’s friend wanting fresh fish. A neighbor (an American-born man) had caught a fish in one of the nearby rivers but was not going to eat it because of his concern about the pollution in the river. Her husband’s friend took the fish that the American wouldn’t eat because it was caught from a river, since to a Russian man it did not matter, given that he was sure he had eaten fish from even more polluted rivers in the FSU.

All of the women interviewed were in the FSU in 1986 when the radiation disaster occurred in Chernobyl. Some of them voiced ongoing concerns both for the current radiation contamination, for which reason they avoided buying food grown in that region even today, and for future health problems related to the contamination of that environment.

Raisa best described what nearly all the women reported:

… Chernobyl is … they talk all the time. They even don’t want to eat the food from that area…. Chernobyl is near Kiev … they see Kiev on anything they think must be … maybe has some radiation … they won’t buy it…. So they always aware of it, all the time. Here in Russian store I was hearing it, somebody really wanted to buy, with something, I don’t know how it’s called, buckwheat…. They say “Oh, look at this, made in Kiev, that’s not, do you have any made, buckwheat made in Russia?” I said, “What is wrong with this one?” Problem is concern for radiation…. So they even here – in USA … they do not want to buy food from near Chernobyl….

In a non-taped discussion, Nadya described her impressions of the American she saw throw away an apple that had a worm. Her observation was that in the United States,
if a worm is found in an apple, it is a sign that the apple is not fit to eat and is thrown away. In the FSU, a worm in the apple is a sign that the apple is fit to eat, that is, it is not contaminated with anything that could kill the worm – so it should be good to eat.

Unfamiliar Communication Patterns

Nonverbal communication and the use of humor by Americans were reported by most of the women as often resulting in confused messages and uncertainty of intentions for the newly arrived immigrant.

Hanna remarked, “People smiled….” Katya stated, “… nobody smiles in Russia.” Hanna described her reactions to the smiling Americans she encountered:

… first time I came here … it was real impressive, everybody smiles, and I said, such good people … they smile to me … they like me … oh, it’s so nice … and then I started hating smiles … I thought, it’s not sincere, why are they smiling, it not sincere … you know, when you are in different position from them and they smile at you, you say, it’s not honest, not sincere…. Then, I went to Russia last summer … I thought, people don’t smile to me and I don’t smile … it was kind of scary … my mind has changed … it seems natural and normal now for me … it becomes normal to you…. I just thought – my feeling was that Russian people are open people, sincere people…. In Russia if they don’t like you, they don’t smile at you … if they do, they smile … in America, don’t….

The use of humor and friendliness expressed by Americans was reported by the women as not easy to interpret by the newly arrived Russian-speaking people.

Hanna stated, “… not knowing what is proper … in America, one … can be funny … one cannot be funny with humor in … FSU – cannot express humor….”
Tatyana described how she felt: “I was afraid to open up because I didn’t know what to expect and America was so friendly.” … “I remember, everybody told me … your English is perfect…. It just my hearing not good…. Could you tell me again? …it was big surprise…. I didn’t expect such a good welcome from American people…."

Nearly all the women also spoke of how Americans were comfortable with talking about themselves and their accomplishments and praising their children. Two of the study participants noted that, in Russian culture, talking about oneself, praising children, telling them how good they are, is not considered appropriate. That is, parenting was described as not involving outward expressions of love and approval as openly as these are expressed in the United States. These behaviors were described by the women as foreign to Russian parents.

Tatyana described her experience of her first job interview and how difficult it was for her to talk about herself as a job candidate and mention the good things about herself. She ended with observing how communication in parenting is different in her homeland and how she wished she could turn back time and tell her son when he was little how much she loved him and how great he was:

… This interview was hard for me … it is hard for me to talk about myself…. You see, that’s part of growing up in Russia, and what was hard on my first interview, going on my first interview for a job to tell good things about yourself…. Because in Russia it wasn’t a good sign to tell about yourself … it’s opposite for sure … you are not good enough … you should be better…. This is what I like about American kids – their parents often tell them, “You are the best” … “You are good” … “You are number one”… In Russia – no – you are
not good enough, you should do better, and I’m sorry my son is already grown up and I couldn’t tell him how good he is – how good he was…. I couldn’t return this time…. Even now I tell him each day, “I love you,” it’s I like it so much … you don’t do this in Russia. More cool … distance…. 

*English as a Second Language*

Trying to express oneself in a second language was described by the study participants as being frustrating. Gaining proficient use of the English language as well as even the thought of learning a new language were stressors expressed by all the study participants. The majority of the women voiced that they often felt intimidated at the thought of having to study and take an examination at their age.

Fekla stated, “… you can never express yourself [properly] in a foreign language.” And Raisa noted:

... Sometimes I cannot clearly explain what I feel ... it’s like in general only … my vocabulary is narrow ... it’s not enough to speak good English ... good American language … it was stress, first was language … when you cannot hear … when you cannot understand and you cannot answer … someone asks you a question ... and you are in shock because you don’t know … you cannot understand … you have a lot of experience but now you’re like you are 3 years old ... maybe less … you a little boy who can’t speak …you is like stupid ... but you are not, of course…. 

Galena similarly described her experience:

… But I was afraid of English. And I … did not go to study. And that was not fine. Maybe some people who did not afraid, they study and try to make tests….
But most people my age could not do it. Because it’s very difficult to study
language that you don’t know well. This is the problem, I think….

Differences in the quality of education

The public school system in the United States was found to be inferior to schools
in the FSU by all the women in the study. They felt that children were simply not being
held to the same levels of accountability and expectations for study and behavior as they
were in the FSU. Children were described by one of the study participants as given
choices in the United States that they did not have in the FSU with regard to study and
learning.

Nadya summed up her impressions: “… the level of education, the level of control
… the level of information … everything, especially relationship in the school between
kids: it was absolutely awful….”

Fekla described the differences in her homeland: “… we were forced to study.
No one asked us if you want, if you don't want. We have to study. And here, I can see
here, okay, if you want you can do it, if you don't want, don't do it. Just to be happy….”

Adolescent Children as Different

The adolescent children of these women were described by the majority of the
women as having to meet their own challenges in their new environment. These
challenges to the adolescent-aged child often were described as resulting in the onset of
discipline and behavior problems in school that added to the family stressors in the
context of the immigration experience. Adolescent children were described by their
mothers as finding it necessary yet difficult at times to gain acceptance from their
American-born peers in their new environment. It was not unusual for the women to
express that their adolescent children manifested behavior difficulties that added to the stress already being experienced by the family in adjusting to their new life in the United States.

Nadya described her experience with her two adolescent sons:

… to my mind they tried to establish themselves. There were not so many Russian people there … they get into trouble in their behavior. And if you look at the results at the school, they’re not good. Their reports are not good, their behavior is not good. They got suspended several times or they’re late or they fight with somebody…. I got notes, I got … knock on door … and exchange with another person….

Different Parenting Issues

The energy devoted to making a new home in a new country was described as leaving little reserves for the energy required for parenting and guiding children, especially adolescent children. Two of the women described a lack of control over their adolescent children. This situation often resulted in strained family relationships and marital disputes.

Fekla stated, “… It’s hard, it’s because we were insecure living here − for a time, and kids feel when parents insecure − they don’t know what to do, how to live − they feel this….”

Nadya described her experience:

… the experience with the school was bad. And the problem, and the problem … I know they can be drunk. We couldn’t control it, you see. We couldn’t control. I was in school full time working and then at night I went to school for a year,
almost for a year. And when I was coming home, I wasn’t able to check how they did their homework. Okay, my husband can check math sometime. I couldn’t check English or anything or something. But it was a hard experience…. I wasn’t thinking of the danger of drugs and alcohol in USA … that this also is a danger for children … didn’t witness the drugs or alcohol…. I have to believe they are good people…. 

… my husband, thank God, he was more persistent. He tried to catch them. He tried to fight with them for better results, for better reports. I was kind of relaxed, and I tried to defend them. So, and then he started in the end of their high school, he started to talk to them. He started to teach them to get them ready for SAT exam. So, we fight, in a fight a lot of times because of it. That I wasn’t so strong like he was. So, as a result, I know that my older child got good SAT only because of math, math was really, I mean mathematic results was really high because of … old background from Russia, not from here....

*Children Finding the Familiar*

The majority of the women stated that, although children can also sense the uncertainty of the parents finding their way in a new land, they tend to adapt quickly and find “home” easier than adults.

Bella described her son’s and daughter’s adaptation to life in America:

… Our son, he’s like two cultures … he knows a lot about Russia and he knows a lot about America…. For him, he can behave this way or that way … and it doesn’t matter … he’s just playing … his best friend is Russian and his girlfriend
is American. My daughter, her friends are all Americans … she knows girls and boys from Russia, but she is not interested in them….

Fekla stated, “… our daughter speaks English better than some native speakers…,” while Hanna described the experience of her older son compared to her husband’s experience: “My older son studied English in Russia … it was easy for him to start over and he is very comfortable, he likes America … and, ah, my husband was in shock … catastrophic to start over … everything is easy when you are young…."

*Differences of the American Health Care System*

One of the most difficult transitions described by the majority of the women was becoming accustomed to the American health care system. In addition, language and the need for an interpreter were identified as a barrier to care by most of the women. All of them stated that they were accustomed to having the physician make house calls in Russia. Waiting to see the health care provider in a waiting area when one is sick made little sense to the majority of study participants, and the concept of making an appointment was a totally strange idea to all the women. Hospitalization in the FSU was described by the women as including extended stays and encounters with other patients.

Nadya’s description of her experience when she first arrived in the United States summed up the majority of the comments by the other study participants:

… there were so many problems – we couldn’t go to doctor, we needed help in translation, we needed help in making appointments, everything was new, and I was getting through a lot of stress – it was so hard here to make an appointment – in Russia it was a lot easier – the whole process of getting sick is so different … the doctor made house calls, you were seen the same day….
Nadya continued:

… For many people going to doctor is a real problem … because sometimes they have to bring a translator, which they’re feeling not comfortable to get, or provide their personal information, and to be in front of a doctor with some, the doctor exam, you and you have a translator who is at least turning your head around and weren’t looking at you … for example, my husband can bring me sometimes and he did it, he brought me, and then he felt uncomfortable because I have to go all the time, and he doesn’t want to do it in front of me or any other relative….

… In the United States, there is no free care and no house calls – seen same day … in Russia … it was absolutely, now I am realizing, it was absolutely wonderful … here you see people going around office coughing, sneezing, hardly working, with crutches, and with different kind of whatever, supplies … people can see you are sick … they are asking questions … you feel not comfortable … this is, unfortunately we saw it here, this was life, didn’t expect it to be like this….

Bella described her feelings after the experience of seeking care for her sick child:

… if kids … have something like a high fever, and even pneumonia, you have to go to your doctor and have this experience … you have to go to make X-rays. I thought, Oh, my God! … it just doesn’t make sense … if you have high fever just 80% chance that you have flu and a lot of other people will be infected….

Nadya compared her hospitalization experiences in Russia and in the United States in this way:
In Russia, I had a tubal pregnancy – I almost died … they saved my life and I stayed in the hospital for two weeks and I was out of work for one month … so here, I got surgery, I was really scared. I was out of bed in few hours, and home the next day, which was a surprise. I had a TV in my room … in Russia I had eight people in my room … I didn’t need any TV … talking to the women was like TV… each person was telling me their life and it was amazing … Chris Rock cannot compare to this …you don’t need TV … with eight people in the room you feel you can manage with people, you can check the person … they need to help each other … this is a nice experience, better than just laying in a bed by yourself and watching TV. So it’s not a luxury, the TV… I like the luxury to have these people to share their thoughts, to share their stories....

*Feeling Like a Stranger in the Homeland*

The women stated that they had experienced more freedom of travel back and forth to the homeland than relatives who had migrated before 1991. Those who had returned to their homeland since migrating expressed that going back to visit resulted in feeling like a stranger there also. The visit to the homeland revealed to them that the homeland had changed and continues to change dramatically. That is, the women felt that the homeland was not the same, nor were they the same. In addition, those who had gone back to visit the homeland described looking at their former home differently. In short, the “home” that they had left was gone. It did not exist. The women verbalized that they had begun a new life in the US and now find that they see things differently and notice things they hadn’t noticed prior to their migration.
Nadya observed, “… I didn’t remember how small and crowded our apartment was….” Katya stated, “… Nobody smiling in Russia…. Lots of food but no money – everyone thinking of money … many changes … no work in FSU…. ” Bella remarked, “… Just visiting is fine … I don’t want to stay…. ”

While love for Mother Russia remained strong in memory, going back to visit the homeland reinforced that the majority of the women do not want their children to live there at this time.

Hanna stated, “… maybe one thing makes me more calm. Ah, I love Russia. I really do. But I don’t want my kids to live there…. When I came this year and I looked at everything around me and I saw this drunk people and I saw young people who drink beers a lot…. ”

_Nostalgia for the Home Remembered_

Nostalgia for the homeland as remembered was mixed with ambivalence about remaining in the United States versus returning to a homeland that has changed from the one remembered. One study participant, Dasha, continued to keep an apartment in the FSU, since she was not sure if she would stay in the United States. She stated, “… I am homesick…. It’s very difficult, when I come America, I have Moscow time on my watch, you know. And I can’t move my watch. It’s like six months I have Moscow time. I really homesick, homesick…. ”

Galena described her ambivalence:

… After going back to visit … even after one year… – many changes seen my country… it was different from one year … it was different … all my life I live there, it was like nostalgia … sometimes we think we move back … then we
decided it’s too many changes … it’s hard to make money in the medical field … if you have a small business it is easier … I would make very little money … in a hospital you can’t do it … there is a big difference from now and what was before…. 

*Seeking a Familiar Place*

The experience of being a stranger as a Russian Jewish immigrant, seeking a place to call “home,” and needing to be recognized and accepted as belonging is summarized by Raisa:

…`I am not American, I am not Russian, I am not Jew – I am just beautiful [smiling as if making a joke] ... I want only a real normal life.... But I don’t have this. I didn’t have this in Russia, and I didn’t have it here…. Because I am like nowhere ... I don’t know ...I’m not Russian; I’m not American. I’m not – it’s my joke about myself, because in Russia I was Jew. By nationality, not by religion ... I’m not a religious person.... And they hate me because I am Jew. But by culture, by everything, I am Russian…. But there I was Jew…. Here I am Russian…. But I’m not Russian…. Because I’m not religious, I am not Jewish. I’m not Russian, I’m not Jewish, now I’m a citizen but I’m not American, because I’m still from Russia…. But I’m a beautiful woman [smiling as she says this]!!! It’s my joke about myself… it’s not really true about being beautiful [explaining to the interviewer that she is making a joke]…. I need to be somebody…. 

During the interviews conducted in the homes of the study participants, the researcher noted that more than half of the homes were decorated with Russian-made items and rugs or curtains in a style very similar to the decorations in the homes visited
by the researcher in Moscow. According to the study participants, some of the items were brought with them when they migrated, and other items were available for purchase in the United States. Eugenia described how she and others decided on items to pack from their homes to bring with them when they immigrated:

… I don’t remember the last days in my country at all ... everything we brought with us is important to us – we gave the rest away – without money – two suitcases for each person … I didn’t think that I lost something – but what awaits me … different people take different things … some take valuables, but there are restrictions from Russian government…. I brought souvenirs – Ukrainian … that’s my decision because I didn’t know that this New York in Brighton have all the same [laughs]…. In New York, Brighton Beach is Russian country … it’s all Russian store and they have the same like I bring with me….

In addition to the visual items from Russia, the interviewer recognized the smell of food bought at the local Russian store and prepared with Russian recipes, as well as the sounds of Russian music and Russia television in the background in the majority of the homes. Since most of the interviews took place in the women’s homes, the interviewer was invited to look at family photographs and memorabilia. The descriptions in the field notes of the artifacts in the homes of the women in the US study were very similar to those of the artifacts in the homes visited and depicted in the field notes taken in the FSU by the researcher in 1998 and 2000. In addition, the hospitality and warmth extended by the Russian-speaking women who were interviewed in their homes was consistent with the experience of the researcher during trips to the FSU in 1998 and 2000. The homes of the study participants contained newspapers, catalogues, and magazines
written in Russian, in addition to satellite television often playing softly in the background with the news in Russian. Phones were answered by the women in Russian, and it was not unusual to see a computer and keyboard with an Internet connection. The interviewer was told that families and friends communicated by telephone and e-mail regularly across town, across the country, and globally.

Katya explained, “…we got Russian channel because we have that, we read Russian books, anything. Russian channel, anything…”

The study participants felt close to other Russian-born neighbors living in the United States and had warm friendships with women of similar age and background. These relationships were described by the study participants as very loyal and very close. Friends were described as being as close as, if not closer than, biological family members and spouses.

Fekla described her feelings about the friendships she has made with other Russian-speaking women in the United States: “I feel closer to other Russians more…. We can explain ourselves … we have same background…. ” She talked about her relationship with her best friend, who is also a midlife Russian-speaking woman, whom she met during the migration process from the homeland: “… my day isn’t over until I talk with her … we are closer than cousins….”

*Expressions of Separateness/Expressions of Belonging*

When discussing their experiences, several of the study participants used phrases suggesting a feeling of separateness from the American-born, such as the phrase Hanna chose to describe her experiences in “your America…. ” Also noted were frequent
comments made by the study participants suggesting that they felt a sense of belonging with other Russian-born immigrants, as when Fekla said, “It’s very strange for us…”

When expressing themselves, the women often used pronouns that suggested that they felt they were speaking as part of a larger group rather than as individuals. That is, the pronoun “we” was sometimes said first, then corrected to “I,” and “us” was used instead of “me.” For example, Galena stated, “… we… I don’t know how to say…,” and Hanna said, “… it’s one thing actually, that’s what makes us feel better here. So, everybody has immigrated from somewhere….”

In a discussion that took place over tea after the taping, one study participant, Raisa, voiced her concern that her young adult son was moving out of the apartment she now shared with him into his own apartment. She wanted the researcher to tell her why young people in the United States and young people who had migrated from Russia tended to move out of the family home into their own apartments. Of even more concern to Raisa was that some of the young people looked to move to apartments in other cities that were far away from the parents. She described how this was totally foreign to her. According to Raisa, in Russia, people stayed in the same house until they married, or longer. If they did move out, it was usually to somewhere near the family home. Although she admitted this was partly due to the housing shortage, she added that she considered this practice as also part of the Russian culture. The perception voiced by Raisa was that, in a capitalistic environment like the United States, the focus is on the individual, that is, what she referred to as “me” and “I.” In contrast, both Raisa and Vera noted that under communism the focus was on “we” and “us” and the greater good. Raisa observed that her generation, and the generation of her mother and father, continued to
embrace the focus on the greater good – that is, the family makes decisions for the greater good of others, sometimes at the sacrifice of the individual. She gave the example of her elderly father giving up his life in the FSU to come to the United States for the hope of a better future for his daughter and grandson, since he knew she would not make the move without him. She was clearly concerned that, here in the United States, her son was thinking more of himself than of the whole family. Her observation was that she is seeing this more and more in the young adult children and the newly arriving young people, and she did not understand why it was so important for young people to move to their own apartment in the United States.

Theme 3 – Grieving and Loss/Building a New Life

The majority of the study participants stated that their decision to migrate to America was based on seeking a better life and future in the United States and fleeing the anti-Semitism experienced in their homeland. Most of the time, the women reported that they had had little time to prepare for the migration. With the exception of one of the participants, whole families migrated together. All study participants stated that it was not unusual for three generations to travel together to join other family members who had already migrated years prior to the fall of the FSU.

The experience of loss and grieving of the former life, along with hope for building a new life, was evident in all the interviews. The study participants were all educated professional women in the FSU. In the new land, all were working in other professions, or in the same area but at a much lower level of functioning and respect than they had been accustomed to in their homeland.
The women all reported that they struggled to learn English and new job skills in the evening while working during the day. This left little time for family. In order to move forward to the future, many of the women found the need to deal with the feelings of grief and loss experienced by themselves and family members.

**Difficulty in Making the Decision to Take the Chance**

Deciding to migrate was described by all the women as not an easy decision to make. Although painful for many of them, it was a necessary decision. Migration was perceived as a chance for a better life and a safer environment in which to raise children.

Galena described her experience:

Of course it’s very, very difficult. It – first time, we all were in big depression because, you know, to leave from one street to another, it’s a big deal…. And it was very hard for me and it was a big depression … I did not know what to do and ah, but I find a job. A little bit close, in medical, it’s not in medical field…. And I work now and I get used to. And it’s a little bit easier now. It’s very hard….

Hanna described how difficult the decision was for her:

… Crushed. I felt crushed. I felt that my life stopped and I won’t have anything ahead of you, ahead of me…. I felt … culture shock. So, you know, it’s a most scary experience I had in my life. Um, so, you know, I felt lost. Completely. Completely. And I, um, I thought, so my life is done. I told you this, and, um, no good thing can happen to me again. And, ah, um, we lost friends, we have to stick [with decision to leave] – leave everything you have in your life. You know, everything is so scary. So, I, I felt very completely lost…. 
… we talk about it when we remember…. Like, ah, nightmare, we remember this first year is just like nightmare....

... You know my father pushed me, kind of. He said … it’s your chance and you have to. For your kids’ sake. So we decided to do it … I never thought I would migrate from Russia … we decided this very quickly ... decision was like a snowball ... so we decided to leave with our kids ... I wasn’t prepared. I never thought about migration.... It’s why I never learned English … that was a problem…. I don’t know how people make the decision … it’s not an easy decision to make … you cannot sleep … it’s sleepless, the decision … but sometimes you just can’t stay where you are born….

Fekla described her experience of taking a chance for a better life: “It was willingness to take a chance … for a better life for my children….”

For Nadya, it was important to maintain a positive outlook:

We tried to see our bright future … in bright colors … not in bad colors … we realized that my husband doesn’t speak English … we can go through problems with kids … but we tried to see it in bright colors…. It can’t be worse than what it was ... it can’t be worse.…

Nadya described how she was so focused on avoiding the anti-Semitism her sons experienced in the FSU that she did not realize the dangers her sons could face in the United States:

… I was scared to death because my younger son was crying, coming home telling that this person told him this [referring to an anti-Semitic remark] … I was scared to death something can happen. So, when we were coming here, I was
relaxed somehow, I felt relaxed that it’s not going to happen, the same thing with them. So, but I forgot, and I didn’t even imagine, that some other things can be dangerous for them, and I wouldn’t be able to follow, being or not realizing what is going on. Like drugs and drinking....

*Women of the “Lost Generation”*

With regard to seeking a better life for themselves and their children, all of the women interviewed described how they valued education. The women had all studied and obtained advanced degrees. Many of them held positions of high esteem and worked in academics, research, and science. However, they also expressed that, by the time they were in their prime earning years, government-sponsored science projects were no longer a priority of the Soviet government and many projects had lost funding. These highly educated women scientists and academics observed that they were not making enough money to eat. That is, the women described that the national priorities changed, and they were too old to go back to school in the FSU to learn something new; moreover, jobs in all areas were scarce.

Bella described her experience of being a member of the “lost generation”:

… When I came here, I was thirty-five years old. And it was 1995. … in ’82 I graduated from the university …and we had … five years. And then, Gorbachev came to power in ’85, and there was no interest in science at the time … we could wait three years and not able to achieve anything in three years…. I was in my post graduate school ... actually at the time … I was in radio astronomy ... I was in one institution … just making observations, with stars, and the other institution said I need to pay them to do this from my own pocket....
… with two master degrees, I was not able to … they just kicked us off from science in Russia … we had to have some money for food and nobody paid a scientist over there. And, just, our generation was very lost generation completely … our generation … we … did not achieve anything by that point … what we have, we had … just survived, and hard to survive if you are getting salary on which you can buy … just two pieces of bread a month…. It’s all the salary could do for you. It was, it was awful…. I got such a great background. I got such a great education, and I wanted a job. I really wanted a job … we can't do anything … nobody needs your brain at all… some company started to hire someone but just they were doing such stupid things. Nothing to do. And more hours and not a lot of computers over there. So no material base and no … money…. Finding the first job in the United States was a painful experience of loss for nearly all of the women who had held positions of high esteem in the FSU. Hanna, with tears in her eyes, described her experience:

… My first job was ... as a ... teacher assistant in ... a child center. And … it was probably… the most hard thing for me because … I was a person who spent a lot of time to be prepared for the job, I mean in my job. I study a lot, and I got … awards … as a best speech pathologist of the year. So I, I felt respect from the people who I helped, who, from parents whose … children I helped. I saw results of my work. So, I was real proud of myself…. And when I … I am … reasonable person and I understood – just thought, I cannot get the same job because of the language. And I get this job and I felt I’m zero, you know? I nobody, and I am zero. It was really big difference for me. Yes … some people are very nice…. 
Understandable…. Very helpful…. And … some of them … were just … looking down (at me)…. 

Although lack of English language skills presented a challenge in finding a job, Hanna told of her experience in which bilingual skills actually helped her find a job:

… So, one day … maybe God help me. Maybe God send this person, she was mother of my … student in school, and she came to me and she told me that school [had created a position for a] … Russian teacher. ‘Do you want to work there?’ she ask me. And I said, if they want to pay me, I will go. And I … I went for interview and I got offered, so … I understood … so life goes on and … everything not as bad as I thought…. I … become little bit more happy than I was before. Because, you know, when you got hope to work … to do your favorite job, your favorite business … you become happy, of course…. 

The majority of the women described their former positions with great passion. Their dedication and commitment to their professions were quite apparent. Nearly all the women began to cry during the interview when talking about their former careers in Russia. Katya, who currently works at two jobs, passionately described her former position as a librarian:

… Oh, it’s – when I talk about, I get upset look at my eyes [eyes tearing up]…. I work for 25 years … in a big factory … factory librarian … in a … chemical library for … the public…. My dream, my dream for, I don’t know, when I was a child. When I was a child, I began to go to library, when I was five years old…. I go to library there … it’s my favorite job for all my life….
Nadya, who was a teacher in Russia, reflected on the opportunity to resume a teaching role in the United States:

… and when I come to school just for visit kids or to parents’ meeting … I saw kids in school and trying to compare kids in school and system in Russia. And I told to myself, man, you have to forget it. It’s not for you … it would be a disaster … so after twenty years of teaching I just forgot about it … and sometimes I’m telling that, if I asked, if somebody asked me my jobs, what was your background … I was telling with such sadness in my previous life I was a teacher for twenty years….

Changing careers in the United States was sometimes a positive experience that resulted in a job, plus finding new friends in the work place. Tatyana described her experience:

… I figured out right away that I have to go to change my profession, because I couldn’t with my English teach math … so I went to college, it was like a business school, for two years, and became a programmer – my first job was great … real good job … I got $8 per hour – I was so happy … all my friends wanted to work with me – they made $5 per hour … in my first job, the people were like family to me – we are still friends … we love each other ….

Bella, also, had a positive experience with regard to a new career:

… I got the real job over here, now I’m very pleased with my job and I like it … actually my husband found his first job … in two months…. I had to change my profession…. I found my first job … in eight months, so it took me some time to learn something about programming….
Settling for employment at a lower position, or employment even after going back to school to learn another occupational skill, was not always easy. Galena, a former research scientist in the FSU, had found it difficult to even get a job interview for a lesser job in the United States:

… when you come here, like me, I work in cardiologist center in a clinic. I do everything. [In the FSU] I was a manager there. I have a high education. I was a doctor at a high level. And then I came here…. Because I don’t know English well, this is the problem. And … it’s very difficult at my age to work. But, you know, it depends if people, too. Maybe if I … know how in English, maybe I have to try to … start. But I was afraid. I was afraid to learn because I thought I don’t understand…. Maybe I can find something in this field. Not like my position what I was before, but a little bit lower…. When I try to send my application for even a less level job in library, nobody wants even to ask for an interview … maybe they see my age … maybe they see I from different country. I don’t know what they see....

Dasha had gone back to school to learn a new trade, but still could not find work after several months of trying. “… I was artist in Russia,” she said. “But here, I am a nail technician…. I just try to find some work, and looks like nobody want me. And I go to the beauty school, and now I am nail technician….”

_Depression as an Unfamiliar Diagnosis_

Although looking for jobs was much more important during the immigration process than attending to their health needs, nearly half of the women reported feeling depressed during this time. Dealing with grieving and loss in the new land sometimes
required outside assistance for treatment of depression. Two of the study participants reported ongoing treatment for depression. The women all stated that depression was not recognized as an abnormal condition to be treated in the FSU. However, according to the study participants, this is changing. The study participants explained that, in the FSU, treatment for mental illness was often associated with punishment for political dissidents and carried a stigma.

According to Raisa:

… in Russia it was not in that time, it was not with diagnosis of depression … it’s like people know, did not talk about this … not in medical world … normal people, not psychiatrist … it’s zero about depression … it is not in medical books … not on television, not on radio, nowhere … because there is no diagnosis, there is not an illness – how can someone talk about it … if it doesn’t exist? … I know why there is not depression, because in Russia in that time, in communist period of time … I think everybody will have this illness because the life and the pressure of the communist party … I think no one was without depression … in high level, in government, in middle class … everybody had this … because in the government they was afraid to lose their position and there was all the time afraid about their money, and especially in the period of time Stalin and everyone after … it was like everybody was afraid all the time … you will be depressed, of course….

Bella and Tatyana described how mental illness and depression were treated in the FSU: “… dissidents were given the diagnosis of being mad – and they were not mad, they were healthy people … there were so many stressful things in Russia … just talking
about all that stuff didn’t make any sense, because the doctors actually had the same problem … everyone has exactly the same problems.

Tatyana stated:

… if you aren’t in a good mood in Russia … you are just crazy … no one would tell you that it might also be treatable somehow … you should go to the doctor and tell what – tell about that I’m in a bad mood all the time? … I didn’t talk about these things in Russia … that I talk about now … the mentality is that it is a shame to talk about these things … I never know the word depression … I know he is always in bad mood … or he is crazy … never didn’t I know was depression….

Loss of Family Proximity

Loss was also expressed as being experienced by the majority of study participants as loss of proximity when family members moved to different cities and different countries as a result of the migration process. The women described that the family, sometimes consisting of three generations, journeyed to the United States to the Southwestern Pennsylvania urban setting to live together. Most would travel in small family units and set up an apartment for other family units to join them. However, the study participants stated that it was not unusual for younger family members to move to another city such as Boston, New York, Philadelphia, or Chicago, to find employment or go to school, leaving middle-aged and older family members in the urban community in Southwestern Pennsylvania. Some family members migrated from Russia to Israel or to other Western countries, especially if family members were there also.
Hanna described her pain in not being able to see her sister, who had migrated to Israel:

… My sister migrated to Israel because her husband’s brother was there … her husband could not live without his brother … she just couldn’t do anything … she decided to go … of course, that is her family … my husband didn’t want to go to Israel and neither did my sons … so, he just refused to go there … it’s also a hard climate for our parents … it’s very hot … we call but cannot see each other as often as we would like to … it’s very painful … very painful … I have friends and family who have decided to migrate to Germany … but I would never do this … because of what happened in the war … I still cannot forgive what happened….

The Sacrifice of the Older Generation

The women described how the older generation often migrated with the younger generations. The older adults were willing to be uprooted for the greater good of younger family members, albeit at great sacrifice of their own needs. Hanna stated, “… We left, we came here together … I would never leave them [parents] … never … it was like big family....”

Tatyana described her mother: “… My mom, she don’t get used to expressing herself – she didn’t complain – she came here not knowing a word of English – she never complain about anything….”

Nadya described the experience of her mother-in-law: “…my 85-year-old mother-in-law traveled with us … was offered a wheelchair at the airport … then, somebody took the wheelchair with her in it to the gate … she started screaming like
crazy because she was scared to lose us … she never was in a wheelchair because she did everything by herself….”

Fekla summarized why the older generation migrated: “… this is very hard on the older generation who came with children, since the children would not have gone if they didn’t go….”

Nadya cried as she told the story of what she had witnessed during her migration: … I remember one person when she was in the flight … and her elderly parents were with her, she was looking at them. How they were tired on the plane…. They looked so tired, they looked so embarrassed, they looked so scared. And she was looking at them, and she was thinking, ‘My dear mom, will you be able to forgive me for this? That I am pulling you from roots and trying to put the old tree in the new soil?’ [crying] …. Raisa blamed herself for her father’s decision to migrate and his subsequent depression:

… my father was very disappointed … he didn’t want to come with us … only because he thought about his children … his daughter … about me … and, of course, about his grandson…. And he did this for us … not for him … it was a very big decision to cut his roots … he understood what would not be good life for him … my mother hoped that it will be better here for us…. My father is very talented, and when he cut his Russian roots, he of course cannot grow up here in different ground … different land … he was very depressed, and because the idea to come here was mine, I felt very big pressure because I did this … it was very
painful … and I became depressed by myself … he want not only to live here but
to die here … he work all the time to be busy not to die….

**Building a New Life**

With regard to the experiences of loss and grieving, nearly all the women voiced
that they realized that building a new life was not easy but tried to be positive about the
struggles experienced. Fekla stated, “It’s another life here….” Tatyana shared how she
tried to make the pain into a positive experience: “… It is painful, but I tried to see it like
an adventure....”

**Theme 4 – Experiencing Changes and Transitions**

Both external and internal forces influenced the health experiences of the women.
External forces included the rapid societal changes experienced in the homeland, unmet
expectations related to employment, and concerns over lack of health insurance in the
United States. Internal forces included transitions related to learning new skills,
experiencing the aging process associated with the onset of chronic disease conditions,
and bodily changes.

**Changes in the Homeland/From a Different Country**

As discussed earlier in this chapter, those immigrating after 1991 might not have
experienced understanding from family members who did not have firsthand experience
of the stressors and uncertainty brought about by the recent political and societal changes
since the fall of the FSU. There have, for example, been a decrease in jobs and a rapid
increase in openness to sex, freedom of religion, drug use, and organized crime. Lack of
police protection, acts of violence, wars, and attacks of terrorists have increased in the
homeland. This has resulted in stress related to uncertainty in regard to employment, personal safety, and safety of family and friends who remain and travel in the FSU.

The extended family members who migrated to the United States prior to 1991, and whom the new arrivals were meeting in the United States, often were not perceived as understanding these changes and the emotional needs and priorities of the newly arrived family members.

Dasha described how the FSU was a different country after 1991:

… it is like they are from different country…. Russians here don’t understand how it is different … there are more changes every year after 1991 … sometimes when people stay together and they talk and some people come here, like fifteen years ago, and they tried to tell you “fifteen years ago in Russia,” you know, and sometimes I feel just like saying every time to them – they forget it, forget it – it is not the same as it was 15 years ago [laughing]…. Everything different….

Vera described the uncertainty of the open society now experienced in the FSU:

“… Nobody knows what kind of system we have now … but all these ideas … it’s open now … not closed … young people have access to Internet….” Fekla stated, “… Now it’s [referring to the FSU] open, absolutely open….” When asked to talk more about the differences in the FSU, Galena stated, “… I’m not sure 100%, because now it’s [society in the FSU] different, different – each area has its own laws…. It was also different from year, one year it was changes….”

*Economic Changes in Homeland Since 1991*

Evgenia described the loss of jobs in the FSU and the extremes being experienced in Russian culture since 1991:
… maybe not in Moscow, in Moscow, its people, most people have job. But, ah, in Moscow and in other cities, very hard life. Because prices, prices like here, and they have, like, hundred dollars a month…. How can they live with this money? … [describing her experience when visiting her sister in Ukraine recently] I buy this food and I see, and it’s terrible cold outside, and I see this woman … that people left food behind, she put it in can, and she said, ‘Oh, it will be good soup.” … It’s terrible…. She pick up all this that people are leaving and she say, “It’s nothing wrong. I will boil it. It will be good soup.” … It’s terrible. It’s so much homeless people…. We are from Ukraine, and my co-workers, our plant, over 5,000 people worked, and they produced weapons – not weapons – but instruments that go with weapons – the plant closed – 5000 people without job. And many plants, military plants, it stopped and, ah, people my age up to 55 they have pension. But pension, it’s like $30 a month. How can they do this … I don’t know how we would manage. How could I live for $30 a month?... This apartment is like palace…. But we are happy we are here. I mean, I found out it’s not easier, not easier.…

… Now in Russia … there is more sex [on television] than here … one side to other extreme … after fall of FSU … it’s terrible … but it should be normal….

According to the study participants, the practice of religion, strongly discouraged under communism, is now permitted. While most of the women described themselves as having been identified as Jewish, they considered themselves atheists. Although strongly discouraged, religious services did take place under communism in a few urban areas and
in small, outlying, poorer villages according to Vera. However, attendance at religious events had the potential to result in public humiliation. Vera, who attended the Russian Orthodox Church in the United States, described what she experienced as a young child as the result of attending religious services under communism:

… They wouldn’t send them to Siberia for that [attending a religious service], no. They would say it’s not good to believe … in God, to go to church, because all the idea of communist was that in the base of everyone has to believe in, you have to believe in yourself…. Everyone human … this is what is the highest, the most, the most highest human being, they would worship humankind…. You have to develop, they would say, you have to develop…. You have to grow professionally, you have to work…. And you only believe in … you have to believe in yourself and to help your comrades, they would say to grow…. Ya, I was worried, because for example … automatically … you become like a member in school, you become … from first grade to fourth, you become a pioneer … then a communist woman, young woman, young people communist and you have to wear this thing like a scarf …when you are a pioneer, you have to have this … and then … it would be very bad … [if you attended a religious service] … because in school … especially on big holidays, like … Christmas or Easter … they would have … some people stand near church … [conducting] some kind of … communist activities … they would chase … they would catch you physically… and they would run from them … they would say and they would write and … in school they would call this student in front, and they would put them … in the room, everyone would sit, those students would sit in front of
everybody and say “shame on you, you went”; it was all, it’s all the religious beliefs … people who believe in that, they would say, that is a shame on you – “future is communist future, and here you are in church, that is a shame on you”; that’s like that, it happens to them like that. But, I know I like to go to church. I don’t know why I was a believer or not, but I wanted to go because it was not allowed – that is what happens … prohibit someone, people always want it, you know – and for me it was some kind of excitement to go to church. I like it….

**New Concerns for Safety**

Regarding the FSU, the women all expressed fear of crime associated with increased drug use and lack of police protection. They also worried about relatives who remained in the FSU, adding that those traveling to the homeland to visit these relatives were likely to experience additional stressors related to changes in laws in the homeland regarding citizenship.

Nadya stated, “… I’m worried more now when I visit Russia … crime … police will never help you … there is no law actually… there is no law you can rely on….” Raisa stated, “… it’s like a wild society … this is the beginning of capitalism….”

Nadya mentioned her surprise in learning of a new law related to her Russian citizenship:

…They told if you come to US before 1993 – so Russia forced all immigrants to cancel their Russian citizenship of all the people who are living here in the US before 1993. After 1994 there was no Russia – no Soviet Union – it was already Russia, and Russia didn’t cancel our citizenship – formally we are still citizens…. If you want to cancel and refuse you are Russian, to give up your Russian citizenship, you have to pay $500, and then if they know that you cancel your
citizenship, they may never give you a visa to get back into Russia … the American Embassy knows situation … they say we kind of close our eyes to the situation … so but please be careful … don’t do this … or that … if case of emergency you have the right to call the American Embassy and get help.…

Rapid Pace of Changes

The women described the open society in the FSU as having resulted in Westernization of the culture and greater familiarity of those in the FSU with American culture.

Evgenia described her experience with her sister who lives in Ukraine:
… now it is different, people know about America. Ten years ago was very different from now … my sister came to visit me last year and nothing surprised her … she knows – there is a lot of information now – a lot of travel back and forth – life in Russia now is close to here … but people is divided – rich about 20-30 percent, rest very poor – people on streets in Russia, Western dress – better than here – [in Russia you] can’t buy house or car but can buy clothes – like prestige….

Values and Beliefs of People Slow to Change

Although major political changes took place along with the disappearance of the USSR in December 1991, the culture, the values, the belief system of the Russian-speaking people of the generation of these midlife women and their parents, who lived their entire lives under communist rule between 1917 and 1991, were not seen as changing so rapidly. Raisa stated, “… people don’t change very quickly … it’s not to be like three generations of people to change something in their mind.…”
The midlife Russian-speaking women in this study expressed that they tended to retain the values of their homeland longer than their children. Young Russian-speaking adults who had become Americanized were described as not being so conservative as their parents in regard to premarital sex, birth control outside of marriage, or living with a partner before marriage. Although the parents had concluded that their young adult children had adopted these American ways, they respected the younger generation’s decision to keep these practices from their parents in order to spare their parents. Fekla described the relationship with her young adult daughter:

… our kids, they understand our feeling. I think my daughter, she understands my feeling and she try not to hurt me … I mean, I know she had a boyfriend. But she does live in an apartment, and she has her own room. She does spend a lot of time with him alone. I know she spends more time with him alone.... Because they grew up in this, ah, in this … in this country here. And she knows for us it’s very difficult to talk about it, sex – So, I don’t know, my husband tells me, why she spends money for this room, and she could live here. And I told him it’s because she doesn’t want us to know, she’s not sure – And she doesn’t want us to think she changed, I guess. I never ask her, where are you? It’s our culture, and she doesn’t want to hurt us.... She’s with him. In Russia it was already like an old maid [laughs] – so her grandmothers, both of them, ask her every day – are you married? This is difficult for her – I think she needs a lot of patience…. I know she takes … pill.... Difficult for us to accept it, too. I mean, she told me before, she said – she had pain – so she is taking the pill for pain … sometimes I think our children don’t tell us these things to spare us....
Changing Focus with the Changing Rules

According to the majority of the study participants, the rules for success in the FSU had changed. Making money quickly was now valued over education, science and the arts. Young men were likely to serve time in the army and to fight in such places as Afghanistan. Life as the women had known it in the FSU continued to change rapidly.

Bella described her personal experience immediately before migration:

… the money I was getting … every month … it was enough to buy like five pieces of bread … there was no job … there were no foreign companies … or big or even small companies who needed our intelligence there…. It was job- related … also, we have a young son … who would go into the army … it was awful, Afghanistan … it’s awful … for several years there was nothing to eat … not completely nothing … you go from store to store to hunt for food over there … and because there is no money, you can’t get anything….

In the FSU the process of obtaining work after graduation appeared now to have changed to more Westernized practices that were unfamiliar to the women raised under communist rule. Former colleagues often migrated to other Western nations to use their skills and education. Bella described the changes she had experienced:

… It used to be, after you finished school, you were assigned a job. Now, just like in US, you must submit a r9sum9 and apply and be interviewed … and we can’t do anything … just nobody needs your brain at all … just some company started to hire someone but just they were doing stupid things … nothing to do … and more hours and no computers…. Looking back on all my college mates, it’s kind of two percent who really survived and really doing … just what were taught to do …
more than 25 percent of my classmates came to the US, Germany, and Britain and are doing just what they want to do … and we still keep in touch….

Changes in Expectations

The unmet expectations of migrating to find a better life, settling for less, and not being able to find meaningful work, work to survive, or work that provided health insurance coverage were stressors for all the women:

Thus Raisa stated, “… I thought I would have a better life … not like manna from the sky … I thought with our working, saving, and everything we can be a little bit higher in success than we are now…. ” Bella observed, “… just, assimilation process is very painful for many of the people because they thought it would be seventh heaven over here, but it’s not…. ”

Evgenia described the challenges she faced due to her age:

… it is difficult to find a job here – when people came here after 50 it’s not real … because American people can’t find job – sometimes Russian people said “Nobody wait for us here” … they shouldn’t be upset – they have social security – it’s not big money, but for Russian people who live all his life on very small money … it is enough. But Russian people like me find a little bit job – but most American people don’t want to go for any job around, they want … ah, prestigious job…. Russian people can go take care of old people for cash – children, cleaning, something for extra money … to survive…. 

Fekla explained how she had believed that it would be not be difficult to find work in the new land:
… You know what, to be honest, of course, when we were there, we thought we were ready to do everything here. To work everywhere, just escape. Of course, somewhere in mind was a thought, someone is waiting here for us. For our quality, for our knowledge, you know, and, ah, it wasn’t very easy. We cleaned, I mean, I cleaned houses, and I took care of one old lady for about three years…. But we are happy we are here. I mean, I found out it’s not easier, not easier….

… my son … he started medical school in Belarus and when we came here, he find out he has to go again college to get the bachelor degree. And someone from Russia, not from America, told us, told him, everyone comes here and wants to be a doctor. But you have to go to make money to work somewhere. Doesn’t matter – just to make money. Everyone wants to be doctor. And, ah, he was depressed for a couple of months….

New Concerns Involving Health Insurance

Many of the midlife women who were interviewed voiced that the lack of health insurance was a problem. The women explained that life in the United States for those too young to receive Social Security had resulted in changes in ability to access health care that had not been an issue in the homeland. Lack of insurance was identified by Dasha as a reason for not seeking health care:

… You know, people who is a refugee from another country, they have better medicine than American people who work whole life in this country. They have care cheap and everything…. You know, it’s very difficult for me because all my children, they have medical insurance from welfare, and the small ones still have it. Because the older one is 22 years old and he is working, he has medical
insurance from his work. And another one, he is 18, and he has everything. And the small one is 8 years old and she have from [unintelligible] medical insurance. It’s really good insurance…. We stand in line for some cheap insurance, you know, but this looks like we stay in line two years. And we still don’t have it. You know, I don’t know what I’m gonna do if something happens in me….

Evgenia reflected on her observation of the American health care system: “… America good for rich people and for very poor people because it’s a lot of program of poor people….”

Fekla described her experience of needing health care when she had no health care insurance and how her Russian-speaking friend acted as an advocate for her to be seen:

... [I had] ... severe bleeding for a couple of years. I didn’t have any insurance. So, finally, [my friend] saved my life. It’s true, ya. She called me and I remember my kids were, it was summertime, my daughter was in Israel. My son was somewhere in Morgantown. And my husband was at work…. So she [her Russian-speaking friend] called me and I was on the floor crying. And she came, she called my husband, and she took me to the hospital. I was in severe pain. And they didn’t want to take me, because I didn’t have any insurance. And she said, Can you see she is dying? I won’t take her home. Okay, so she’ll die here in this room…. And, ah, they accept me. And ah, they started to, what’s the name, intervene…. I don’t have insurance for a long time. Couple of years. Of course, I didn’t go to see doctor….
Having insurance coverage in the United States was stated as a reason by Vera for seeking routine care. “… And here I would like to use, it’s not so much, I go to the doctor, not because it’s possible that he will find something – I just go sometimes just because I have insurance. That’s the honest … I feel that I have insurance, that I have to use it, and I usually am not concerned I am sick….”

Dasha described a lack of understanding and frustration that is also experienced by many of the immigrants who have been accustomed to a system of free medical care:

… sometimes I don’t understand medical system in America. I really don’t understand it…. How it possible 57 million people in the country don’t have medical insurance? I don’t understand it. You know, when I thinking about it … it’s amazing … it’s so rich country and people don’t have free medicine? Whole world have it … couple months ago, was … on news, and American people, you know, they say, oh, it’s amazing … you live in stress … economy is so bad … American people, they all are stressed. They afraid if they gonna lose their work, then it mean they don’t have medical insurance … no work and no medical insurance…. It is a big problem. Maybe most people don’t understand it. They don’t know about in other countries…. Most people know all world have free medical insurance. I don’t know what people can do in this country…. Maybe I don’t understand something…. I know the people who don’t have enough money, they can go to the hospital and they have a lot of programs. I don’t understand exactly how it work, but … I just asking why you don’t wanna go to the emergency room, just go…. 
Fekla described her experience with her older parents who traveled with her and are eligible to receive Social Security benefits due to refugee status:

… It’s hard. But, you know what, they understand. Finally, they understand the life is much, much better for them here. And they understand they didn’t do anything for this country and they have everything…. They’re safe, healthy, they have apartment. They have a lot of food, more than enough. And ah, everything is covered, I mean their medication, doctor’s visits, everything. So, they’re fine….

Internal Transitions

The midlife women all experienced many transitions within the context of immigration. These included learning to become more comfortable with the English language, mastering skills such as driving, and learning new job skills. All but one of the women experienced children growing up, some into adulthood, in the United States, and older parents aging. Two of the women reported that they recently became grandmothers – that is, grandmothers to the next generation of children, who are the first generation of the family to be American-born.

Age and Migration

Although age was reported by several of the women as a factor that made migration difficult for them, age and maturity were also identified as strengths in the migration experience. Evgenia expressed how age was a stressor to her during the migration process: “… it was a very stressful situation because I did not know … what I should expect … in new country in my age…."

For Vera, the fear of not being able to succeed in starting a new life due to age was a concern more than the fear of travel itself:
… I was not afraid … because we lived in the kind of life you had in Ukraine, kind of not afraid of anything that it’s very hard…. I knew the country will be different, it will be new everything. I wasn’t afraid something that would be difficult or I would be lost. I never get lost anywhere – because, you know, if you’re living in Ukraine you kind of find, you are so practical, you need to find everything around you. Just, ah, when it’s something new, and if you have to change something, you knew that you were going to America, but it not so exciting maybe, just because maybe I was a little bit older, and just because everything would be new to me. But I was afraid … to be a failure…. It was too late for me to … become a president of company or something. But just as successful as is Ukraine – I didn’t make any money over there, but at least I always was first, among first … not the very first….

… I thought that people come to America to start a new life…. I thought that I was too old to start over … although I experienced so much hardship in Ukraine just before my departure because it was so, it was Gorbachev times. Maybe he’s very popular here, Gorbachev, but over there he was not. Because during the time we had – it was nothing on the stores, the shelves, they were empty. All the factories and plants started to close. Now it’s a bit better…. So I thought it was too late … I was feeling that it was too late to start a new life. I was not looking forward to anything much....

*Transitioning to New Roles*

In addition to transitioning to life in the United States, and transitioning to new roles, the midlife women all reported experiencing bodily changes either
related to the aging process or to the onset of chronic illness. They reported that they continue to care for the home, aging parents who migrated with them, and often small grandchildren in addition to working outside the home.

Caterina stated,

… I have mama here and I have mother-in-law here, and I am busy…. They go to doctors and treatment. And everything they need. Sometimes I think of how my father died, 86, in Russia. He was very sick with something his heart, something. I don’t remember. And I sometimes think, if he was here, maybe he live….

Evgenia, who cared for her grandchild, noted, “… But it’s very hard being with her [grandchild] all day…. I don’t remember that it was so hard with me with my own children….”

Fekla described her concern for her aging mother:

… she [80+-year-old mother] was very active person all her life. Very active.

And, ah, now she doesn’t know where to put energy. So she feels very lonely … they didn’t want to leave Russia. It was a problem for us…. Actually, she almost deaf … so, she can’t communicate with people, you know. It’s difficult. No one wants to talk to her. No one have the patience. So she calls a lot of time….

Nearly half of the study participants reported that, although they care in some way for their aging parent or parents, the latter live in their own apartment or house. Galena stated, “…he [80+-year-old father-in-law] lives in different home and we prepare for him sometimes food….”

Hanna described her routine of caring for her aging parents:
… it’s just five minutes by car for me, even less … we keep in touch … every day … the problem is they … don’t … go to store. I have to bring food for them … the most difficult thing for me is … I have to … bring them to appointments … they need a lot of appointments with doctor and I have to accompany them.

*Learning New Survival Skills*

In order to make the transitions needed to survive in the new land, the women all realized that learning English and obtaining new job skills were essential. They also realized that the right attitude and willingness to seek support from resources available to help them were essential to their success.

Nadya stated, “… knowledge of English, the willing to get some education here, to learn new stuff, our friends, the organization which has supported us to come, and, ah, the good attitude, the good feeling, you see, the feeling that everything fine, perfect.…”

The women reported that the English learned in the FSU was British English, a source of frustration to them when trying to understand American English. Bella summed up the frustration she encountered:

… Oh … that was the main problem…. I was learning English in Russia … I learned British English, not American English. It was main problem. I was able to … talk about everything, so, I knew English, actually. And, to actually, to read, to talk and to explain myself. I did not understand the words that the Americans said at all. I did not recognize the words. I did not recognize the … the accents and dialects actually. So that was the hardest time … I can talk, but they don’t understand you because of my other problems, because, you know, your accent; you’re talking in different language, so that was just, that was the main problem …
I can’t understand most people from Texas … My God! They are just mumbling all the time, it’s, it’s unbelievable … it’s just this is dialect problems, I don’t understand other people from New York.…

Dasha conveyed a similar experience:

… I learn English in school, in the University. But I come here to different English … British … I had one customer, and she come in and we just talk about something. And she had like a very heavy accent, think she come from Europe, you know, like maybe from Poland. Maybe something like this. And when I ask her, she say she come from England, from British, I was so surprised. It’s so different....

The women often reported that they learned English more quickly and with more proficiency than their husbands.

Evgenia related her experience and her explanation for the differences in learning:

… because it was a very stressful situation, because I did not know what, what should I expect, expect in new country in my age. What will I do without language, without anything, without money? ... I learn in high school and couple months before I came here, in couple months. But, when I came here I understand, understood, that it was not enough…. It was the same language, but it’s just more. I did not understand anything. I can tell some word, but I cannot make conversation and I did not understand anything. I cannot understand conversation, and I did not understand completely America. And I had people who know English more better than me, didn’t understand here, too, for a long time … it’s the hearing, the pronunciation … but I am study English in here – I go
right now to a couple times a week … use watching TV … for improving English. But my husband, he watch TV the same time like me, and his English is very bad, it’s very bad. It depend on different people, different kind of brain….

Although the women attended formal classes for language and job skills, many of them reported that they were self-taught. Bella stated, … But I can’t remember anything bad, I was thinking about it. You start a new life; a new page…. You need to do whatever you can to get whatever you wish … I taught myself, I just bought some books. I taught myself, what does it mean, and started to look for a job as a programmer…. I’m teaching myself, consistently, actually…. Learning to drive was described as a challenge for all the women, but seen as a necessary skill for women in the United States. They all shared that the possibility of owning a car in the FSU had not even been considered.

Nadya described her experience of learning to drive: … I wasn’t afraid to learn new stuff. And my husband was eager to learn new stuff. We never had a car for a year here and we, ah, walked and we took public transportation and we get better knowledge of the town…. And Evgenia described her experience thus:

… He [husband] has heart problem … maybe it’s not enough adopting this, another language. But I try, because one person should know English in the family, because without, when we came here it was terrible … [our children were] so busy every time and … we should count on ourselves…. I decided I should study English as good as possible … because we did not have car and even not
dream about it. But when we came here, my son said, if I want to be comfortable in America, I should study how to drive….

The women all expressed that they experienced self-confidence in gaining life skills. They attributed their ability to learn quickly to having had the experience of being an educated professional in the homeland. Making the transition by learning new skills was described as taking small steps and being persistent. Bella stated,

… just you do something, you can move just very small steps, and each step might be a big thing for you, so you just know, okay, now I can do this. What else can I do? … ‘cause I have more experience, some things I can learn them fast, much faster….

Nadya described her experiences learning to use the computer, learning to drive, and convincing her older father that she was a safe driver.

… I never touched computer. I know how, I didn’t know how to turn it on. I could see it, but I never looked at it. I saw it, ah, in school. And the people, I couldn’t even, I don’t need it. Why should I go and look how to turn it on? So I start to use computer here. We never drove in our entire life. We never had a car. In a year we realized we cannot manage here, we cannot live here without getting a car and know how to drive. We came through this. So, some of the people still not driving, because they decided 45 was too late. I will let my husband to learn how to drive. But my husband told me, I’m not going to go shopping with you. So, and stay in an hour in a car … if you want, you have to know how to drive. So, he pushed me and we studied, we studied, to learn how to drive, which was also like an adventure. And I remember that somebody brought us to Monroeville
to buy first TV in a store. And they have to use highway, and they have to use different kind of exits. And when I was looking at all these crazy exits and everything, I just pledged to myself, I will never drive. Never…. So, this was the feeling. I will never drive. I won’t be able to sit in the car. Especially, ah, my mom actually was killed in a car accident…. And when I told my dad that I am driving he was getting crazy. He told no, you can’t do this. You can’t do this…. They came … three years after us. So, and he was really scared to get in the car … at time I was driving, now. Then he realized that I’m a careful driver, I’m a good driver, I’m a careful driver. So he was able to do this….

If finding a job was not possible, several women reported that they volunteered in order to practice using the English language and to gain practical experience working in the American culture. Galena stated:

… But when I came here, like a wall between me and this language. And I so afraid about it. This is my big problem. Maybe I can teach, ah, study something and I can, ah, I want to find, ah, I was looking for job and the research, in university. I was … a volunteer….

During the interviews, the women spoke in English. If the phone rang, they sometimes initially spoke in English and then changed to Russian or vice versa. Bella explained how she found that she continued to speak in Russian on the phone and to other Russian-speaking women, but changed to English and sometimes a combination of both English and Russian at the workplace.

If you are talking in just job-related things, I am talking in English and I’m better. Otherwise it’s so awful mixture of Russian and English. Worse, because I don’t
want to translate from English … just into Russian. Even some terms, I have no idea what they are in Russian. So it’s a mixture, if you’re talking to Russian guys about job-related questions, it’s just a mixture. It’s better for me to talk in English.…

*Coming to Terms with Migration Experience*

Although migrating at an older age was described as being a challenge by most of the women, they expressed that they were happy with the decision. Hanna stated, “… I think everyone was so stressed, and of course it’s affected their health. A person should be strong to do it [to immigrate]…."

Nadya said,

… Oy, with immigration, it’s so hard for our age. People should immigrate when they teens, I don’t know, teenagers…. Thank God we are here…. Now [after 10 years] my husband tell me that he in his life… two best things … two right things … he married right person and he moved to the United States.…

Evgenia stated, “… I’m so happy here…. If I have my age twenty years minus, I will be better [laughs], I will be happy…."

*Onset of Chronic Medical Conditions*

All the women in the study reported that they had experienced the stressors of migration, and nearly all of them attributed these stressors to age. They expressed that the stressors of age and migration had affected their health and caused such changes as weight gain and/or the onset of chronic diseases such as diabetes, hypertension, thyroid disease, decreased vision, and depression. Since migration, two women self-reported that they had undergone surgery for a nonmalignant breast condition and one of the women
reported that she was treated for breast cancer. Seven of the women self-reported that they had undergone testing and treatment for thyroid conditions since migration, including one for a confirmed malignancy.

Katya stated,

… stresses, stresses, stresses…. And I got, I think, I got blood sugar [diabetes] just from stresses…. Ah, blood pressure, headache. When I was 50 I don’t, 54, I didn’t have that. That’s age. Now, America, Russia, it’s … age. Age a lot of, ah, you know, immigration for our age, it’s not good…. It’s so hard. It’s our choice…. Life is changed….”

Nearly all the women reported exhaustion and fatigue as interfering with their ability to take of themselves and participate in physical activities. With regard to exhaustion, Caterina stated:

… Very bad, I take care of myself. I understand I need more probably walk outside, exercises. I know this. I know already what to do…. But I don’t have time like my... husband to go to park, swimming. More time in summer, but now too cold … is very cold. But for me … don’t like to go park. If I go, I go just for him because he want me to go. And for me this is not fun…. I’m so tired. I don’t know why. But I don’t have fun. For me more fun if I’m reading … lying down … if I go, I don’t know ... I don’t like stores. I need go, but I don’t spend a lot of time in stores, I don’t like. I like it more lay down than anything … I cannot feel for 25… if I ready to turn 50. [laughs] I'm so tired. I'm more tired than two years ago….
Evgenia described why she was tired: “… I care for baby [grandchild] … I'm so exhausted….”

Galena, describing the depression shared by many of the women, said:
… just a little bit. I am lazy for this, if it’s true … I get so tired … I am working one time in the morning from 6:00 to 2:30; and one time from 2:30 to 11:00…. And between these I have to care for my home and cook and everything…. We … I don’t know how to say … about depression. This is very big problem because they change everything and it’s very hard for them. And they need help with, to get used to this land. And to help them. Because sometimes you can’t help yourself….”

Fekla described her migraines:
… I have migraine for many years. But when I came here, I remember for a couple of years it was much, much better. I don’t know why.... And now it become worse again. Maybe because of my age, I don’t know. Probably…. You know what, I think everyone was so stressed, and of course it’s affected their health. A person should be strong to do it [to immigrate]…. 

Chronic musculoskeletal pain was reported and attributed to aging by several of the women. Galena attributed her pain to age and migration: “… I did not have problems with my joint like now … now I have problems with my feet. Pain in one, here, and I could not walk a lot.... Because I can’t stand without uncomfortable situation or strong pain….“

Evgenia explained,
… ya, but I’m 61 and not 35. I don’t know how this affects my joint, my back, shoulders, my knee, every my joints is bad…. I think that arthritis it’s very depressed me … because it’s pain, chronic, chronic pain the whole time. This is my major problems. But I used this pain and what should I do, I don’t have choice … my husband has chest pain but it's more dangerous, but, ah, it's not annoy at him all time like this arthritis annoys me. I cannot walk, I cannot make, ah, some, some job that I want, physically, physically….

“Changing Inside”

Aging past 50 was identified by Caterina as a time of “changing inside.” In fact, the majority of the women interviewed reported that they had experienced the cessation of menstruation, the onset of chronic conditions, and weight gain as part of aging in the United States. Caterina related that, in the FSU, women did not receive medical treatment for menopause or have blood tests to determine menopause. The conflicting reports from the medical community in recent years regarding hormone treatment, along with advice from their mothers and friends, had resulted in much confusion for several of these women.

Caterina stated, “… I feel my age…. It's not true when people talking sometimes, you feel like you feel, like you young, you feel young. This is not true. If you 50, you feel 50, and you cannot feel for 20, uh, uh…..” Katya said, “… I became too older and I have more, not more health, not good health…..”

According to Galena:

… Yes, but here, maybe I was in another age…. Maybe these people like my age right now I think it’s very old. [laughs] And I did not think that a lot of people, a
lot of women have breast cancer, but here I hear a lot of this breast cancer, I think….

Caterina described her experience with cessation of menstruation:

… I have problem, right now it’s like change my life, but I don’t have my period. Last time three months ago, I don’t have my period…. I go to doctor’s office. He’s told me, this maybe start of menopause. Maybe not, he don’t know this, because when we take it, test, hormones, test, hormones. This is one time. Second time, it’s second, because this is different – the blood test results…. They don’t know, but if not, three months. You have to take hormones. Like you need, take it, this period again. Why? If not, I don’t want period. In Russia it was different. If you don’t have period, it’s okay. This is start, you’re okay…. This is just start, everybody knows. Forty-nine years, today it’s three months no period, and second three months you can have period. This is, like, change. I can’t understand why you have to take it period…. I can talk about this with my friend. Also doctors, too … I'm very fat, you know. And I'm not eating a lot…. This is not for eating, this is for age. Because there hormones – I am changing inside … everything okay. But I'm fat….”

… I cannot understand there, thirteen years ago, hormones was what all doctors told us. Not hormones, not hormones, not hormones ... all my life, from mom…. But here I just, no, just hormones. There was not hormones, then yes hormones. I understand this is not very good for a woman…. Some doctors say, yes, you can use these hormones. Second doctor, um, I don’t know; maybe yes, maybe no.
Some doctors say it’s okay, if you take it – it’s okay for you. What’s the difference, I can’t understand….

The transition into menopause was identified as a sign of aging, and the onset of chronic conditions was expressed as an acceptable expectation of aging. Thus, Caterina stated, “… Well, everything's together. Everything together. My eyes. My head…. Age. Anybody who 50 years old, this is change….” According to Galena, “… when I get older and older, you know, I feel some problem with my health. First I recognize what I have, high cholesterol….”

Hanna reported, … You know, as an older person, I have pain. Here and there, but actually I don’t really pay any attention and, ah, I try to keep myself moving. I try to walk. I try to work on it, my health. I, ah, thank God, I didn’t have any serious problems here. Yes I got a surgery. I got a surgery. I got cyst in my breast….

Katya observed, “… I became too older and I have more, not more health, not good health….”

The women attributed weight gain to the different foods available in the United States and also to age. According to Caterina,

… This is just aging. I was very skinny. Very, very skinny…. Right now I'm fat… and I'm not eating a lot. Yes, I like it. I like it all, candies, cakes, right. But anyway I'm not eating a lot, okay. And I'm fat. Why? This is not for eating, this is for age. Because these hormones – I am changing inside … everything okay … but I’m fat…. I’m very nervous because I don’t like fat people….

Bella described her reaction to her weight gain,
... I started to think … three years ago I understood that I needed to do something
... I’m gaining weight ... yes, it was a marker for me that something is going
wrong and I need to analyze what’s going on, and take care of all that stuff….

Evgenia described her thoughts on her weight gain in the United States:
... I don't know if, ah, about obesity? It's many Russian people when they came
here gain weight here…. I think it’s something wrong here with food ... because
Russian people, if I spend life in Russia, I cannot eat more here, oh I have the
same amount. My stomach used to this amount of food, but different food. I don't
know, maybe it’s something chemical, something hormones. I don't know why,
but everybody gain weight here … if you were in Russia, this wouldn't have
happened, but here in the United States, weight gain. Ya, I don't know what it is
... I think it's connection with food. They preserve food for spoiled and this
chemical, maybe something, I don't know…. 

*Concern About Past Environmental Exposures*

As mentioned earlier in this chapter, the women reported that they were all living
in the FSU when the environmental nuclear disaster occurred at Chernobyl in 1986.
Reference to the radiation exposure caused by this incident continued to resonate through
the interviews with nearly all the women.

Raisa described her experience:
... they always talk about it. My father says, he writing letters to me, I see so
many young people, so many like, I read a lot of newspapers how long people live
in the United States, in other countries, here people die by 50-60, even younger
people. I don’t know why it’s like that, maybe because of Chernobyl, but in the
newspapers – Chernobyl really, really makes you, many sick people – I don’t know. Maybe I don’t feel it now, but affected most of the people….

Evgenia described her experience of living close to Chernobyl during the time of the disaster:

… different women have different, has different problems. I know that many women has arthritis because, especially from Ukraine, because we think maybe it’s not right that after children are born, it’s influence maybe for our problems, for our bones … because we live from ‘86 to ‘95 in Kiev, and Chernobyl like sixty miles from Kiev…. Maybe this is problems. And many women has, I know that my close friend has, the same breast like me, the same time. Different two weeks … it’s the same. And I did not hear in Russia so many breast cancers. I did not meet these people. Maybe this breast cancer it’s spread in another part and people died, but here, I, ah, I met these people more often than in Russia that’s cured from breast cancer. I don’t know…. Or, ah, maybe here it’s more hypersensitive of cancer than in Russia. Maybe in Russia we did not know good diagnosis…. I did not know about so much breast cancer in Russia….

Theme 5 – Trusting Self

The women expressed a lack of trust in health care professionals and health-related treatments both in the FSU and in the United States. In the homeland, they relied on themselves to seek out information and to know about diseases and when medical care was essential for survival. Trusting oneself to make decisions was important to the Russian-speaking women in terms of self-management of health. The women observed
that American coworkers did not seem to use common sense or to trust themselves to
solve problems and make quick decisions in the workplace.

Fekla described her impressions regarding decision making in the American
workplace thus:

… I don't know it's culture or not. I know from my work … I work with people …
they have a lot trouble and they came to me with all kind of trouble … sometimes
they come if they just have questions and what I do all the time. I don't think what
to do and they go here, there, and I find something for them. And when I talk to
my supervisor she always would tell me okay, we'll bring up this question in our
meeting. And in this meeting they will talk, talk, and talk, and there is no solution,
and there is nothing to do, nothing gets decided, and nothing gets done…. So,
sometimes I even don't bring up. I just do it … you forget how to think….

Bella made a similar observation in regard to her experience with those having
difficulty making decisions: “… it’s just common sense sometimes….”

The women did not freely trust health care providers or follow their advice
blindly, as they perceived the American-born did. Evgenia, for example, described her
observations of differences between Russian-born and American-born in regard to
trusting physicians: “… I don’t trust … usually, different between Russian people and
American people, that American people trust doctor … and follow advice … interesting
about them. We did not trust anybody in Russia.” [laughs]

Bella outlines her impressions of why Russian women chose not to seek medical
care:
… People are trying to fight the diseases themselves. That’s why over here Russian women are not coming to doctor’s office … 80% of them already know how to treat their diseases, disregarding what doctor will say. This is not because they know everything much better than the doctors. No. It’s kind of self-defense issues that they brought from Russia, because if you do not understand how to treat yourself, there is a good chance that you will die. So it’s very, very different system. So when Russian come to doctor over here, they almost always already know what they need and how to treat their disease. They might not listen to the doctor over here, and it’s not because they think that they are much cleverer than doctor, no…."

*Seeking Knowledge*

Two of the women who self-reported that they had been diagnosed with a malignancy since migration reported that they had done reading on their own about cancer and cancer treatments. In addition, Russian-speaking health care providers were used by Russian-speaking women who were concerned that they might not comprehend all the issues discussed about health or a specific medical problem or treatment. The women reported that they did not always follow the advice given to them without seeking information from other Russian-speaking health care providers referred to them through friends.

Seeking information about a diagnosis was reported to be commonplace both in the FSU and in the United States. Physicians whose first language was Russian were reported to be sought out for discussion of questions related to new diagnoses and treatment options.
Nadya explained:

…. I’m getting older and I’m trying to go deep in what is going on, what they’re telling me. I need to get all information. I realize that I can get a second opinion. I can see that can be different, this second opinion…. I want to get as much information as I can get and compare this information and to get this information from different sources … nobody could get information in Russia from Internet when I came – there was no Internet – we can go to just regular encyclopedia and to check something. So … here if the doctor telling me something to do, I’m trying to get a second opinion, or my primary doctor who can speak Russian can go into details with me. And I’m asking him a lot of questions, and I trust him and I can discuss it. Or if it is a possible way to find a Russian doctor as a specialist, I can go and get detailed information in Russian, because I’m afraid that I’m not, I can miss, even assuming that I am speaking good or whatever – I am afraid I will miss some detail which can be important. … for me, I’m trying to get as much information to be absolutely clear what’s going on….

Evgenia, who reported that she was recently diagnosed and treated for breast cancer, stated: “…. I read more information about this ... now I know all this information about curable and not curable cancer and, because I met this problem.…”

Fekla described her experience with a newly diagnosed thyroid condition:

… I have problem with my throat [pointing to the region of the thyroid] … surgeon told me I need surgery. And then I went and I saw endocrinologist, he said, no, we'll wait. And when he found out – he told me, you need the surgery, and I didn't know what to do. So, my daughter and I went to see a friend who is
Russian endocrinologist, she's in Baltimore, she told me, don't do anything. To me she was right, because in a year I checked ... it was fine...

**Negative Experiences**

Nearly all the women reported that they had had a negative experience with American health care providers. Lack of caring was frequently perceived by the women, as well as rudeness by office staff and physicians.

According to Bella,

... I had a really bad experience with health care provider ... I had pneumonia, was sick, absolutely high fever; I had to go to doctor. And they forgot me in the office.... I had to stay there for two hours. And I was so sick; I was not able even to get on the chair, to get into the corridor to tell somebody what’s going on.... It’s not the cultural issues. It is how do you care. So I will never go to that provider again. Period....

At least six of the women reported that they felt upset that they had to wait for an appointment and could not be seen the same day by the physician. According to Dasha:

... one time my daughter, she have some red spot on her skin, and I called the doctor and, you know, I was rather afraid, what is it? And they think, you know, we can’t take you today; we can’t take you tomorrow; maybe we [give] appointment after two weeks. And you know, I really was upset.... [In FSU] ... today I have a problem, I can go to see doctor today. And here is a problem, I have to make an appointment and I would see doctor in a month....

Less than positive experiences were attributed by nearly all the women to the language barrier. This was also perceived by one of the women as creating an inability
for the Russian-speaking woman to experience her full rights as a patient. Hanna described her negative experience with breast surgery:

… I had a bad experience in my breast surgery. I went to doctor who …. made a cut near, next to the cyst, not directly. He didn’t cut it off…. I remember I felt something wrong, I see the cyst. I see cyst and I see scar near the cyst, but cyst is still there. [laughs] … And I came to him and I tried to delicately say to him, you didn’t cut off my cyst. Probably, maybe, he didn’t understand my language, but he say, it’s okay, everything is fine. We can do again. We can do it again, another surgery. And you know, he cut off, ah, I would say a lot of, massive, um, space, body, a lot of my segment from my breast … it was absolutely awful, because it was a very small cyst and he made it … maybe I have to sue him, but you understand that people who doesn’t speak English enough, they just cannot … use their rights…. If it was in Russia I would, probably, I would sue him. Of course I would do. But here because I, I kind of rightless person because of language, I didn’t start anything. But I really wanted to, I really wanted to…..

These less than positive experiences resulted in a hesitancy to use health care services by more than half of the women. Hanna stated, “… since then I kind of avoided American health system. Not whole system, but some doctors. And he is considered a wonderful doctor, actually. My cousin recommended him to me…. It looks ugly, and I feel hesitating to undress…."

Several women spoke of their distrust of American physicians related to communication issues. Evgenia, for example, stated, “… first couple years, you know,
one year, we go with translator…. It’s not good, because maybe, ah, something I did not understand translator did not understand….”

*Health Care Perceived as a Business*

One of the reasons for distrust of American health care professionals was the perception by most of the women in the study that medicine is a business and physicians are focused more on making money than on caring for people. Dasha expressed her dislike of American physicians: “… I don’t like American doctors … sometimes they thinking just only about money … he just look me and say, okay, I understand everything, you can go…” Fekla mentioned the dilemma of making a health decision based on a business model: “… Because, you know, Russian people say medicine in the United States is a business…. It’s difficult to make a decision [about health] not based on a business decision….”

The high cost of American medical and dental care has resulted in an increase in travel to the FSU for care, which is often less expensive than having the same procedure done in the United States. Dasha described the practice of going back to the homeland for surgical and dental procedures found to be too expensive to undergo in the United States.

… the Russian people, they go to the Russia … I have friend, he have some problem with his teeth, and the doctor [in the United States] say he must … get it [a root canal] … cost around $800, and my friend just bought a ticket to Russia… [in order to have the dental work done less expensively in Russia]…. Who can afford this? It’s amazing price. I don’t know. You know, interesting, nobody thinking about it. It’s really nobody thinking about it. Looks like nobody see these
people without teeth – I don’t understand it…. I don’t have friends, you know, who can afford it. It’s amazing, these prices….

Belief in Natural Healers

Seeking treatment from a natural healer was described as commonplace by the women. Even though they described natural healers as outlawed under communist rule, the women admitted that the citizens of the FSU often learned of natural healers through word of mouth and sought their care. Fekla described her experience: “… I remember, my father took me even once to some person who healed by his hand…. It was actually prohibited … it was illegal….”

Fekla also told how her mother, in her 80s, who lived near her in the United States, recently sought reading materials published by a natural healer she had encountered through Russian satellite television:

… My mom found a person, I think on Russian TV, I don’t know, she believes this … she reads books and she does everything he wants her to…. But it’s look ridiculous to me … she calls everywhere, New York Russian store, and they sent her these books … she called my friend in St Petersburg … I don’t know how she found the phone number … in Russia! She called her cousin in Moscow if she needs something … she gets it … she is a very strong person….

Fekla expressed her belief in the power of healing through energy transmitted through others by touch and sight. She explained that she does not believe in the current healers who are no longer outlawed in the FSU and who claim to be able to heal remotely as through the television set.
You know, I believe in people’s energy from hand, even eye. And if a person is very kind and very good and want to give it to someone, I believe this. But now it became very ridiculous…. People do it through paper, through TV, through whatever …my daughter has a friend who is in medical school who took a class in healing touch … when she’s here, they would call close friends … she always does it for myself … and I love it … it’s hands … I think she will be great doctor … this energy from her … I think she can just do miracles…. [In Russia] you could never read about it …wasn’t advertised – just from each other….

*Pharmaceuticals as Chemicals and Poison*

Lack of trust of pharmaceutical care, or “chemicals,” as described in the majority of the interviews, was also commonplace. Pharmaceuticals were considered “poison” by nearly all the women. They felt that, in America, Americans considered a doctor to be a good doctor if the doctor gave the patient pills to do the healing. In contrast, in the Russian culture, a doctor was considered a good doctor if he or she did not use pills to do the healing. Nearly all the women reported that they had their own home supply of medications, a source of home remedies, and access to medical and pharmaceutical, as well as natural healing reference materials in both English and Russian. Raisa stated, “…heal with pills…. It’s problem, I think, in America. Because …surgical industry and medical industry are related to each other and it’s not right. In Russia, if the doctor is good, he will give you less medicine. He will try to do something else. Here, opposite. Here, pills…” Fekla offered this explanation: “… maybe because [Russian] people understand all medication is poison….” Hanna voiced her fear of prescription
medications: “… for me, just pills seem like a chemical thing and I afraid of some of them….”

Nearly all the women in the study expressed that they had supplies of healing agents in their homes. Dasha explained, “… I always have something [medicine] at home....” Katya reported, “… I have big pharmacy at home in my refrigerator....”

Managing Own Medications

Nearly all the women reported that they often stopped taking prescription medications or adjusted the dose on their own after reading about or experiencing side effects. Galena explained:

… and then I, ah, one week maybe, I started regular dose. At night, I thought I would die. It was so strong heart pain. It was, I could not sleep. It was so exciting, I don't know what it was, but I stop this medication. Because I read what some side effects, it’s like heart thing. I went to my doctor and I told her and she said, okay, don’t take. Stop taking....

The women also reported that medication was not taken or stopped due to the belief that the disease would run its course and the person would feel better again in time. Bella shared a joke she had heard in Russia:

If you have something ... it’s okay, it doesn’t matter. It will go away. You know there was a joke in Russia … the nose will stop running in a week if you do nothing. And it will stop running in seven days if you take the medication....

Deciding When to Seek Care

On the other hand, women did report that they would consider going to a physician as they got older more so than when they were younger. Bella explained:
... When I was at University in Moscow, we had the doctor who was it responsible – was like, 2,000 students over there, and I did realize over here that this doctor, she was really wonderful, because for the doctor in Moscow, the students were under 25 years old. And the students were in good health and they just survived with little need for a doctor. They can survive. They still survive. So, when I came here, I was not thinking about the doctors as, you know, like I really needed one at all....

Nearly all the women reported that health care would be sought if pain out of the ordinary was experienced. Galena summed up her reasons for seeking care:

... I go if it’s a strong pain, or I feel that I need to go ... I know that I have to go.... It’s not that doctors tell me I have to go. Sometimes maybe, you’re right. But, ah, usually I go when I feel I need to go.... I don’t like medication, to take medication. And, ah, when doctor recommended me, I tried to figure out what is this medication, how it will help me. And sometimes it’s my fault, but I don’t take it because I understand that it’s not so necessary at this time. Maybe it’s bad, but I don’t like....

According to Hanna, she would go to seek care under the following conditions:

“... to relieve some pain ... something unusual happen to me, would never happen to me before, for example, like, ah, unusual pain, unusual tightness, something unusual....”

*Self-Care as the First Step to Healing*

Nearly all the women reported that a belief in self-care was an essential first step in the healing process. Self-care with home remedies learned in the homeland and from other Russian-speaking women was reportedly used frequently. According to Fekla, “...
do what you have to do to take care of self first…. We have to help ourselves…, usually they just people talk to each other how to heal something…. “Katya stated, “… I think people can by yourself do anything … anything…. If you want, you can do it…. If you want to live, you can do it…. “

Hanna described in detail some home remedies she had used:

… we used our home remedies lot of times … we used the medicine which they give us, of course. But most the time … we used our home remedies like … like honey and hot tea, hot milk. Lemon with this honey for cough. So, I know a lot of remedies … if I have a cough, I use hot milk. Hot milk with, ah, teaspoon of honey and soda. Little bit of soda…. I gargle with iodine. Cup of warm water, few drops of iodine … teaspoon of salt, maybe half of a teaspoon, not whole, salt and soda…. Gargle. It helped a lot…. So we, you know, I really don’t trust chemistry. I, before, using home remedies. I still do…. All same things, I think. But what I know, what we learned from Russia, we still use here … for pain, ice…. It depends on where pain is….

Use of Russian Natural Herbs

It was not unusual for the women to report that they ordered natural herbs, roots, and cosmetics from Russian catalogs. For example, Katya stated,

… I have a lot of catalogs from Russian pharmacy … in New York…. It’s English translate, you can see Russian text, American text, it’s for description … it’s from food. From good food … from root … for cholesterol…. I took this … root … is good for sugar….
And Galena stated, “… Because when I came I took Zoloft … it doesn't work. I stopped
this … medication. I just take [uses Russian term] roots….”

*Aging and Concern for Vitamins*

The women reported that they had more of a concern about the need for
supplemental vitamin and the need for knowledge related to health care as they became
older. The women expressed that they believed vitamins to be chemicals just like the
prescription medications. Hanna stated, “… But, you know, the older you getting, maybe
it’s bad for you to take some vitamins. I don’t know, I don’t know about this. For me, just
pills seem like a chemical thing and I afraid of some of them…”

*Openly Challenging Treatment Plans*

The women nearly all reported that they did not always follow the treatment plan
of their physician. They were not afraid of openly challenging the treatment plan.

Katya explained:

… I have books. I have a lot of books … American family medicine…. It’s
translated into Russian…. I know what I’m taking … if I see it’s not for me, I’m
not gonna take…. Because I read side effects…. So, okay, he gave me medicine.
When I, when I read side effect, I said no. I said no … I start on diet, ah, maybe
six or seven months, I lose, let me see how many, about twenty-five pounds…. I
had exercise, I said no. I said if I want to, if I want to live, I can change my life ...
so one week, I made exercise, I no sweet, I no eat sweet, I no eat nothing. I feel
good. I feel good again....
Knowledge About Staying Healthy

These women were knowledgeable about how to stay healthy, healthy diets, and exercise. At least three of the homes had exercise equipment such as a treadmill in sight. Nearly all the women performed some type of daily exercise such as walking. However, exhaustion was the most common reason given for not exercising. Katya stated:

… When I’m tired, I don’t think about exercises, but of course we need. I understand what we need, to walk a little bit. To walk, the gym, or something … I read. I try to find something how to care … of course, if I have time to go, I’m a little bit lazy for my health, how my friends say, you nothing to do, to do, um, yourself better. I can read, but I don’t go to the doctor. But if it’s, as I said before, if I think that I can’t stand, then go to the doctor … I think for keep healthy, need more time than I have.…

Bella reported that she strives to avoid health problems: “… I can actually do my best to avoid some problems….Well, I see myself healthy. I might not be, but…."

Theme 6 – The Importance of Hope

Hope was mentioned by nearly all the women in the context of a better future as being an important reason to migrate; they also emphasized the importance of not taking hope away from a person who had been diagnosed with a malignancy. In the FSU, discovery of a malignancy was reported by all the women to be considered fatal.

Hoping for a Better Future

In regard to the decision to migrate because of hoping for a better life, Raisa described it as follows:
It can’t be worse … than I have in my natural country…. I am thinking it will be better … it’s not possible to be worse. I hope for this and I think I will be more successful here…. I was hoping for something better…. 

According to all the women, cancer was a diagnosis feared by most of them. That is, diagnosis of a malignancy in the FSU was described as being associated with no hope for cure and a promise of certain death. In order to maintain hope, the women reported that patients in the FSU are not routinely told if they have a confirmed malignancy. Only family members are told. All the women in the study reported that routine health screening in the FSU was considered by the Russian people to be “just looking for trouble.”

**Withholding the Diagnosis from the Patient**

In Russian culture, according to all the study participants, the diagnosis of cancer was not shared with the patient in order for the patient not to lose hope. Thus Bella explained,

… If you have it [cancer] … it’s like 95% you will die … like stage four, just doesn’t matter, right …so do you want to know that you have to live like a half year? … I don’t know … do I want to know, I have no idea … but not to know about it …will fight it….

Fekla further clarified:

… in Russia, doctor will never say person if a person has cancer, for example…. Why is it? I think it’s, ah, right. Because, someone told me about a relative, she was, I mean, he was not bad, that she was, she functioned. She did her duties, and when she found out, she came home, lie down in her bed, and she never stand up.
And she died…. It’s [cancer] almost synonymous [with death], yes.... Ya. It’s very strange for us …you have to learn to live with this…. Who knows, it’s difficult to say what’s wrong, what’s right. It’s just different....

Galena explained:

… And for our people, you don’t used to this. And it’s very bad. In our country it was as a law, don’t tell people that he has cancer or something. I think, for maybe it’s better. Because you don’t worry. It’s good maybe when it’s first step and you can do something. And when you cannot help and you know that you’re dying, it’s difficult…. We tried to keep him not to know. It difficult, of course, because you know and you have to make yourself, ah, to spend time with him the same as it was, but it’s very difficult…. The study participants explained that not sharing the diagnosis was equated with giving the patient the chance for hope. According to Bella, “… You know, as far as you don’t know − there is some hope … if you know that you will die in half a year maybe … you won’t fight against something....

Caterina observed:

... Doctors say everything, but just not with cancer [in the FSU] … I know one woman ... she’s cancer. Who knows how long she will live? Nobody knows. Relative [who is a] doctor say, yes ,you have cancer, you will die. This is not, my opinion, this is not professional. Doctor knows about this, it’s okay. Doctor tells just relative, mother, father, I don’t know. Children, but these people don’t have to know about it. This is, like, I cannot understand why doctors have to say....
Cancer as a Diagnosis to be Dreaded

The fear of cancer was attributed by the women in the study to the high incidence of cancers in the FSU resulting in death. “Not knowing” is felt to be better than the potential diagnosis of a malignancy, which is equated to hopelessness and inevitable death. As a result, routine screening for malignancy is not done by most Russian-speaking women. Dasha explained,

… It’s because we have a lot of cancer, you know, in the last study, ‘cause people don’t want to check something. Like here they’re saying you must check, like breast exam every year. Just, if you go to Russia and ask the Russian women if they have this check every year, they just were laughing, you know….

Nadya talked about “not wanting to know”: “… sometimes I feel that the people who don’t go to the doctor maybe can feel that they’re healthy, because nothing was wrong with them so far. They don’t want to know….”

Experiencing Cancer in the United States

The experience of being diagnosed with breast cancer, recently discovered by accident and treated in the United States, was described by Evgenia as not being as frightening a diagnosis as it would have been in the homeland.

… But in Russia everybody thought that breast cancer … fatal. Yes. It’s fatal …yes. Here people can live many years with this … more, I read more information about this, because, ya, now I know all this information about curable and not curable cancer and, because I met this problem…. My friend also has breast cancer … It’s the same. And I did not hear in Russia so many breast cancer. I did not meet these people. Maybe this breast cancer, it’s spread in another part,
and people died, but here, I, ah, I met these people more often than in Russia that’s cured from breast cancer. I don’t know…. Or, ah, maybe here it’s more hypersensitive of cancer than in Russia. Maybe in Russia we did not know good diagnosis….

Seeking Care Only When Ill

In the homeland, the study participants noted that they did not go to the physician unless they were sick. Tatyana stated “… that it was considered shameful to go to the physician in Russia if one was not sick.” In the United States, in contrast, the women agreed that they understood that they were encouraged to go for annual routine examinations. More than half the women shared that they did not participate in annual screening. One reason expressed by Hanna was that she was too tired from taking her older parents to physician offices for routine appointments and sitting with them during hospitalizations to take care of herself:

... you go to doctor just when sick – when you’re not, when you, ah, healthy, no…. You go to doctor just when you’re sick. Here, I know we have to go to see the doctor when you are feel okay, just for checking. But it’s not in our custom, so I have to make myself to do it. … I know …you have to go, but, you know, I so tired of taking my parents … to doctors … I’m so tired. And even cannot see any doctors – I have seen so many … hospitals. I know it’s not right. I have to and maybe I will go soon, but, um, I push myself too hard. I don’t go actually. And last time I saw doctor, few years ago, I saw a specialist but I did not saw my physician….
Screening as “Just Looking for Trouble”

To seek care when one is not ill was considered by nearly all the study participants as “just looking for trouble.” Bella stated, that if people are looking for a problem, if they do not have one, they will eventually find one.

Although six of the study participants reported that they followed recommended health screening procedures, the remaining women declared that they would not consider going to a gynecologist or a dentist even if they had insurance, unless they had an illness or a dental problem causing pain. Tatyana reported that in the FSU she waited until the later months of pregnancy to seek care, since she felt good: “…When I was pregnant, I felt good, so I didn’t go until I was about 5 months pregnant....” Nadya explained that Russian people preferred and actually did go to the doctors when not feeling good:

… people never ... go to any gynecology doctor or to any dental providers or any kind of tests if they don’t feeling that they have a problem … something is wrong … something have a pain … or anywhere.... So, if you were tell in Russia that I’m going to gyne every year so somebody can tell me … you just looking for trouble…. You are so sensitive and you are so precaution and you took too much in your head. You don’t need to do this. Do you have pain? Do you have a problem? Why you need to go to the doctor?...

The notion that one will find a problem if one is looking for a problem was compared by Bella to the degree of stress they were experiencing in their lives and the priorities that they had chosen. That is, according to Bella, if there is not so much to worry about, a person will find something to worry about. Living in the United States was thought by most of the women to be less stressful than living in the FSU. As a result,
Bella suggested, maybe Americans tended to create conditions to worry about and seek outside help for themselves rather than solve their own problems:

… Over here [in the USA] it just is really relaxed and people are going to find problems, they are looking for trouble … if a person does not have a problem, he will create it. There were no such problems [in the FSU], except, you know, just very significant ones. Like stress … there were no such problems in Russia, because you had to survive. You do not pay attention to all that stupid stuff that might go on in your mind. You do not have time for that … in Russia … there are some psychic diseases that are real … and they did exist … but if you are stressed or depressed you go visit friends, just talk to them, just cry with them, that’s it … so nobody will solve your problem … you have to….

Bella gave an example by citing her perception of a rise in the incidence of diagnosis of ulcers in Russian soldiers after World War II:

… After World War II a lot of men developed ulcers. There were no ulcers during World War II because it was so stressful you needed to survive … all stomachs were fine at that time. But when war was over … and it was peacetime … all that stuff started … people are looking for trouble … they can’t live without problem to solve … some are solvable and some are not … and how you deal with not solvable problems is up to you…. If you don’t have a problem, you will develop it … you need to have an enemy … you know … to fight with….
Past Painful Experiences with Gynecological and Dental Procedures

According to Nadya, anesthesia was not routinely used in the FSU to accompany gynecological or dental procedures. As a result, visits to the gynecologist and dentist are often associated with pain and are avoided if possible:

… The two worst doctors in my life … gynecologist and dentist … you usually go to dentist when you have a pain which you can’t live without … you can’t live with this pain … only in this case … and you have tried everything to deal with pain … and you’re getting into more trouble with more pain because they never did filling with any kind of anesthesia. So the filling was done alive, and it was absolutely awful….

Visits to the gynecologist in Russia were described by Tatyana as often embarrassing, due to the lack of provisions for privacy during the exam: “… In Russia, I never received a simple thing like a sheet when I went to see the gyne … you feel so exposed … such a simple thing … I’m not afraid to go to the gynecologist here….”

According to Nadya and Fekla, due to lack of traditional birth control methods, abortion was ordinarily used for birth control. Abortions were very common and were carried out without anesthesia or analgesia. Nadya stated, “… when you go to gyne … the people who go into abortion, they have also no local anesthesia that was done….” Fekla stated,

… we had a lot of abortions of course, because … didn’t have anything [birth control options] … but we did it because you couldn’t have a lot of kids and it was difficult to raise them, and we didn’t have anything to protect ourselves, that’s why….
Cancer as a Disease that Happens to Others

Another reason mentioned by Nadya for not having an annual screening is the belief that cancer and disease happen to other people who are older, but not to oneself at midlife. Nadya, who reported in a non-taped discussion that she had been diagnosed, treated, and cured of a malignancy, shared how she thought about cancer prior to her diagnosis:

... And I was thinking, I was, even I was reading on something bad in a paper, because as soon as you open a paper you can see about cancer, you can see about heart disease, you can see about everything. I always thought, well, this is not my problem. And, um, it can’t happen to me. Even it can happen to my dad. I was still thinking that I’m too young for this, so it won’t happen to me. And it gives me, whatever, joy and was giving me hope that it’s not happening to me….

D. Summary

In sum, six themes were identified from the analysis of the data collection. The themes related to the meaning of health, health within the context of migration, and current health and health practices. The findings depict connections among meanings found within and across transcripts.
V. DISCUSSION OF FINDINGS, CONCLUSIONS, AND IMPLICATIONS

A. Introduction

The study of the phenomenon of health is central to nursing. This study set out to learn about health from the perspective of midlife Russian-speaking women themselves. In this section, the data are interpreted and findings discussed. The three research questions are examined according to identified themes with comments related to the hermeneutic phenomenological perspective and a brief review of the relevance of situation-specific theory and Transitions Theory as frameworks for interpretation of the study findings. This chapter ends with conclusions and implications for nursing practice, policy, and future nursing research.

B. Interpretation of Findings Related to the Research Questions

In this section, each of three research questions will be discussed. These questions are: 1) What is the meaning of health among midlife Russian-speaking women in the United States? 2) How has immigration influenced the experiences, values, and practices concerning health of the midlife Russian-speaking women? and 3) What are the health experiences of the mid-life Russian-speaking women in the United States?
Research Question 1. What is the Meaning of Health among Midlife Russian-Speaking Women in the United States?

The findings of the study suggest that, to the midlife Russian-speaking women who participated in this study, health is a highly valued possession. The value of health is consistent with findings in other studies (Lipson, Weinstein, Gladstone, & Sarnoff, 2002; Smith, 1996). The study participants described health as very similar to the four models of health identified by Smith (1981, 1983), namely, dimensions related to role performance in addition to clinical, eudaimonistic, and adaptive dimensions.

In this study, health was associated with both physical and mental functioning and the time in one’s life. That is, health was associated with youth, and lack of health was associated with the normal aging process. This suggests that the women expected to experience diminished health as they got older. The absence of health was associated by this group of women with pain and disease and an expectation of aging.

Health was described as both internal and external to the individual. Health was associated internally with a sense of balance and emotional well being, and externally with the environment, including the health of others. The women further defined health in their own lives to include the health of their family.

Health was expressed as tacitly experienced. It was described as a balance, taken for granted, and as a possession in the sense that health is given to the individual. Although a source of the gift of health was not identified, all the women remarked that self-care to restore health was essential to healing.

In contrast to the reported findings of two other studies, one of older Iranian immigrants in Sweden (Emami, Benner, & Ekman, 2001) and one of American women
over the age of 55 (Maddox, 1999), none of these study participants directly mentioned a spiritual component to health. This finding may be attributed to the commitment to atheism that was supported under communism. Although eleven of the twelve study participants reported that they were ethnically Jewish, the majority of the eleven women reported that they did not actively practice the Jewish faith. This finding of identifying oneself as ethnically but not religiously Jewish concurs with other studies of émigrés who migrated in the 1970s and 1980s that suggest that, although Russian-speaking émigrés retain a strong identity of being Jewish, this identity is secular and not of a religious nature (Birman & Tyler, 1994; Gitelman, 1977; Simon & Simon, 1982).

Although spirituality was not mentioned or directly referenced in regard to health by any of the women, “balance” was mentioned by several of them. In a study of multiethnic groups in the Pacific Northwest, “balance” was used as a descriptor associated with “harmony” and being “spiritually whole” (Woods, Laffrey, Duffy, Lentz, Mitchell, Taylor, & Cowan, 1988). That is, “balance” was associated in the Woods et al. (1988) study of multiethnic women to include being “spiritually whole,” whereas this aspect was not described directly by the women in this study.

The description of health by the study participants suggested that it was experienced on a continuum of time and space, which was consistent with the literature (Payne, 1985). Time was a factor in regard to youth and aging, and space was relevant to the internal environment of the body and the external environment outside the body. The findings suggest that health was felt by the women to be affected by past environmental exposures to toxins, present-day stressors, and a future associated with the process of aging. These findings concur with the study conclusions reported by Lipson, Weinstein,
Gladstone, and Sarnoff (2002) and Smith (1996) based on the transcripts of focus groups with Russian-speaking émigrés in other geographical locations in the United States.

Health was seen as necessary to enjoy the future and to enjoy life. The concept of one’s individual health extended beyond the woman to her family. This suggests that the women considered their family an extension of themselves with regard to health. Midlife women in this study often reported that they acted as the caregivers for others. This agrees with other studies that include midlife Russian-speaking women (Aroian, Khatutsky, Tran, & Balsam, 2001; Remennick, 1999c).


Health in the context of migration was experienced as unnoticed and tacit. According to the study participants, health was not thought about during migration, nor was health a priority at this time. The women reported that it was only in retrospect that they could see that they had to have been healthy in order to carry out the physical and mental responsibilities required of them during migration. The women placed the health needs of others before their own, focusing their energy on the needs of the family. That is, nearly all the women reported that they put the needs of the older generation, the younger generation, and their partner before their own needs. This finding was consistent with those from other studies of Russian-speaking immigrant women in Israel (Remennick, 1999c, 2001) and in the United States (specifically, Boston) (Aroian, Spitzer, & Bell, 1998).

The theme of being a stranger/seeking the familiar concurs with the literature on other immigrants (Aroian, Norris, Patsdaughter, & Tran, 1998), which suggest that the Russian-speaking women felt like strangers in many ways. That is, the study participants
spoke of experiencing differences in the United States related to the environment, living space, and friends and family who had migrated to the United States before them. The feeling expressed by a majority of the women was that the people who had migrated several years before them did not know what life in the FSU was like for these women prior to migration. Those study participants who had had the opportunity to return to visit their homeland remarked that they no longer felt that the homeland was the same one they had left. In essence, they reported that they felt like strangers in both the land of destination and the homeland. It was common for the women to express nostalgia for the homeland as it was remembered but no longer existed. The study participants observed that they felt more comfortable seeking out relationships with other women who had similar backgrounds, since they shared a common language in addition to a common history.

Experiencing the environment as unfamiliar, having difficulty with communication, and trying to create a home for themselves and their families resulted in great expenditures of time and energy for the midlife women. This, then, created an imbalance, resulting at times in parental concerns and marital disputes. These findings again concur with those of the study by Aroian, Norris, Patsdaughter, and Tran (1998), in which the researchers investigated the predictors of stress in a sample of over a thousand Russian-speaking émigrés in the United States.

Language was a source of great difficulty for most of the women. Unfamiliar communication patterns resulted in misunderstanding sincerity. An example offered several times was the observation that the American-born smile a lot; Russian-speaking women were used to smiling only at people they liked, not just to be polite. Nonverbal
behaviors early on in the immigration process resulted in the interpretation of insincerity in the American-born person who was communicating to the Russian-speaking woman. This finding was not reported in other studies. An explanation may be that the one-on-one interview and open-ended structure of the questions asked of the study participants permitted them to lead the interview and voice their own experiences and impressions privately and without being prompted or judged.

Knowing English imperfectly as a second language and not understanding American English were obstacles to finding employment at the level the women had been used to in the FSU. They had learned British English in formal classes in the homeland and had to spend more time learning American English once they migrated. This finding agrees with that of a study of Polish immigrants by Aroian (1990).

The Russian-speaking midlife women in this study placed more importance on the needs of their parents, children, and husbands than on their own. These findings were also noted by Remennick (1999c). When adolescent and young adult children expressed individualist needs over those of the family, conflict was experienced. The parents of the midlife women also demonstrated their commitment to putting the needs of the family over their own needs by uprooting themselves and moving with their children and grandchildren to the United States. The older generation, knowing that their children would not travel without them, made the sacrifice to move so that the younger generations would have a better life.

Worry over children, especially adolescent children, possibly becoming involved in alcohol and drugs was significant. The women were not able to spend sufficient time in parenting due to the time needed to care for older family members, keep house, and work
outside the home, in addition to going to classes to learn English and such skills as driving and computer literacy needed to survive in the United States.

Children of the midlife women, although not directly interviewed in this study, were described by their mothers as experiencing the demands of two cultures. They faced bicultural issues and conflicting expectations regarding making choices and decisions based on their own needs versus the good of the family. This study suggested that the children of the midlife women identified with the American culture quickly, more quickly than their parents. This finding does not agree with the study results reported by Birman and Tricket (2001) of adolescent Russian-speaking émigrés who migrated between 1990 and 1998 to an urban area in Maryland. Birman and Tricket (2001) reported that adolescents identified more with the Russian culture than their parents did. The authors attributed this finding in their study to the discrimination perceived by the adolescents in the United States and their strong identification with Russian culture as a reaction to the discrimination.

Earlier studies conducted in the 1980s refer to the challenges perceived by American-born health care providers in caring for older Russian-speaking émigrés (Wheat, Brownstein, & Kvitash, 1983), and describe the pattern of health care utilization as “difficult or maladaptive” (p. 300). Perceived extensive use of health care by older Russian-speaking émigrés was also noted by Aroian, Khatutsky, Tran, and Balsam (2001). In the current study, overuse or inappropriate use of services by the midlife women was not apparent in the analysis of the data. The study participants were of a different generation, migration cohort, and gender, which could explain the difference in study conclusions. The findings of this study suggested that the sense of strangeness
expressed by the women in regard to the American health care system included the concept of making an appointment to go to the health care provider versus having a house call made. This finding concurs with the study by Lipson, Weinstein, Gladstone, and Sarnoff (2002) of Russian-speaking émigrés in Northern California. This could be interpreted by American-born health care providers as the Russian-speaking person expecting paternalistic care; however, the women expressed this expectation as “common sense.” That is, it seemed to make little sense to the study participants for a sick patient with a fever to go to an office to contaminate everyone else. It made even less sense to have to work when one was obviously sick and spreading germs to coworkers.

A negative perception of the hospitalization experience was described by one of the study participants, as she talked about having a private room and a private television in the United States after abdominal surgery. This was strange for her, because she missed sharing her room with other people, as she had experienced during a hospitalization in the FSU; at that time, she appreciated that sharing a room had resulted in the patients exchanging human stories and helping one another. This human contact was clearly favored over being alone in a hospital room with only a television set for company.

Also noted in the analysis of the transcripts was that the women in the study often used the pronouns “we” and “us” in their narratives. The novelist Slavenka Drakulic, a midlife woman born in Croatia in 1949 who grew up under communism, described in her book, *Café Europa: Life after Communism* (1996), her realization that in her writing during the years 1992 and 1996 she constantly used the pronouns “we” and “us” as “something coming to me naturally…” (p. 1). She continued,
I grew up with ‘we’ and ‘us’: in kindergarten, at school, in the pioneer and youth organizations, in the community, at work. I grew up listening to the speeches of politicians saying, ‘Comrades, we must…’ and with these comrades we did what we were told, because we did not exist in any other grammatical form (p. 2).

Although the FSU changed essentially overnight in December 1991 from a communist state to a capitalistic one, the people of this generation have not changed as quickly. The study findings suggest that the midlife women saw themselves as a “lost generation” in the Russian-speaking culture. They had grown up and gone to school in the 1960s during the space age. The world view as expressed by Drakulic (quoted above) was also suggested by the women in this study. They did what they were told. There was no choice regarding whether to study or not; they just followed instructions. This compliance with authority did not seem to carry over for these women in regard to medical care. That is, the majority of women interviewed in this study reported that they often did not follow the treatment plan or take the prescription drugs ordered by the health care provider in the United States. This finding concurs with that of Lipson et al. (2002).

In regard to health in the context of immigration, health was influenced by immigration, and immigration was influenced by health. That is, migration was possible due to the good health of the women. At the same time, their health was stressed due to the demands of migration. The description of the overwhelming stress of immigration concurs with other studies (Aroian, Spitzer, & Bell, 1996; Smith, 1996).
The immigration experience did not change the values learned in the homeland, although values there were rapidly changing due to the openness experienced by the FSU since December 1991. Goldstein (1978) supports the notion that émigrés from the FSU continue to carry within themselves the ideals of the totalitarian culture that was part of their history from their homeland.

Loss and grieving for the former life coincided with the process of building a new life in a new land for self and family. The women in the study were highly educated and expressed a strong identity with their former professions. All reported that they were currently employed in another field or in a lesser position than they had attained in the FSU. These findings were similar to those of Miller and Chandler (2002) in their study of Russian-speaking women aged 45-65 living in the United States. Feelings of marginalization expressed in terms of not belonging in either the United States or in their homeland concur with the findings of other studies (Anderson, 1985) that suggest that immigrant women often experience a similar sense of not belonging anywhere.

Health in the context of immigration was often affected by depression, according to the women in the study. The diagnosis and treatment of depression were new to these women, since they reported that depression was not a diagnosis with which they were familiar in the FSU. That is, while the symptoms existed in the homeland, using the term “depression” to refer to a condition that was treatable was new to them. Symptoms associated with the diagnosis of depression in the United States did not lead to such a diagnosis in the FSU.

Cultural beliefs and values related to emotional and mental disorders in the United States were very different and foreign to the women. Although some of them self-
reported being treated for depression, other study participants viewed emotional and mental disorders as a function of a society that did not have more serious problems with which to deal. Yaglom (1993) suggests that mourning was not publicly recognized as a process in the FSU; historically, all cultural and religious customs related to mourning were banned. According to Yaglom, “it was considered a sign of bourgeois weakness to grieve” (p. 137).

Immigrating was remembered as a time of overwhelming stress associated with great expenditures of energy related to the immigration process in addition to attending to the needs of others in the family and carrying out multiple roles. Nearly all the study participants shared with deep emotion their experience of migration and loss of profession in the United States. Feelings of loss and depression were commonly reported. These findings are consistent with those reported by Aroian, Norris, Patsdaughter, and Tran (1998) of Russian-speaking émigrés of various age groups living in Boston, by Lipson, Weinstein, Gladstone, and Sarnoff (2002) of Russian-speaking émigrés in Northern California, and by Gutkovich, Rosenthal, Galynker, Muran, Batchelder, and Itskhoki (1999) of Russian-Jewish émigré men and women between the ages of 34 and 54 who had lived in the United States less than six years. Gutkovich et al. (1999) hypothesized that the distress described in their research was similar to the phenomena of demoralization and learned helplessness associated with an external locus of control or the belief that control over one’s life came from an external source rather than from within oneself.

In contrast, the study participants, like those in the study by Lipson et al. (2002), indicated that they relied on self-care as the first line in the health process, while
continuing to seek health care information and care on their own, rather than trusting in the information and care received from health care providers. This expressed trust in self-care suggests that these women believed that they could control some aspects of their own health in regard to health-restoring behaviors.

Themes of self-help and self-care strategies were also identified by Smith (1996) as an outcome of the findings from several focus groups of Russian-speaking émigrés in the 1990s. Other aspects relating to changes in health, such as the diagnosis of a malignancy, could not be changed, at least not in their past experience from the FSU. Recognition of an external locus of control for all health-related issues was not found in this study, in contrast to that by Ivanov and Buck (2002), who used a focus group approach with questions based on the six dimensions of patient satisfaction of a Western-centered framework.

One of the assumptions of the framework used in the Ivanov and Buck (2002) study was that people get involved with the health care system based on satisfaction. In the study conclusions reported by Ivanov and Buck (2002), no mention was made that fear of a diagnosis of cancer prevented use of the health care system. One explanation could be that the study by Ivanov and Buck (2002) used a focus group approach. According to Aroian, Khatutsky, Tran, and Balsam (2001), public disclosure of personal feelings was not something commonly done under the communist regime. Lipson, Weinstein, Gladstone, and Sarnoff (2002) also noted that formal interview structures and focus groups were not as effective in data gathering with Bosnians and study participants from the FSU as were more informal interactions.
Public expressions of emotions or personal feelings and beliefs might not be comfortable for émigrés who have a history of living most of their lives under communist rule. Another explanation could be that the Russian-speaking émigrés in the study by Ivanov and Buck (2002) were predominately Pentecostal and not Jewish by ethnicity, as were the participants in this study.

Research Question 3. What are the Health Experiences of Midlife Russian-Speaking Women in the United States?

The women in this current study continue to use Russian herbs and home remedies learned in the FSU. This finding was consistent with reports from other studies (Lipson, Weinstein, Gladstone, & Sarnoff, 2002; Smith, 1996). The interviews suggested an internal locus of control and belief in self-efficacy related to self-care. These findings do not appear to be the same as those of learned helplessness associated with an external locus of control or the belief that control over one’s life came from an external source rather than from within oneself (Gutkovich, Rosenthal, Galynker, Muran, Batchelder, & Itskhoki, 1999). Several women had access to the Internet and home libraries of medical reference materials in both English and Russian. This may be due to the age group of the study participants and the history experienced by the women in this study who had migrated since the fall of the FSU, compared to the older participants in the Gutkovich et al. (1999) study, most of whom were unemployed. The differences in study findings may also be related to the method of data collection. That is, Gutkovich et al. (1999) used a quantitative design with questionnaires that were developed in the West and translated into Russian, whereas the current study used a qualitative approach and semi-structured, open-ended questions that enabled the study participants themselves to direct the interview process.
The findings of this study suggest that the women were very much aware of the effects of pollution such as that from the radiation contamination disaster in Chernobyl in 1986. This finding agrees with the study results reported by Lipson et al. (2002) and Smith (1996). The women all voiced knowledge of ways to stay healthy by avoiding contaminated foods. They continued to make choices about the safety of food in the United States with respect to contamination. They based current food choices and judged the safety of food in regard to the effects of past experiences with pollution and radiation.

For example, fresh fish would be judged edible even if caught from a river in the local area that by the American-born was considered contaminated. An apple with a worm inside would be considered edible, since the worm had not been killed by any chemicals that might have been on the apple. However, grain grown in Kiev for sale in the Russian store was avoided due to the concern about the radiation from Chernobyl. In fact, this reported concern about radiation exposure was supported in the literature, in that approximately eighty percent of all FSR immigrants to the United States have come from areas affected by the 1986 nuclear power plant disaster and subsequent clean-up efforts in Chernobyl (Ackerman, 1997).

Most participants reported at least one less than positive experience with the American health care system. Understanding the differences between the health care system in the United States and that in the FSU, as well as experiencing the perceived inferior quality of public education compared to the FSU, were both difficult for these women.

Changes have continued rapidly in the FSU in the last decade. In seeking a new home, and traveling back to the homeland to visit, the women reported that the homeland
that they remembered had changed. The balance in the society, if it ever did exist, had
tipped, and the country had changed to a more open state; however, people had not kept
pace with the rapid rate of changes around them. Recollections of the homeland
continued to affect the experience of changes in the new land, resulting in uncertainty and
worry for those remaining in the homeland and those visiting friends and relatives there.

As time passed, the midlife women reported bodily changes related to aging,
including cessation of menstruation and the onset of chronic diseases since migrating.
The family dynamics were also changing, as children were growing older and moving out
of the family home and even, sometimes, out of state. Older family members often
moved to senior apartment complexes, or into nursing homes once they could no longer
care for themselves, because their midlife children were uneasy leaving them alone at
home during the day. In some ways this type of move relieved the burden of worry of
having an older person who could not care for himself or herself in the home.

On the other hand, it suggested that the midlife children spent extended periods of
time staying with aging parents in hospitals or nursing homes, since the older generation
usually did not speak English and, as a result, depended on the midlife children. This
finding correlates with those of other studies that suggest that older Russians relied
primarily on their children for support, even though children did not have the time that
they did in the FSU (Aroian, Khatutsky, Tran, & Balsam, 2001; Gelfand, 1986;
Remennick, 1999c). This also suggests that midlife women were spending large amounts
of time transporting older family members to health-related appointments and waiting for
them in hospitals and out-patient settings.
While over half of the study participants reported that they engaged in recommended preventive screening in the United States, the remaining women reported that they did not. Although lack of health insurance was mentioned as a reason for not seeking care, only one of the study participants reported that she did not have current health care insurance.

In this study, participating in routine preventive screening was equated to “looking for trouble” and the notion that, if one were looking for a problem, one would find it. The avoidance of routine screening for a latent or early malignancy was associated with the belief from the homeland that any malignancy had a fatal outcome. Not knowing was better than knowing, since knowing one had a malignancy might destroy hope. The importance of hope, along with the concern that one would lose hope, was the rationale given for the reported accepted practice in the FSU of not telling a patient of a diagnosis of cancer.

These findings concur with those of Lipson et al. (2002) and may be compared to those in a study of preventive behavior and cancer screening of Russian-speaking women over 35 who immigrated to Israel after 1989. Remennick (1999a) found that universal access to preventive care did not always result in this immigrant population’s use of preventive services by “…even those who knew the key cancer facts, believed in their own susceptibility and in the benefit of early detection (p. 1669).” Remennick (1999a) attributed this finding to the demands of resettlement, a sense of low self-efficacy and external locus of control, and cultural barriers.

In the current study, findings suggest that the Russian-speaking women experienced a lack of control under the health care system in the FSU in regard to the
ability to receive analgesia or anesthesia for painful gynecological and dental procedures. They did not trust or follow the advice of the health care system in the FSU without seeking advice and referrals from other women. Although other studies have suggested that the health care providers under the FSU were paternalistic and authoritative (Brod & Heurtin-Roberts, 1992; Remennick & Ottenstein-Eisen, 1998), the women in this study did not express this perception. Instead, the findings suggest that the midlife women sought referrals from other Russian-speaking women in seeking trusted health care providers.

The women in this study were all highly educated and very capable of understanding where to find information related to health, disease, and treatment options. The women seldom trusted the treatment plans of the health care provider without taking the responsibility to seek more information on their own about the disease, its management, and alternative therapies. The women trusted other Russian-speaking women to refer and suggest health care providers and treatment options. It is very common to seek herbals and roots and self-care remedies and advice from other Russian-speaking women rather than to trust the prescriptions ordered by the US health care provider.

The study findings suggest that using less medication to heal is valued over using more medication to heal. This finding does not agree with research suggesting the overuse of the medical system in earlier studies of older émigrés in Boston (Aroian, Khatutsky, Tran, & Balsan, 2001). This conflict in findings may be due to age and gender differences between the two cohorts of participants in each of the studies.
The findings suggest that health is a valued possession that, although unnoticed at the time, was experienced in the energy needed to endure the physical and mental challenges in making the decision to immigrate. The importance of hoping in regard to health and to migration was repeatedly stated in the interviews. Hope was also mentioned as related to the common practice in the FSU of informing family members but not the patient of the diagnosis of a malignancy.

Although no studies were found dealing with the notion of hope and Russian-speaking émigrés, one review article by Yaglom (1993) addressed hope in regard to émigrés from the FSU by quoting Searles (1984) and the identification of two categories of hope, one realistic and the other not realistic. In the article by Yaglom (1993), the author quotes Searles (1984) as describing realistic hope as being based on the capacity to experience loss and unrealistic hope as being grounded in denial.

*Interpretation of the Study Findings Related to the Theme of Hope from a Heideggerian Perspective*

Hope for a better future was voiced by the women as a motive for their decision to emigrate. The importance of not losing hope was given as the reason for the common practice in Russian culture of not telling patients of the diagnosis of a malignancy.

The phenomenology of Martin Heidegger focuses on the origin of knowledge that is part of everyday life (van Manen, 1990). Time according to Heidegger involves moving forward in time toward the future, but this cannot happen in the presence of fear (Gelven, 1989). Fear from the past, in short, would hinder movement forward to the future (Heidegger, 1962).
In this study, the women stated they were not afraid to leave their homeland; although the decision to leave was associated with much stress, loss, and grief, the women had made the choice to migrate because of the hope for a better future not only for themselves, but especially for their children. The migration from the homeland involved moving toward the future by acting in the present and remembering the past. While the women migrated to the United States, the majority of them had also traveled back to the homeland to visit. The women voiced that they thought about and prepared for the future, but also thought about the past and experienced nostalgia when reminiscing.

The study findings suggested that, for the majority of women interviewed, the diagnosis of malignancy was associated with death and no future. The study participants voiced that in Russian culture it was better “not to know” if one had a diagnosis of cancer in order to maintain “hope.”

Preventive screening was identified by the majority of the women as “just looking for trouble.” Reading about cancers and death prior to one’s own diagnosis was described by two of the study participants in terms of believing that cancers and death happened only to others.

According to Heidegger, death sets a boundary in which one ceases to be in the world and becomes aware of the limits of one’s existence (Gelven, 1989; Macquarrie, 1969). If one gives no thought to death, one’s own possibility of death, then the future is thought of as being indefinite. Heidegger refers to this as an inauthentic mode of existence in which there is no sense of urgency or responsibility in one’s life. In this mode, although death is recognized, it is handled with euphemisms and considered as
something in the indefinite future. For Heidegger, to recognize that all existence is moving toward death, rather than to deny it, is to move toward an authentic existence. Such an existence, Heidegger implies, refers to anticipating that life ends in death; by recognizing one’s boundary of existing in time, one can achieve a perspective on life around which the possibilities of one’s life are organized (Gelven, 1989; Macquarrie, 1969).

**Situation-Specific Theory**

Analysis of the findings in this study supports the concept of situation-specific theory (Im & Meleis, 1999b; Meleis, 1997). Situation-specific theories refer to those that are in a social and historical context, involve a specific population, and focus on a specific phenomenon related to nursing. The purpose of these theories is to create a framework in which to understand the unique situation of a particular population. In regard to the interpretation of the findings of this study, a situation-specific theory could result in the conceptualization of the patterns of responses that the midlife Russian-speaking women expressed in regard to transitions experienced related to health within the context of immigration.

**Transitions Framework**

Meleis, Sawyer, Im, Messias, and Schumacher (2000) describe the concept of migration as a transnational transition. Findings in this study suggest that all the women interviewed experienced transnational migration associated with some degree of transition related to profession, health, changes in self-identity, and aging. Some of the occupational transitions resulted in the perceived lowering of social status. The study
findings suggest support for the use of a transition framework to understand and explain the experiences of migration for the Russian-speaking women.

Major components of this framework include interactions on the nature of transitions, transition conditions, patterns of responses, and nursing therapeutics (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). Types of transitions include those periods in which change is observed or perceived as occurring by the individual or others (Lipson & Meleis, 1999). Types of transitions included in this framework are developmental, situational, health and illness, and organizational.

**Summary**

Health was interpreted to be a highly valued possession that changed over time. Dimensions of health included physical and mental functioning, the absence of disease and pain, balance, and emotional well-being. Health was associated with others, the environment, and hope for the future.

Within the context of immigration, health was not a priority of the women in this study. During the immigration process, energies were focused on the care of the older and younger generations in the family. Their own needs were placed last.

The experience of immigration involved the sense of being a stranger and seeking out the familiar. The women reported stressors related to experiencing the unfamiliar, nostalgia for the homeland, and seeking a familiar place. Building a new life for these highly educated women involved letting go of former professions and learning new skills for survival in the United States.

The experience of external changes and internal transitions was ongoing, as the midlife women adjusted to their new homes. Health experiences included maintaining
and restoring health by seeking health-related knowledge, engaging in self-care, and
openly challenging treatment plans. Health with respect to time in this study was
identified as being affected by the past (stressors/toxins/exposures), present (stressors/
toxins/exposures), and future (aging).

Both health and migration in this study involved the importance of hope in the
context of hope for the future, which was described as a dimension of health. A major
reason for migration was also identified as hope for the future. In this study, health and
migration involved the family unit, with the midlife woman as the central caretaker.
Findings of the study suggest that trusting oneself to make decisions about one’s own
care was considered essential to survival. That is, the women valued knowledge and
wanted to know as much as possible about health-related issues in order to control and
take care of themselves and family members using natural remedies, rather than relying
on a health care provider who used only pharmaceuticals to heal. The study findings
suggest that the women did not readily accept the notion of screening for malignancy in
the absence of signs and indications to do so. Since a diagnosis of cancer in the FSU was
associated with a fatal outcome, not knowing of a diagnosis meant hope, and knowing
was associated with lack of hope, since the assumption was that nothing could be done to
cure the malignancy and the person was going to die. To screen for disease before
symptoms manifested was equated to looking for trouble, and, in looking for trouble, one
would eventually find it.

In sum, the findings from this study support the concepts of situation-specific
theory (Im & Meleis, 1999b; Meleis, 1997) and Transitions Framework (Meleis, Sawyer,
Im, Messias, & Schumacher, 2000). The properties and approaches used in the
development of situation-specific theories support the philosophical assumptions of the hermeneutic design of this study. The Transitions Framework is also consistent with the findings of this study.

C. Conclusions

The findings of this study suggest that midlife Russian-speaking women who have migrated to the United States since 1991 have experienced historical events unlike those of other cohorts of Russian-speaking immigrants. Study findings indicate that midlife Russian-speaking women value health, are knowledgeable about health-related issues and treatments, participate in self-care practices, trust their own abilities to make self-care decisions, and seek out health-related information when they are unsure. At the same time, this is a vulnerable population at risk for the onset of chronic medical conditions associated with the process of aging, past exposures, and current stressors related to migration and the tendency to avoid health screening.

This is a rapid time of change between the old ways that are no longer valued and the new ways that are strange and unfamiliar. The women belong to the middle generation, responsible for the health care of the older generation of parents and the younger generation of children, often putting their own health needs last.

With migration, family support systems often experienced change. This change was related to extended family members deciding to migrate to Western cultures other than the United States and to acculturation and opportunities associated with relocation experienced by the younger generation.
D. Limitations of Study

The findings of this study are constrained by the nature of the group, the immigration cohort they represent, the community in which they live, and the voluntary nature of their participation in the research. This study involved a specific group of highly educated, midlife Russian-speaking women who also spoke English and lived in a specific geographical area in Southwestern Pennsylvania with a high concentration of Russian-speaking people of Jewish descent. The women in this study shared a common history, having migrated to the United States during the specific time period from 1991 to 2001. Thus the findings apply to these women in this time and place and cannot be extrapolated to other groups.

E. Implications and Recommendations

Advanced practice nurses are continually challenged to develop innovative practice models in population-based community health. Culturally appropriate community health services require that the nurse be knowledgeable about the meaning of health and the health beliefs of the population being served. This knowledge will result in strategies to meet national health objectives by increasing the years of healthy living and decreasing health disparities (USDHHS, 1991; USDHHS, 2000).

_Nursing Practice_

Health is highly valued, and health-related information is often sought in the Russian language. Implications for nursing practice include the need for nursing interventions that build trust, assess self-care practices, and address concerns over treatment plans. Giving clients opportunities to discuss concerns and fears related to
health of self and family in both English and Russian is essential. One-on-one teaching and counseling may be more culturally appropriate than support groups, since Russian-speaking individuals from the FSU may not feel comfortable asking questions about private matters in a public setting.

Making the decision to immigrate is often difficult and associated with loss and grieving. Advanced practice nurses need to assess reasons and circumstances involved in migration of this population. Special attention should be focused on screening for depression.

The majority of the women in the study reported that they did not trust pharmaceuticals ordered for them by health care providers. In order to build a trusting relationship with the Russian-speaking client, the health care provider needs to have an understanding of that client’s knowledge, beliefs, and values surrounding treatment plans and pharmaceutical prescriptions.

The findings suggest that the women are very knowledgeable about health care and pharmaceuticals. Issues related to adherence to treatment need to be addressed openly and honestly. Providing written information to the client in both languages about the risk and benefit ratios of taking prescription drugs and herbal medicines is essential.

Ideally, the American health care provider should explore language support and access to a Russian-speaking health care provider to explain treatment options in Russian, if needed, so an informed decision is made by the client about all aspects of care. In addition, health care providers need to become aware of the customs, beliefs and values in regard to grieving and end-of-life issues of their Russian-speaking clients.
Policy

Lack of health insurance is of concern to the women who were not able to find employment that provided health benefits. State policies need to be assessed for cost benefits regarding insurance coverage of refugee and immigrant populations over extended periods of time to encourage appropriate access to health care services when needed.

Women often sought out other Russian-speaking women from their own cohort for health-related referrals. Since many variations in historical experience and culture exist within the Russian-speaking community, members of that community who are considered gatekeepers, and come from the same cohort as the population, need to be included in order to design culturally competent health initiatives aimed at high risk groups within this population and in order to build on the strength of the ethnic community and the friendship and trust of other Russian-speaking women.

Language support is essential to ensure clear communication regarding health issues. In areas with large concentrations of Russian-speaking individuals, utilizing creative ways to access the services of Russian-speaking health care providers who can explain complex health-related issues and treatment plans locally and from a distance is essential. The study findings suggest that the women valued the ability to find Russian-speaking health care providers who could answer their questions either in person or on the phone, or even from a distance through the Internet, when possible.

As the children of these midlife women tend to move out of the family home and relocate to other geographical areas to pursue opportunities, support currently offered by family members may not be available to the midlife women as they age, becoming less
physically independent and facing end-of-life issues. This may result in this current
generation of midlife women needing more care through social agencies and assisted care
facilities in the future than currently experienced, as this midlife generation tends to care
for aging parents privately and in their homes.

Findings from the study suggest that health is highly valued and hope for the
future is an important aspect regarding health. Population-based community health
programs that include members of the community and reflect the benefits of early
detection in regard to hope for a healthy future may be one way of encouraging
involvement in recommended health screenings.

The findings of the study suggest that the majority of the women are employed at
jobs below their level of education. Exploring creative programs to facilitate the ability of
these women to use their education and life experiences to meet the needs of the larger
community might well be therapeutic.

Future Nursing Research

Recommendations for future nursing research include replication of this study
with other samples and collaboration with researchers in other Western nations that have
received an influx of Russian-speaking immigrants. Other recommendations suggested by
the findings of this study include sampling that would identify other high risk groups
within Russian-speaking immigrant populations, and comparing different cohorts and
their changing needs. In addition, it might be of value for future nursing research to
include studies designed to understand the dominant culture’s perceptions of immigrant
groups.
The recent literature relating to the health of Russian-speaking immigrants contains several studies using focus groups. According to the findings of this study, focus groups in this population may not lead to the same findings as research conducted using individual interviews. In addition, longitudinal designs were not represented in the literature for this group. Use of such designs would enable the study of changes in the group over time. The findings of this study support the concepts of situation-specific theory (Im & Meleis, 1999b; Meleis, 1999) and transitions framework (Meleis, Sawyer, Im, Messias, & Shumacher, 2000) in designing future nursing research.

Other recommendations for future nursing research suggested by the findings of this study include seeking to understand curative practices; the meaning of death and dying and end-of-life issues; the meaning and activities surrounding mourning or grieving; and the connections among spirituality, gender-related issues, and the concept of hope.

As Meleis, Isenberg, Koerner, Lacey, and Stern (1995) suggest, since immigration is a global issue and many midlife Russian-speaking women immigrate to other Western nations, collaborative international studies to research migration patterns of women and the effect of migration on gender roles, social status, and health could provide interesting findings that would be applicable internationally. These authors also suggest that studies be replicated in the country of origin to study patterns of behaviors and responses in the absence of migration.
F. Summary

This cohort of women immigrants represents a group with a history different from any other cohort of Russian-speaking immigrants. The women in this group tend to be independent and highly educated, with untapped talents to offer their new homeland. To provide immigrant populations with health care programs that assist in promoting, maintaining, and restoring health, the health care provider must take into account the meaning of health to an individual and identify the healthy behaviors currently used by that individual. Bringing to light the meaning of one’s experiences in everyday living enables the health care provider to better understand the meaning of health and the experiences of immigrant women. As immigration increases nationally and globally, more knowledge will be needed about specific cohorts of immigrants and refugees in order to improve access to culturally competent health care delivery services that result in positive outcomes. The goal would be to add to the health and well being of the individual and the community, and to prevent unnecessary suffering and expenditure of limited health care resources locally, regionally, nationally, and globally.
APPENDIX A

Needed: Women from the Former Soviet Union
to participate in a study about the
Health of Women from the Former Soviet Union in the United States

This study is being done to learn more about the health experiences of women who are between the ages of 40 and 60 and who have emigrated from the former Soviet Union to live in the United States within the past 10 years or less.

For your time, a gift certificate worth $10 and redeemable at any Giant Eagle grocery store will be given to you during each interview.

This study involves 2 interviews a few weeks apart.

The purpose of the first interview is to learn about your experiences about health, what it means to you to be healthy, what you do to stay healthy, what you do when you do not feel healthy, and how immigrating to a new place has influenced how you feel about health at this time in your life. The interviews are confidential and aimed at understanding your perspective. The interviews will last approximately 1 and ½ hours.

The second interview will be scheduled a few weeks later to review the information from the first interview to be sure that the interviewer has understood your responses completely.

QUESTIONS ABOUT THIS STUDY: call Leni Resick, Doctoral Candidate, Duquesne University, School of Nursing, 412-396-5228.
Appendix B

Приглашаются: женщины из бывшего Советского Союза принять участие в исследовании о здоровье женщин в Соединенных Штатах после эмиграции.

Это исследование проводится для того, чтобы выяснить какой опыт приобрели женщины возрастна между 40-60, эммигрировавшие из Советского Союза 10 и менее лет тому назад, в вопросах здоровья. В благодарность за участие в исследовании, в момент каждого интервью вам будет выдан подарок на $10.00, который вы можете использовать в Giant Eagle. Вы должны понимать и отвечать на вопросы по-английски. Изучение включает в себя 2 интервью с интервалом в несколько недель.

Цель первого интервью — изучить ваш личный опыт в вопросах здоровья, что означает для вас быть здоровой и что вы делаете для того, чтобы быть здоровой. Что вы делаете, когда не чувствуете себя здоровой, и как повлияла эмиграция на ваше представление о здоровье.

Интервью, продолжительностью 1-1,5 часа и абсолютно анонимно. Цель — определить вашу точку зрения по этому вопросу.

Второе интервью будет назначено через несколько недель для подтверждения информации из первого интервью, чтобы убедиться, что человек, проводивший интервью, понял все правильно.

По всем вопросам по этому исследованию обращаться к:
Лени Резик, Duquesne University, School of Nursing, (412)396-5228.
CONSENT TO PARTICIPATE IN A RESEARCH STUDY
(English Version)

TITLE: The Meaning of Health Among Midlife Russian-Speaking Immigrant Women in the United States

INVESTIGATOR: Lenore (Leni) K. Resick
Doctoral Candidate, Associate Professor
525 Fisher Hall
Duquesne University School of Nursing
Pittsburgh, PA 15282
412-396-5228

ADVISOR: Dr. Joan S. Lockhart
Professor, Associate Dean, Academic Programs
Duquesne University School of Nursing
412-396-6540

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the degree of Doctor of Philosophy, Duquesne University School of Nursing.

PURPOSE: You are being asked to participate in a research project that seeks to understand the meaning of health among women who have emigrated from the former Soviet Union to live in the United States. Two interviews will be required of you. Each interview will last about 1-1/2 hours. The interviews will be audiotaped or recorded on tape. The purpose of the first interview is to learn about your experiences about health, what it means to you to be healthy, what you do to stay healthy, what you do when you do not feel healthy, and how immigrating to a new place has influenced how you feel about health at this time in your life.

Your name and all other personal information will not be used. You will be identified by a number. All information will remain confidential. The second interview will be done a few weeks later. The purpose of the second interview is to...
review the information from the first interview to be sure that the interviewer has understood your responses correctly.

These are the only requests that will be made of you.

**RISKS AND BENEFITS:**

There are no anticipated risks as a result of you taking part in this study. In the unlikelyhood that you would become distressed in any way as a result of taking part in this study, the researcher who is conducting the interview will stop the interview and talk with you. If needed, you will be referred to a health care professional in the community.

The benefit of your participation in this study is that you will be providing information that will help to improve the health and wellness of women from the former Soviet Union.

**COMPENSATION:**

For your time, a gift certificate worth $10 and redeemable at any Giant Eagle grocery store will be given to you during the time of each of the interviews. Participation in the project will require no monetary cost to you.

**CONFIDENTIALITY:**

Your name will never appear on any survey or research instruments. No identification will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher’s office. Audiotapes will be stored in a locked place that only the researcher will have access to, until they are destroyed. When the tapes are transcribed, all sections that identify subjects or anyone subjects talk about will be deleted. Your responses will only appear in statistical data summaries. All materials will be destroyed at the completion of the research.

**RIGHT TO WITHDRAW:**

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

**SUMMARY OF RESULTS:**

A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:**

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason.

Participant’s Initials_____
On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board, at 412-396-6326.

Participant's Signature

Date

Researcher's Signature

Date
Соглашение на участвие в научном исследовании
(Русская версия)

Название: Значение здоровья для женщин средних лет, русско-говорящих иммигрантов в Америке.

Исследователь: Лени Резик, кандидат в доктора, профессор
525 Fisher Hall
Duquesne University of Nursing School
Pittsburgh, PA 15282
412-396-5228

Консультант: Dr. Joan S. Lockhart, профессор,
Декан Академической программы Duquesne University

Источник Поддержки: Это исследование выполняется как часть требований для получения звания доктора философии Школы медицинских сестер Duquesne University.

Цель: Вас просят принять участие в научном исследовании, которое имеет целью понять, что означает здоровье для женщин, иммигрировавших из стран бывшего Советского Союза в Соединенные Штаты Америки.
Вам будет предложено 2 интервью, продолжительностью 1-1,5 часа. Интервью будут записаны на магнитофонную пленку. Цель первого интервью изучить ваш опыт по поддержанию своего здоровья; что означает для вас быть здоровой; что вы делаете, если не чувствуете себя здоровой; и как иммигрантская жизнь повлияла на ваше отношение к вопросам здоровья.
Ваше имя и другая информация не будут использованы. Вы будете закодированы под определенным номером. Вся информация будет конфиденциальна. Второе интервью будет проведено через несколько недель. Цель второго интервью — пересмотр информации первого интервью, чтобы убедиться, что исследователь и интервьюированный поняли друг друга правильно. Это единственное требование к вам.

Риск и польза: 
Нет никакого риска в связи с вашим участием в этом исследовании. Что навряд ли возможно, если вы будете рассстроены чем-то в ходе разговора, человек который проводит интервью, остановит беседу и успокоит вас. И если это необходимо, предложит вам или посоветует необходимую помощь специалиста. Польза заключается в том, что вы участвуя в этом исследовании, представляете информацию, которая может быть использована для улучшения здоровья женщин из бывшего Советского Союза.

Page 2 of 4
Компенсация: В благодарность за услугу вы получите 2 подарочных сертификата по 10 долларов каждый, которые вы сможете использовать в любом супермаркете Giant Eagle. Участие в этом исследовании не представляет для вас никаких материальных затрат.

Конфиденциальность: Ваше имя никогда не появится ни в каких опросах или документах по исследованию. При анализе данных имена не будут использованы. Все письменные материалы и соглашения на участие в исследовании будут храниться в закрытом сейфе в офисе исследователя. Пленки с записью вашего интервью будут храниться также в закрытом месте, к которому только исследователь будет иметь доступ до тех пор, пока они будут уничтожены. Когда все материалы будут изучены и обработаны, те части, где упоминаются имена и данные о человеке будут уничтожены. Только ваши ответы будут использованы в анализе статистических данных. Все материалы будут ликвидированы по окончанию исследования.

Право прервать Участие: У нас нет никаких обязательств по участию в исследовании. Вы можете прервать соглашение в любое время.

Результаты: Окончательные результаты будут представлены вам по вашей просьбе, свободно для вас, без оплаты.
Добровольное соглашение:

Я прочитала вышеуказанное соглашение и поняла, что от меня требуется. Также я
понимаю, что мое участие в исследовании
добровольное и я могу в любое время, по
любой причине прервать этот договор.
Учитывая это, я подтверждаю, что я желаю
участвовать в этом научном исследовании.
Я понимаю, что если у меня возникнут в
дальнейшем вопросы, я могу позвонить
Dr. Paul Richer, Chair of the Duquesne University
Institutional Review Board 412-396-6326.

_________________________________________   ______________________________________
Подпись участника                                            Дата

_________________________________________   ______________________________________
Подпись исследователя                                        Дата

Инициалы участника
Appendix E

Demographic Questionnaire (DQ)

Interviewer Script: “Thank you for agreeing to participate in this study. Please accept this small token of my appreciation for your time.” (At this time the interviewer will present the study participant with the gift bag containing a small box of tea, a healthy snack, and a $10 gift voucher redeemable at any Giant Eagle Supermarket.)

Interviewer: “Before I ask you some questions about health, your health experiences, and immigration experience, I would like to ask you some general demographic questions. If there are any questions you prefer not to answer, you don’t have to answer them.

“My first questions are…

1. What is your age?

2. Where were you born?

3. When did you arrive in the USA?

Interviewer closing: “Thank you. This is the end of the questions for the first part of the interview. Now I would like to move on to questions about your health experiences and immigration experiences.”
Appendix F

The Semi-Structured Interview Questionnaire (SSIQ)

Interviewer Script:

“Thank you for completing the demographic questionnaire. Now I would like to move on to the interview about health, your health experiences, and immigration experience. At any time, if there are any questions you prefer not to answer, you don’t have to answer them.

1. “I would like to begin by having you tell me what health means to you. What does it mean to you to be healthy?” (Probes: “Describe for me a time when you felt healthy. Describe the experience when you felt healthy. Describe what it feels like to be healthy.”)

2. “What has it been like for you to move from your homeland to the United States?” (Probes: “Tell me about your immigration experience to the United States. Can you describe an experience that stands out for you during immigration? Describe for me an immigration experience that you did not expect to happen.”)

3. “Tell me about your health now in the United States.” (Probes: Can you describe what health is like for you now? Tell me about your health since you have come to the United States. Tell me about an experience that stands out for you about your health since you have come to the United States.”)
End of Interview Debriefing Questions:

1. “Is there anything else about health and immigration that you think I should know?”

2. “I will be interviewing other women from the FSU about their immigration experience and health. What has this interview been like for you?”

General Probes that may also be used during the interview include the following:

“How was that helpful?”

“What did that mean?”

“How did you feel?”

“Yes, go on….”

“Please give an example of that.”

“Please say more about that.”
Appendix G

The Meaning of Health Among Midlife Russian Speaking Women in the United States

CONFIDENTIALITY STATEMENT

I understand that in the course of my experience in this research study I may have access to confidential information about study participants. I understand that this information has been obtained and recorded for the purpose of research. I agree that I will use this information only for the purpose of this research study under the Duquesne University Internal Review Board protocol and under no circumstances will I disclose any information about any study participant to non-authorized individuals.

I understand that violation of this policy constitutes breech of study participant confidentiality and the Duquesne University Internal Review Board policies. I agree that if I have any questions about this Confidentiality Statement, I will consult the principal investigator of this project.

___________________________                                          ________________________
(Date)       (Name: Please Print)

________________________
(Signature)

Lenore K. Resick, Principal Investigator
REFERENCES


