

2009

## Views About Health of Russian-Americans Living in Central California

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### Recommended Citation

Fiterman, Mark, "Views About Health of Russian-Americans Living in Central California" (2009). *Master's Projects*. 761.

DOI: <https://doi.org/10.31979/etd.hv6v-ypvy>

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**SAN JOSE STATE UNIVERSITY  
SCHOOL OF NURSING**

**MASTER'S PROGRAM PROJECT OPTION (PLAN B)  
PROJECT SIGNATURE FORM**

STUDENT NAME MARK FITERMAN

SEMESTER ENROLLED SPRING 2004

TITLE OF PROJECT VIEWS ABOUT HEALTH OF RUSSIAN-  
AMERICANS LIVING IN CENTRAL CALIFORNIA

NAME OF JOURNAL JOURNAL OF TRANSCULTURAL NURSING

The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

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**Running head: VIEWS ABOUT HEALTH OF RUSSIAN-AMERICANS LIVING IN  
CENTRAL CALIFORNIA**

**Views About Health of Russian-Americans  
Living in Central California**

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**KEY WORDS: Russian-Americans, health care, SF-36, nursing**

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**Views About Health of Russian-Americans  
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### Abstract

This quantitative research explored the health views of Russian-Americans to discover information about the health needs of this population. Data were collected via a demographic form and a tool, SF-36 Health Survey. 46 respondents participated and returned completed packets. Results were scored in eight scales representing two different groups of health measurement, physical health and mental health. The scores for each scale and group were compared to the norm-based scoring for general U.S. population. The mean for the physical component summary (PCS) was 33.31, and the mean for the mental health summary (MCS) was 48.53 indicating that the physical health of people from this sample was much lower than the average for the US general population. However, the mental health of the sample was very close to the average for the US general population. Suggestions are offered for how health care providers can use this information in working with Russian-Americans.

### Research Problem

This study explored the views about health of Russian-American immigrants living in an urban area of Central California. The results of the study might provide information about recommendations and referrals to appropriate health care facilities and providers that serve to meet the needs of this population.

Immigration is an enormous stressor for people. Immigrants leave their relatives, friends, and homes to move to another country and, often, to another continent. For various reasons, a great number of people have immigrated to the United States. Around 7.6 million people immigrated to the United States between 1991 and 1998 (US Census Bureau, 2000). According to Sabatello and Basok and Brym (as cited in Aroian & Norris, 2000), more than 850,000 of Russian speaking people immigrated to Australia, United States, Canada, and Israel from the 1970s to the 1990s. Many of these immigrants have come to the United States. Subsequently, the population of immigrants from the former Soviet Union to the United States has grown significantly in the last 25 years (Tran, Khatutsky, Aroian, Balsam, & Conway, 2000). Around 419,000 people from the former Soviet Union immigrated to the US between 1991 and 1998 (US Census Bureau, 2000).

The population of Russian-Americans in Central California is growing as well. Gelb (2003) states that there are around 7,000 immigrants from the former Soviet Union living in the Greater San Jose area, and these immigrants from the former Soviet Union are an appropriate focus for research (Aroian & Norris, 2002; Goldenberg & Saxe, 1996). However, little health research has been done with this group. This creates a problem for

care providers. In order to give the best health care to these Russian-American immigrants, knowledge of their cultural and ethnic differences in health and illness patterns is vital for appropriate health care.

#### Research Question

The research question was, "What are the views about health of Russian-Americans living in Central California?" The purpose of the study was to explore the health views of Russian-American immigrants to develop a knowledge base for health care providers to understand the needs of this aggregate.

#### Literature Review

There have been few research studies done regarding the health status of Russian-American immigrants, and their health image is still developing (Duncan & Simmons, 1996). Aroian and Norris (2002) did a 2-year research study to assess the risk for depression among immigrants from the former Soviet Union in the Boston area. The researchers studied a sample of 468 immigrants who had been living in the United States up to 5 years. The findings included that the Russian immigrants who had depression in the past, did not have jobs, recently had resettled, and lived without any known close relatives in the area had a high risk for depression.

In another study, Aroian and Norris (2000) with a sample of 450 immigrants to Israel from the former USSR looked for any correlation among resilience, demographics, immigration stress and anxiety, and depression. In contrast to some theories of how resistance is associated with psychosomatic outcomes, no evidence was established for resilience modifying the connection between the stress of immigration and depression.

Aroian and Norris (2000) stated that immigration has the capability to be painful despite individual coping abilities.

Tran et al. (2000) studied a correlation between health status, depressive symptoms, and living conditions in a sample of 300 elderly Russian-Americans in the Boston area. The investigators used the survey method with self-administered questionnaires for this study. The researchers found that Russian-Americans who lived isolated had a higher chance of experiencing despair than people who lived with their families.

Cockerham (2000) analyzed health lifestyles in the former Soviet Union using data provided by the nationwide Russian Longitudinal Monitoring Survey. This research study involved 8,402 participants in the former Soviet Union. The findings indicated that the neglected health lifestyle of middle-aged men in the former Soviet Union was the primary social cause that correlated with a declining life expectancy. The poor health lifestyle included large alcohol intake (Cockerham, 2000; Rahav, Hasin & Paykin, 1999). Smoking, high fat-food consumption, and inadequate daily physical exercise were the other components of the poor health habits of middle-aged men in the former Soviet Union (Cockerham, 2000; Duncan & Simmons, 1996). Cockerham (2000) mentioned that the poor health behavior existed in the former Soviet Union due to the society's belief that individuals were less important than a group. In addition, it was prevalent that the state would treat an individual in a case of a serious illness, so people did not seem to pay enough attention to their own health behaviors and lifestyle.

Duncan and Simmons (1996) did an exploratory study to find out likely health



situations and ethnic principles of a sample of 30 immigrants from the former Soviet Union. The investigators identified assorted dental problems, obesity, and lack of knowledge of primary health screening procedures such as cholesterol and blood pressure tests, and necessity of performing mammograms, Pap smears, and breast self-examinations. A majority of the study participants identified their health status as poor or fair, and about 50% stated that they have a need for the use of translators.

Rahav et al. (1999) studied alcohol-drinking patterns among Russian immigrants to Israel and compared them to other Israeli citizens. The survey method was used, and the sample included 292 Russian-speaking immigrants among 4984 Israelis. The investigators found out that the recent Russian immigrants to Israel consume more alcohol than the other Israelis.

Slonim-Nevo, Sharaga, and Mirsky (1999) studied a culturally perceptive method for examining two families of Russian-speaking immigrants to Israel. The researchers found out that it is better to use a family-system method rather than individual treatment when providing care especially for the immigrants from the former Soviet Union.

Bobak, Pikhart, Hertzman, Rose, and Marmot (1998) conducted a cross-sectional survey using a sample of 1599 people more than 18 years old in Russia. Life expectancy in the Russian Federation is the lowest among developed countries. Shkolnikov et al. (as cited in Bobak et al., 1998) stated that heart problems, accidents, injuries, and suicides in middle age had the most influence on low life expectancy among Russians. Bobak et al. (1998) believed that inferior health status in Russia was related to a malfunction of societal structures, socioeconomic deficiencies, and a lack of professed management of

health problems. The researchers suggested that deficient and low apparent management of health problems might be significant mediators among the societal environment and health in people undergoing different changes in life.

Wei and Spigner (1994) studied health status and the pattern of using medical clinic services by 743 Southeast Asian and Russian refugees in Portland, Oregon. The researchers found that the top five health problems reported by Russian-Americans were “general health problems, pediatric health problems, cardiovascular diseases, gastrointestinal diseases (male), reproductive care (female), and ear, nose, and throat” (p. 268). Also, compared to the Southeast Asian population, Russian immigrants had fewer clinic visits according to this study.

#### Theoretical Perspective/Conceptual Framework

The Purnell (2002) Model for Cultural Competence was used as a conceptual framework for this study. This model helps to study cultures that are dynamic and in a continuous stage of development. The model has 12 domains, is based on many theories, and indicates that the primary characteristics of a culture are (a) race, (b) nationality, (c) age, (d) gender, (e) color, and (f) spiritual attachment. Secondary characteristics include (a) socioeconomic and educational status, (b) political viewpoints, (c) profession, (d) military experiences, (e) metropolitan versus countryside habitation, (f) commune uniqueness, (g) nuptial and parental conditions, (h) physical characteristics, (i) sexual orientation and issues, (j) cause for relocation, and (k) immigration status. The domains include (a) overview/heritage, (b) communication, (c) family roles and organization, (d) workforce issues, (e) biocultural ecology, (f) high-risk behaviors, (g) nutrition,

(h) pregnancy and childbearing, (i) death rituals, (j) spirituality, (k) health care practice, and (l) health care practitioner. All these domains are affected by each other and are related to each other.

According to this model, a health care provider giving the care should make a connection with patients. Using the domains, such as spirituality, nutrition, health care practices, family role and organization, and other, family can be involved in the process of health care. That may help understand more about a cultural group, prolong lives of patients, and help a community to reduce cost of medical care by keeping people out of the hospitals.

## Methodology

### Design and Participants

In this study, a survey with questions about general demographic data and the SF-36 Health Survey developed by Medical Outcomes Trust and Quality Metric Incorporated (1988) about patients' health in the Russian language were mailed to study participants. They were asked to answer the questions and return the survey in an addressed stamped envelope. The survey was anonymous, and the identity of the participants was unknown.

There were 46 participants for this study, which was conducted through the All-American Association of Invalids and Veterans of World War II Immigrated to the USA from Russia (Division of San Jose). The members of this organization are Russian speaking males and females who are 70 years old and older, who have emigrated from the former Soviet Union to the United States, and who live in the Central California. This

demographic group was selected because elderly people tend to have more frequent visits to medical care providers for their health needs than young or middle age adults.

### Procedures

A letter to the President of the association asking permission (Appendix A) to use this organization's membership for the study was sent, and he granted permission. The researcher contacted the members of All-American Association of Invalids and Veterans of World War II Immigrated to the USA from Russia (Division of San Jose) by mail explaining the purpose of the study, the anonymous status of the participants, and the minimal risk involved. The letter (Appendix B) included the questionnaire (Appendix D) and the demographic form (Appendix C) and a stamped envelope with the return address of the researcher.

Because participants were anonymous, no consent form was used, and this was explained in the letter. Completing the instrument and mailing it back indicated agreement of the individual to participate in the study. The participants were asked to complete the instrument and mail it back to the researcher.

### Instruments

The research tool used in this study was the SF-36 Health Survey questionnaire that was developed and used by John E. Ware, Jr., founder of Quality Metric Incorporated (Medical Outcomes Trust, 2002), Lincoln, Rhode Island. Quality Metric had given permission to use the questionnaire (Appendix D). The response options of this questionnaire ranged from "Yes" and "No" for some questions to as many as six options for the answers ranging from "All of the time" to "None of the time" for other questions.

The questionnaire had 36 questions written in Russian because many of the people from the aggregate might experience problems with English. The Demographic Form (Appendix C) included the age range, sex, marital status, years of residency in area, and experience with the utilization of physicians or nurse practitioners. All data collected by these instruments were anonymous.

### Results

To obtain the information, 117 SF-36 Health Survey and demographic questionnaires were mailed, and 46 of them were returned that included 26 males and 20 females. According to the results of the demographic questionnaire (Table 1), 36 people or 78.3% of the 46 respondents were between 76 and 85 years old. The married respondents were 27 or 58.7%. The widowed were 18 people or 39.1%. One respondent or 2.2% had never been married. No divorced or separated respondents were reported. A majority of the aggregate (58.7% or 27 respondents) had 10 to 15 years of education, and 15 people or 32.6% had 16 to 20 years of education. The majority of the people in this sample (25 or 54.3%) have been living in California between 11 and 15 years, and 20 people or 43.5% have been living in California for 6 to 10 years. Everyone from this sample had used medical services. People who seek help from medical doctors were 42 or 91.3%. However, many of these people (30 or 65.2%) go to see nurse practitioners as well, and 13 people or 28.3% see other medical providers, which were not specifically identified in the responses.

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Insert Table 1 Here

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The results of the SF-36 Health Survey were formatted in comma delimited file (CSV) and sent to Quality Metric for scoring. Scoring was done in eight different scales, including (a) physical functioning (PF), (b) role-physical (RP), (c) bodily pain (BP), (d) general health (GH), (e) vitality (VT) which included energy level and fatigue, (f) social functioning (SF), (g) role-emotional (RE), and (h) mental health (MH). The responses for each of these eight scales grouped as follows: (a) PF is the responses of the participants in the study to items 3a through 3j; (b) RP includes the responses to items 4a through 4d; (c) BP is the responses to items 7 and 8; (d) GH includes the responses to items 1 and 11a through 11d; (e) VT is responses to items 9a, 9e, 9g, and 9i; (f) SF includes the responses to items 6 and 10; (g) RE is the responses to items 5a, 5b, and 5c; and (h) MH includes the responses to items 9b through 9d, 9f, and 9h. Health transition item (HT) is the response to question #2; it is considered separately and is not used in scoring the scales or summary measures.

These eight scales created two different groups or categories of measurement, physical health (PH) and mental health (MH). According to Ware and Kosinski (2001), bodily pain, role-physical, and physical functioning link to the physical factor and have the most influence in the scoring of the physical component summary (PCS) rate of that factor. Social functioning, role-emotional, and mental health link to the mental health factor and have the most influence in the scoring of the mental component summary (MCS). Vitality and general health influence both factors. Because of the importance to differentiate the physical component summary (PCS) from the mental component

summary (MCS), it is important to describe results of the study using these two factors (Ware & Kosinski, 2001).

According to Ware and Kosinski (2001), for the interpretation of the results, it is easier to use the norm-based scoring (NBS) approach. This method is used to compare results across of different studies to the 1998 US general population norms. The mean for both PCS and MCS is 50, and the standard deviation for both is 10. The scores above the mean are considered better health status, and scores below the mean are considered as decline of health (Ware & Kosinski, 2001).

The results of this study show that the mean for PCS is 33.31 and the mean for MCS is 48.53. This suggests that the physical health of this Russian-American group is much lower than the average for the US general population. However, the mental health of these Russian-Americans is just below the mean of general US population. The other mean numbers for each of the eight scales in this study are the following: (a) mean for physical functioning (PF) is 40.0; (b) mean for role-physical (RP) is 26.63; (c) mean for bodily pain (BP) is 55.0; (d) mean for general health (GH) is 37.24; (e) mean for vitality (VT) is 45.43; (f) mean for social functioning (SF) is 66.85; (g) mean for role emotional (RE) is 64.49; and (h) mean for mental health (MH) is 65.65.

This information indicates potential problems in the areas of (a) role-physical, which includes different problems with physical health in daily activities or work, (b) physical functioning, and (c) general health. At the same time, the results suggest strengths in the areas of (a) social functioning, (b) role-emotional that includes problems with work and daily activities due to depression or anxiety, and (c) mental health. The

means for bodily pain and vitality are in the normal range for the U.S. general population.

### Implications

The results of this study may help health care providers to distinguish the areas of strength and potential problems in health status of the elderly Russian-Americans. This means that the health care providers in order to diagnose and treat elderly Russian immigrants may focus on the area of physical health, and may use the area of mental health as a supportive resource. The primary health providers will be able to react more quickly to the medical complaints of their Russian-speaking patients, diagnose them correctly, and, if it is necessary, send them to the appropriate tests and procedures, or to the different specialists. This may prolong lives in this group of patients and save many millions of dollars to MediCare or Medicaid by keeping more patients out of hospitals.

One of the suggestions to treat the problems with physical health of the elderly Russian-Americans is to use support groups. These groups may consist of Russian immigrants who have different physical problems and have a repertoire of methods for successfully coping with them. These facts may increase the quality of life for this aggregate and their families.

### Conclusion

This research study was done to discover the views about health of Russian-Americans living in California and to help health care providers to focus on the areas of potential health problems. However, this study has several limitations that have to be considered by health care providers and future researchers. The limitations that have to be



considered are (a) small sample size, (b) age of the respondents, (c) area of living, (d) style of living, (e) social life, (f) financial situation, and (g) level of education. A suggestion for the future research is to use a larger sample size, different age groups, different areas of living, and comparing people with the different financial and social situations. Also, more research is needed seeking detailed information about problems in daily activities or work, physical functioning, and general health. Future research would assist nurse practitioners and other health care providers to deliver culturally competent health care to this population.

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**Table 1**  
**Demographic Results**

<b>Category</b>	<b>n</b>	<b>%</b>
<b>Age: 76-85 years</b>	36	78.3%
<b>Marital Status</b>		
Married	27	58.7%
Widowed	18	39.1%
Single	1	2.2%
<b>Education</b>		
10-15 years	27	58.7%
16-20 years	15	32.6%
<b>Living in California</b>		
11-15 years	25	54.3%
6-10 years	20	43.5%
<b>Health care providers</b>		
Physicians	42	91.3%
Nurse practitioners	30	65.2%
Other	13	28.3%