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Meaning and knowledge of health among older adult immigrants from Russia: a phenomenological study

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Abstract

This qualitative study examined the meaning and knowledge of health among older adult Russians who have immigrated to the US. Prior studies have shown that this group has a high rate of chronic disease and low compliance with preventative health behaviors. However, little is known about the knowledge and beliefs about health among Russian immigrants that may be driving their low participation in health behaviors. The goal of the present study was to use a phenomenological approach to gain a deeper understanding of the experience of health in this population. Twelve older adults were recruited through English language classes, and interviewed in focus groups about their experience with health and health care. Qualitative analysis using the phenomenological approach revealed a number of important health themes: participants (1) define health as the absence of disease, (2) feel distrust toward media information about health, (3) experience alienation from their current health care system, and (4) experience a sense of stress and helplessness in the US because they do not understand the English language or the US health care system. These themes may underlie the immigrants' lack of participation in health practices and in seeking out information about health. Information about the Russian immigrants' knowledge about health behavior is also reported. This study represents a first step toward better understanding the barriers facing older adult Russian immigrants in learning about and practicing health behaviors. The study also draws attention to the ways in which beliefs about health may impact health behavior.

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Introduction

How one defines health may vary by cultural background, and may influence health practices and compliance to medical treatment (Rodin and Salovey, 1989). In the US, recent immigrant and minority groups are especially likely to have a different understanding of health than their physicians and other health care professionals. This can result in alienation from the health care system, poor compliance to treatment for chronic disease and non-participation in preventative health behaviors such as cancer screenings, exercising or healthy eating (Rajaman and Rahidi, 1998). Health promotion interventions and public health campaigns to facilitate health behavior change may also be less effective if they are not tailored to the health beliefs of a specific population. Recently, the need for attention to the role of culture in health promotion research has been stated (Krumeich *et al.*, 2001). For these reasons, it is important to understand health beliefs and health knowledge of recent immigrant groups in the US.

The theoretical framework of cultural explanatory models (CEMs) explains health-related

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behavior by focusing on sociocultural context, knowledge and attitudes around health (Rajaram and Rashidi, 1998). CEMs determine the personal and social meanings one attributes to health, and how they influence a person's perceived health behavior and treatment options. Differing CEMs between physician and patient may result in ineffective treatment strategies. Ethnicity, acculturation and socioeconomic status are some of the factors that may guide cultural explanatory models.

Health care professionals benefit from understanding their patients' CEMs because it improves the effectiveness of provider–patient communication (Rajaman and Rashidi, 1998). For example, if the patient is receptive to a doctor's message, the patient is more likely to comply with treatment and other health-related recommendations (Elder *et al.*, 1998).

Research into the CEMs of low-income immigrant and minority groups in the US has elucidated several reasons why people may have poor compliance to health behavior recommendations and medical treatment. One reason is that the health care system in the US does not conform to the health-related beliefs and practices around health of many ethnically diverse groups (Meyerowitz *et al.*, 1998b). If the health care system is perceived as impersonal, complex or intimidating, these factors will act as deterrents in the patient's willingness to comply with medical treatment (Rajaram and Rashidi, 1998). This is especially true of individuals who also experience language barriers or immigrated recently to the US (Holland *et al.*, 1987).

Another reason recent immigrants to the US may not participate in health behaviors is because lack of knowledge about health or chronic disease management is likely to contribute to non-adherence to medical and behavioral treatment (Meyerowitz *et al.*, 1998a). Recent immigrants or people who live in segregated neighborhoods are more likely to get their health information exclusively from their own ethnic group and may not be familiar with western interventions (Rajaram and Rashidi, 1998). Finally, some studies have shown that beliefs around a specific health practice or medical issue may influence whether treatment is pursued at all (Chapple, 2001).

One recent immigrant group in the US that has a high incidence of chronic disease is immigrants from the former Soviet Union (FSR). Little is known about the cultural explanatory models of this group. However, it is known that recent immigrants from the FSR have a low compliance rate to screening behaviors and voice a large number of health complaints (Duncan and Simmons, 1996). Data from the nationwide Russian Longitudinal Monitoring Survey show that heavy alcohol use and smoking, a high-fat diet, and lack of leisure-time exercise are the primary culprits in fostering high rates of heart disease and other causes of premature mortality in middle-age and older adult Russians (Cockerham, 2000). Although there are studies showing the high rate of chronic disease and lack of screening behaviors among Russian immigrants, the literature is lacking on their perspective on health and health care (Fitzpatrick and Freed, 2000).

Health care among Russian immigrants

Data from both the US and Israel show that there is an absence of basic health screening measures such as cholesterol testing, blood pressure screening, Pap smears and mammograms among Russian immigrants (Duncan and Simmons, 1996; Remennick, 1999a,b). In Israel, there was a reversal of the pre-emigration pattern: two-thirds of respondents underwent cancer screening in Russia, but only one-third in Israel (Remennick, 1999a). This indicates that there may be something in either the immigration process or the health care system of the new country that is acting as a deterrent.

Duncan and Simmons interviewed a group of recent immigrants in Virginia and found a large number of health complaints, including cardiovascular symptoms and dental problems (Duncan and Simmons, 1996). They found there is a need for education regarding preventative self-care, such as breast self-examinations. No literature was found concerning the immigrants' health knowledge or how they acquire information about health.

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The goal of the present study is to take a phenomenological approach to understand the experience of health of older adult Russian immigrants. The objective of the phenomenological approach is primarily to understand a problem from the perspective of those being studied (Creswell, 1998). It is a search for the central underlying meaning of an experience. The phenomenological approach was used in this study to understand the meaning of health for older adult Russian immigrants as reflected in their thoughts on health, health care and health knowledge. Understanding their perspective will help to elucidate the cultural explanatory models of this recent immigrant group and may be helpful for health care professionals in working with them effectively.

Methods

Role of the researchers

Both of the researchers in this study have an interest in health promotion and in Russian immigrant health. We deemed a qualitative approach to be the appropriate methodology since there is little other research on the health experience of this population. The primary researcher is Russian-born and has been residing in the US for over 25 years. She is fluent in Russian, and so was able to recruit and conduct the focus groups in Russian and translate the data into English. Part of phenomenology is to set aside (bracket) prior beliefs to allow participants to express their own experience of a phenomenon (Creswell, 1998). In this case, we were aware there was dissatisfaction in the immigrant community among older adults with health care in the US. We also were aware of the literature and statistics showing the high rate of disease and low rate of compliance to health behaviors among Russian immigrants. However, we did not have prior knowledge of what the experience of health was like for older adult Russian immigrants. We approached the focus groups as an opportunity for this group to share their experience of health with us.

Participants

Twelve participants were recruited for this study. The recommended number of participants in a phenomenological study generally is 10 (Riemen, 1986; Moustakas, 1994; Creswell, 1998; McCracken, 1998). For other forms of qualitative methods where theory is being built, e.g. in grounded theory qualitative methodology, a larger number of participants from a variety of sites is necessary in order to find exceptions to the theory being developed. However, in phenomenology, the researcher is interested in setting aside his or her own beliefs to understand a phenomenon as experienced by participants. Thus, a small number of people (generally about 10) are interviewed individually or in focus groups in greater depth. The recommended time is 1 h (Riemen, 1986; Creswell, 1998). All participants may be drawn from a single site as long as they have experienced the phenomenon being study and are able to articulate this experience (Creswell, 1998; McCracken, 1998).

Participants were recruited through English second language (ESL) and citizenship classes for older adult Russian immigrants from a community center in the San Francisco Bay Area. Citizenship classes are focused on preparation for the examination immigrants must pass after 5 years in the US in order to become US citizens. Participants were over the age of 65 and had immigrated to the US from Russia or Ukraine in the last 5 years. They had immigrated under US refugee status. In order to receive this status, they had to establish to the US that they were (1) a minority (in this case, the participants were Jewish), and (2) that they had suffered oppression and discrimination in the former Soviet Union due to their minority status. The US program under which these participants immigrated is a family reunification program through Immigration and Naturalization Services. Thus, all of the participants had at least one close relative (sibling, spouse or child) in the US when they arrived.

Data collection

We developed open-ended questions to capture the experience of health in our focus groups (Table I).

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Table I. *Focus group interview questions*

Meaning of health
What health concerns do you have?
What are health concerns in your community?
How do you know when you are healthy?
What do you do during the day to improve your health?
How healthy do you feel?
If you have questions about health, whom do you ask?
How do you get information about health?
Health knowledge
Are you aware of the effects of exercise, diet, and stress management on health?
What constitutes a healthy diet?
How much exercise does a person need?
What do you do to deal with the stress in your life?

First, we pilot tested the questions during two advanced ESL and citizenship classes with about five participants in each class. Then, members of four beginner and intermediate classes were asked to participate in the focus groups. The primary researcher came into the classes and described to the students in Russian about herself and her interest in the health of Russian immigrants. She then invited students to participate in the focus groups and advised them that they would be asked to talk about their thoughts regarding health. Their teacher encouraged participation in the focus groups.

The focus groups were split by gender to ensure that people did not feel hindered by the presence of the other gender in speaking openly about health. Splitting the focus group by gender also allowed us an opportunity to validate the themes that emerged in each group against each other. The women's group had eight attendants and the men's group had four. This was fairly proportional to the gender distribution in the ESL classes.

Since transportation was a potential barrier for many of the class members to take part in the focus groups (they arrive and depart from their ESL classes in a shuttle bus provided by the community center), transportation was provided. The focus groups were held for 1 h at the community center immediately before or after the ESL class.

Focus groups were conducted in Russian by the primary researcher. Participants were told at the beginning of the focus group that they would be asked about their thoughts on health. Participants were given a consent form (in Russian) for their records. They were not offered compensation for their participation. Focus groups were conducted in Russian and tape-recorded. The cassette tapes were later translated and transcribed for analysis by the primary researcher.

Data analysis

In the phenomenological approach, once data is transcribed, the researchers read through the text and make margin notes and initial codes. Statements about the meaning of an experience are then grouped into themes (this is called horizonalization). The researcher then reflects on the emergent themes to develop a structural description of the underlying meaning of an experience for a particular group of people (Miles and Huberman, 1994; Creswell, 1998). Creswell describes this part of the analysis as follows (Creswell, 1998):

> The researcher reflects on his or her own description...seeking all possible meanings and divergent perspectives, varying the frames of reference about the phenomenon, and constructing a description of how the phenomenon was experienced.

Data analysis in this study followed the recommendations for phenomenological and qualitative analysis set forth by Creswell (Creswell, 1998) and Miles and Huberman (Miles and Huberman, 1994) as described here. Data from the women's group and the men's group were analyzed separately. For each group, we read of over the translated transcript several times and then made codes in the margins next to particular statements to delineate the topics that were discussed. The margin codes were then reviewed for emergent themes. Once we had a general sense of the themes, we re-read the transcript again to ensure the themes felt appropriate to the data. We then compared the themes that emerged from the women and men's groups and found there to be no notable differences. Next, we looked for common elements to the themes to hypothesize whether there was an under-

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lying structure to the experience of health for the older adult Russian immigrants.

To begin a preliminary process of validation of whether the themes we found were appropriate, we had the themes independently evaluated by two experts in the health practices and cultural beliefs of Russian immigrants. The first evaluator is a Russian-born physician who practiced medicine for 15 years in Russians before immigrating to the US and practicing medicine in the US for the past 20 years. She is of the same generation as the participants of this study and continues to treat many recent immigrants. The second evaluator is an American-born and educated physician who for the past 15 years has devoted part of his medical practice to treating recent immigrants from the former Soviet Union with the help of an interpreter. Both felt the themes described in this study captured those they confronted on a daily basis working with this population.

Results

Knowledge about health behavior

Participants were asked several questions about what constitutes health behavior. Since we asked about this explicitly, responses were not coded as an emergent theme. There was an understanding that behavior affects health, but much of what participants discussed was either scientifically unfounded or was partial information. Participants were aware that fruit and vegetable consumption and exercise are beneficial, and smoking and drinking have negative health consequences. Several people mentioned that taking cold showers or pouring cold water on oneself was a positive health practice because it improved blood circulation. Getting fresh air was also considered a beneficial health practice. When asked about how to eat healthfully or exercise, participants generally did not have concrete ideas for how to do this. Several people expressed that one needs to exercise every day to have benefits, that 10–15 min of exercise is adequate and that a healthy diet involves not overeating to the point where one feels ill. It was apparent that in order to practice health promotion, this group would first need to acquire information about health and what constitutes health behavior. The remaining data were analyzed for emergent themes to understand the CEMs that may be guiding the immigrants' health knowledge and health behavior.

Health meaning: emergent themes

Four central themes regarding health emerged from the data. These themes were labeled (1) absence of disease as health, (2) distrust, (3) alienation and (4) stress. A brief description of each theme including quotes from the focus groups is provided in the following paragraphs.

Absence of disease as health

Participants were never asked questions about physicians or medicine and the focus groups were purposely held in a non-medical setting. The questions asked were of a much more general nature, such as 'What is health?' and 'How do you know when you have health?'. However, respondents tended to answer these questions by talking about their doctors, what medications they were taking, and what illnesses they have had in the past and present. For example, the reply to a follow-up question asking 'What do you do for your health other than going to doctors?' was 'I take pills for my heart and blood pressure'. An answer to a question about what area of health participants would like to learn more about was 'What medicines are out there'.

Health was consistently defined as the lack of a negative rather than the presence of a positive state. Questions about health behaviors led to responses about illness. Answers to the question what is health included 'When I am not sick', 'When nothing hurts' and 'If you don't feel bad, if you're not going to a doctor, you're healthy'.

Distrust of health messages

The theme of distrust of messages about health was characterized as distrust of media sources such as Russian newspapers and radio, but also true of information they received from their doctors.

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Participants felt that since media messages about what is healthful are inconsistent, there was no point in listening to any messages. They attributed the reason for inconsistent messages to ulterior motives, such as someone trying to sell a product or get rid of an excess of supply of goods. The following quotes exemplify this perspective:

> What ever is available is good for you, what ever isn't is bad for you. That's how it was in Russia. Here everyone wants to sell something. So what ever he is selling for you is the best for your health, the best for you. The other guy's product is bad for you. Everything is a commercial.

> If there is a lot of bread, you read that bread is good for you. If there is a shortage, it's bad for you. If the tomato crop is good that year, suddenly tomatoes are good for everything. If the crop is ruined, suddenly tomatoes are harmful.

Participants also expressed distrust of media messages due to inconsistencies between messages in the US and Russia.

> One group says it's good for you. Another says it's bad for you. How are you supposed to know who to listen to? In Russia they used to tell us to eat lamb a lot. They said it was good for digestion. Here they tell us the opposite.

Russian newspapers and Russian radio were the media formats most frequently mentioned as sources of health information. Life experience and intuition were cited as a way to get information about health. 'Each person trusts his own body. He knows what is good for him and what harms him and each person adjusts accordingly.'

Although participants expressed distrust about information they received from physicians, they still cited doctors as the most trusted source of health information. This apparent contradiction is addressed in the discussion. One participant summed up distrust of doctors in the following way: 'There is an old Russian joke. Do we treat this man or do we let him live. I choose to live so I don't go to doctors'. Another source that was cited as trustworthy were the interpreters at the health clinic where most of the immigrants go, even though participants were not aware as to whether the interpreters had any formal medical training.

Alienation from the US medical system

Participants expressed concern that they were getting substandard medical care because they do not speak English. They feel limited with respect to having to go to doctors who either speak Russian or have interpreters on site. 'It's such a hassle without translators that we try not to even turn to a doctor with our medical problems.' The participants mostly visit general practitioners and are concerned that their physicians may be slow to refer them to specialists because there will not be interpreters available. Sometimes they ask their adult children to translate but feel that this is a big inconvenience for their busy children.

> Here they don't seem to care if you don't understand. But I guess that's to be expected when you don't speak the language.

It is also new for this population for doctors not to make house calls and to have to make an appointment in advance to see a doctor.

> Of course there are some inconveniences here. For example, doctors do not come to your house so even if you have a fever, you have to go to them. That's very American.

Another participant stated, 'If you get sick, you can't go to a doctor right away. This is a huge inconvenience'. They also expressed dissatisfaction in communication with doctors and the perceived lack of communication between doctors. One man said he wanted his general practitioner to talk to his specialist and report back to him, and was told by his practitioner that this was not possible. 'The bond is broken between doctors. Each doctor feels he does his own part but no one communicates with anyone else.'

Participants also said that compliance to medication was challenging for them because in Russia,

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anti-hypertension medications were usually taken once a month in the form of an injection. They find it difficult and inconvenient to take pills daily and indefinitely.

Causes of stress

Many of the stressors mentioned related directly to immigration, adjusting to a new culture, and not speaking English. They spoke about how even simple tasks like grocery shopping are stressful because of the language barrier.

> You need to understand what a big part of our experience it is in every way not to speak English. Even going into a store is difficult and embarrassing.

The women talked about how parent–child relationships are different in the US. Here, they do not see or speak to their children as much because their children are busier. Both genders expressed feeling useless and burdensome to their children. The citizenship exam is another cause of stress.

> It very negatively affects the health of older people that we have to take an exam to receive our citizenship...I haven't even submitted my documents yet but I'm already losing sleep because they failed two of our people and I'm afraid they'll fail me, too.

Also, participants referred to a sense of homelessness that was explained as knowing the former Soviet Union was no longer their home but also not feeling at home in the US.

> Of course you want to go back. Even though it was hard. We all spent a huge part of our lives there. That's where we lived our youths. Even though it was hard there. It was our lives.

One woman stated:

> Sometimes we feel so lucky to be here and sometimes we feel so depressed. I think I could have just stayed there and been eating my two sausages a day, and not have had to go through any of this.

The immigration process itself was also described as an extremely stressful time.

> The worst stress we were under is when we were immigrating. It would tear families apart. The children wanted to come to the US, older people didn't. Somehow you have to come to a decision. It's very difficult.

Although participants in this study discussed the stress in their life, there were also statements about how life in the US allowed them more time for themselves than life in Russia. People felt they did not have to work as hard here.

> We've all gotten younger by 10 years. Nobody could even imagine that we would be going to school, taking walks, going to concerts frequently, going to casinos, on excursions, we were deprived of all that.

Several people said they felt they could finally focus on health and take care of themselves in a way their stressful lives in Russia did not allow.

> In Russia we didn't have time to take care of ourselves... [In the US] we do not have to worry about tomorrow. This is very important. Because we know we have a roof over our heads, we have everything we need materially.

These statements indicate that health care professionals may have an important window of opportunity to intervene with this population.

Discussion

Underlying structure

Using the phenomenological approach, the four emergent themes were qualitatively explored for an underlying descriptive structure with regard to the Russian immigrants' knowledge and beliefs around health. Themes of distrust and alienation emerged when participants shared their thoughts about health knowledge and acquiring health information. Many of their reasons for not seeking out health information or practicing health behaviors stemmed from distrust and alienation.

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For example, several participants expressed they did not follow dietary recommendations because they changed continuously based on crop performances or other political agendas. There may be an underlying belief that farmers have the authority to influence the media or that there is a central system that coordinates both of these industries. These sorts of beliefs are most likely left over from the participants' experience in the former Soviet Union under a centralized government that had tight controls over the media. Alienation appears to affect behavior in that participants expressed that they sometimes did not go to the doctor because they did not feel that doctors took the time to communicate with them. This was the case even though participants had also stated that the physician was the source of information that they trusted most. It appears that distrust and alienation underlie the older adult immigrants' hesitation to seek out health information and to practice health behaviors. It may be that the distrust and alienation need to be addressed for the immigrants to become interested in making lifestyle changes.

Another explanation for why the immigrants do not practice preventative health behaviors may lie in their definition of health. When health is defined as the absence of disease or when nothing hurts, it may be natural not to take any measures toward health until 'something hurts'. These definitions are consistent with the medical model of health practiced in the US for much of the 20th century. However, in the last 20–30 years, the biopsychosocial model has gained increasing acceptance (Rodin and Salovey, 1989). In this model, health is defined as the presence of positive quality of life. This includes practicing preventative health behaviors, and taking care of oneself physically, psychologically and socially in order to maintain a positive health state.

Another way in which having a medical definition of health may hinder the immigrants from seeking out information and practicing health behaviors is that the most credible source of health information is the physician, yet this population will only go to physicians when they are already sick. Thus, healthy people are unlikely to hear from a source credible to them about what they should be doing to remain healthy. It is likely that as the Russian immigrants acculturate they will expand their list of credible sources. However, in the meantime, an outreach program may be helpful in getting information to people who are not currently receiving it.

Finally, the stress of the immigration and acculturation process and the language barrier experienced by the participants may also be acting as a deterrent to finding information about health behavior.

In light of the thoughts and feelings that emerge as part of the experience of health for older adult Russian immigrants, it becomes more clear why it may be difficult for this group to take proactive steps toward improving one's health and quality of life. In drawing attention to the relationship between the participants' beliefs about health and their health practice, this study demonstrates the importance in understanding the underlying meaning of health in order to understand a populations' health practices.

In order to improve their health and lower health care costs, older adult Russian immigrants will need to acquire information about health and adopt new health behaviors. Interventions are sometimes targeted based on demographic variables. Targeting based on beliefs and meaning of health may be an effective way to improve the efficacy of hard to reach populations. However, current psychosocial models of health behavior emphasize gathering information as an important strategy for making changes. For example, according to the Transtheoretical Model, people use the process of information gathering (consciousness raising) to help them move from earlier motivation stages involving contemplation into action stages involving actual health behavior change (Prochaska *et al.*, 1992). Many health promotion interventions use processes such as this to help people change. However, this approach may not work with this population because of the distrust that exists toward information about health. Community interventions also often are education oriented with messages

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conveyed through media such as radio spots, posters and mailings. Alienation from the health care system and distrust of health information may make such methods of intervention less effective with this population than others.

However, several statements were made during the focus groups that implied participants may have more time in the US to focus on their health than they had in Russia. Health care professionals may have an important window of opportunity to intervene with this population. It was clear from the focus groups that in order for any effort at health promotion to be effective with this population, it would have to be convenient (e.g. transportation provided) and in Russian. Since the study findings indicated that physicians are the most credible source of health information, even if they too are viewed with suspicion, it may be helpful if any health promotion efforts were led or at least introduced by physicians. Future studies are necessary to understand the most effective methods by which health care professionals can make use of this window of opportunity to address the health promotion needs of older adult Russian immigrants.

Limitations and future directions

Although the small sample size and qualitative design of this study was an effective way in which to gather initial open-ended information about health beliefs and knowledge among Russian immigrants, the small sample size may limit the generalizations that can be made from this study. Future research with larger sample size is necessary to replicate and expand upon the relevancy and accuracy of the themes that emerged in this study. Another study limitation is that it remains unclear what part of the health experience for this group is idiosyncratic to older adult Russian immigrants and what is more common, either to older adults or other immigrant groups. It is also possible that their experience may be based in part on factors outside of culture, such as socioeconomic status. Future studies should elucidate how to address the health promotion and health care needs of older adult Russian immigrants in the US. The small sample size also made it difficult to assess whether gender differences were present. Quantitative studies with a larger group of participants can assess whether addressing the feelings of distrust and alienation may be a method for improving efficacy of health promotion interventions among the older adult Russian immigrant population.

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