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A TALE OF TWO CULTURES: THE EFFECTS OF CULTURAL INVOLVEMENT ON THE ADJUSTMENT OF OLDER ADULT IMMIGRANTS FROM THE FORMER USSR

By

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ABSTRACT

A TALE OF TWO CULTURES:
THE EFFECTS OF CULTURAL INVOLVEMENT ON THE ADJUSTMENT OF OLDER ADULT IMMIGRANTS FROM THE FORMER USSR

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The purpose of this study was to test the relationship between acculturation and psychological adjustment in a sample of 144 older adult immigrants (mean age = 67) from the former Soviet Union, who are currently residing in the United States. The Soviet-Jewish Acculturation Measure (SAM), a culture-specific instrument measuring cultural involvement in the Soviet-Jewish culture and in the U.S. culture, was developed for this study. Factor analyses revealed a single factor for the Soviet-Jewish Involvement Scale (ISJ) and two factors for the U.S. Involvement Scale (IUS): U.S. Values and U.S. Behavior Preferences. Regression analyses were used to determine whether cultural involvement was associated with better mental health and an increase in the amount of perceived social support from that culture. Results indicated that different types of involvement (e.g., values, behavior preferences) are associated with different outcomes. Recommendations for English as a Second Language (ESL) classes and community interventions are offered.

To my late grandparents, who gracefully faced the challenges of immigration at a late age.

Their little Russian bakery in Chicago is one of my favorite memories of my culture.

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It is with great pleasure that I write this section. To be sure, some of the pleasure comes from being done with a challenging, long-standing task. However, I am also glad to finally have the opportunity to formally thank several individuals who gave so freely of their time, energy, and knowledge, not only during the course of my dissertation research but throughout my graduate career. To begin with, I would like to thank Michael Lambert, my mentor and dissertation co-chair, for sparking my interest in research by giving me both responsibility and the freedom to learn and make mistakes. I would also like to thank Bill Davidson, my other co-chair, for his good humor and good sense, as well as his honest feedback throughout the dissertation process, and particularly in the early stages regarding feasibility issues. In addition, I want to thank my other two committee members: Anne Bogat, for her personal encouragement and support, as well as her help in conceptualizing the role of social support in my dissertation study, and Rick DeShon, who I have long appreciated for both his uncanny ability to explain statistical concepts and his genuine niceness and openness to answering big and little questions alike.

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Finally, my personal experience of working on this dissertation has certainly bore out the many studies describing the benefits of social support. I would, therefore, like to thank my parents for their love and support, as well as informal feedback about my ideas. And lastly and mostly, I would like to thank my life partner, who has always believed in me and has helped me every step of the way.

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Chapter 1

IMMIGRATION: A TALE OF TWO CULTURES

"Remember always that all of us are descended from immigrants."
(Franklin D. Roosevelt, in Esar, 1968)

The population of the United States is mostly comprised of immigrants and descendants of immigrants from across the world, and despite a projected decline in the population growth rate, the proportion of new immigrants to our nation is expected to keep growing (Culbertson, 1993). The statistics are illustrative: In 1990, 39% of the population growth in the United States was due to immigration, up from 18% in 1980 and 9% in 1950 (U.S. Census Bureau, 1992). Moreover, in some cities (e.g., New York), immigrants and their U.S. born children already constitute a majority of the city's population (NYC Press Office, 1990).

The large numbers of immigrants bring with them their own sociocultural backgrounds and associated values and attitudes, some of which can be in sharp contrast to the values and attitudes of the new culture. Undoubtedly, the cultural diversity of values and attitudes can positively contribute to the experience of both the immigrants and the host culture. However, the values of the old and new cultures sometimes clash, and this conflict, as well as other immigration-related stressors (e.g., language deficits, drop in SES) can negatively impact immigrants' adjustment to the new culture and,

consequently, their mental health (Rogler, 1994; Hovey, 2000). These findings, as well as the increasing numbers of immigrants in the United States, warrant further study of the immigration process and the associated stressors.

Unfortunately, there is still a paucity of research devoted to cultural issues in general and immigration in particular (Rogler, 1994; Sue, 1999). For example, in a bibliographical search of articles published between 1974 and 1993 in 21 primary journals, only 390 of 31,791 published articles were deemed relevant to cross-national migration, acculturation, or other cross-cultural issues (Rogler, 1994). Moreover, as many researchers (e.g., Baca Zinn, 1989) have pointed out, the tremendous variability in attitudes, expectations, values, and even phenotype make it difficult to generalize from one immigrant group to another. As a result, separate studies of different immigrant groups are necessary, not only to gain knowledge about particular groups, but to test the general processes, principles, and theories regarding acculturation (Sue, 1999). In addition, since age has been shown to have a significant effect on the acculturation process (Rogler, 1994; Szapocznik & Kurtines, 1993), studies of different age-groups are also necessary to develop a better understanding of the immigration experience of a specific group, as well as the acculturation process in general.

One immigrant group that has not received much attention from researchers is Jewish immigrants from the former Soviet Union, particularly elderly immigrants. Although several researchers (e.g., Althausen, 1993; Kohn, Flaherty, & Levav, 1989) have written about various aspects of their experience in the United States, including psychological adjustment, no one has yet examined the impact of acculturation strategies

(i.e., cultural involvement) on their mental health. This is a critical lack, because while studies with other immigrant groups, such as Cubans (Lang, Munoz, Bernal, & Sorenson, 1982) and Southeast Asians (Wong-Rieger & Quintana, 1987), have found that biculturalism (i.e., involvement in both the traditional and host culture) is usually associated with the best levels of adjustment in adults, there is also evidence that, in some circumstances, it may be more adaptive for immigrants to be involved either in one culture or the other (Berry, Kim, Power, Young, & Bujaki, 1989).

The goal of the present study was to begin to simultaneously address the lack of acculturation research in two groups of immigrants: Russian-Jews and older adults, by focusing on individual-level factors that may be affecting psychological adjustment. More specifically, the present study of older Russian-Jewish immigrants in the United States, developed and tested a psychosocial model in which cultural involvement is associated with better mental health and social support provides a protection from the negative outcomes that are associated with high levels of stress (Figure 1). However, to place the study into a frame of reference, it is first necessary to review the literature on the stressors of immigration for the Russian-Jewish elderly, the impact of stress on mental health, and on the potential positive effects of social support and cultural involvement. This is the focus of the next chapter.

Chapter 2

REVIEW OF THE LITERATURE

There is a story about a Soviet man who spent several weeks in the United States and upon his return home as an "expert" on American society, gave the following report: "Comrades, the situation of the proletariat under advanced capitalism can only deteriorate, just as Marx and Lenin predicted. Imagine, comrades, American workers are so poor that they resort to eating dog meat, which is sold openly in the form of sausages, called, appropriately enough, 'hot dogs.' And [he added], I went to one of those baseball games the American capitalists organize to keep unemployed workers off the streets and to distract them from mounting a revolution. I distinctly heard one worker ask his companion whether she wanted one of those dog meat sausages and you know, comrades, what her answer was? 'Yes, please, John, I am dying of hunger!' So, you see how bad it is for the American worker" (Goldstein, 1984).

"If I wanted to start an insane asylum, I would just admit applicants that thought they knew something about Russia" (Will Rogers, in Esar, 1968).

Although dated, the humor in both of these quotations illustrates how citizens of the Soviet Union and the United States have historically known very little about each other. The unfamiliarity also extends to Soviet immigrants in this country and, although U.S. professionals have learned much about immigrants from the former Soviet Union in the last decade, many psychologists and other mental health service providers who work with Soviet immigrants remain uninformed about the people and culture of the former Soviet Union. This is problematic because Russian-speaking immigrants[1] constitute a

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[1] Although Jews comprised only a small minority (e.g., <1% in Russia, 1.3% in Ukraine) of the former Soviet Union's population (Giarchi, 1996), prior to the government's collapse, almost all of the immigrants from the Soviet Union were Jewish (Orleck, 1999).

sizable and rapidly growing population in the United States. For example, Russia alone (not including other Republics that made up the Soviet Union) ranked seventh among all U.S. immigrant groups in the rankings of countries of origin between 1820 and 1992 (Immigration Naturalization Service, 1994). More recently, in fiscal year 1996, immigrants from the former Soviet Union (e.g., Russia, Ukraine) ranked sixth in size among all immigrant groups in the United States (Immigration Naturalization Service, 1996). Furthermore, as Orleck (1999) pointed out, with more than 400,000 Soviet immigrants now estimated to be living in the United States and conditions in the former Soviet Union still deteriorating, the migration shows no sign of ending.

The Soviet Jews migrated to the United States for a variety of reasons, the most common of which were to escape anti-Semitism, to give their children a better future, and to stay connected (or to reconnect) with family members (Simon, 1997). Anti-Semitism, in particular, was mentioned more often than any other factor (49% of respondents) and was given by three times as many people as concerns about religious freedom or Jewish identity (Simon, 1997). While these two items may seem at odds with each other, in the words of former dissident Alexander Sirotin, "In the USSR, Jewishness had nothing to do with religion. Jewishness was a nationality" (in Orleck, 1999, p. 60). To that end, all Soviet citizens were required to carry a domestic passport, which had to be presented when traveling, enrolling for school, or applying for jobs, and the letter "J" on the 5th line subjected Jews to both verbal and physical harassment and official discrimination, such as loss of employment or a denial of admission to University (Orleck, 1999). For many Jews, it was this oppression rather than other hardships that motivated them to emigrate.

While much of the anti-Semitism and oppression was institutional, it did not stop as a result of the Soviet Union's collapse in 1991. The consequent shift to a more democratic regime and a capitalist economy was well celebrated in the United States. However, for Jews in the former Soviet Union, the changes were largely negative, as the new government was accompanied by food and housing shortages, sharp inflation, increased anti-Semitism, and an explosion of violent crime that makes the most violent cities in the U.S. seem idyllic in comparison (Orleck, 1999). For example, in 1996, 22,000 murders were reported in Moscow, compared with 983 the same year in New York (Orleck, 1999). Thus, in addition to the reasons for previous cohorts, many post-communist immigrants, known as the "Fourth Wave" were also driven out by their fear of crime and deteriorating economic conditions (Orleck, 1999).

During the 1970s and 1980s, nearly one-third of Soviet immigrants in the United States were over the age of 60, and there is evidence that members of the Fourth Wave are even older (Orleck, 1999). After a life-time in a culture much different than that of the United States, older adult immigrants from the Soviet Union experience two sets of stressors upon arrival: the stressors resulting from immersion into a different culture (acculturative stress) and the age-related stressors that often accompany old age. Since stress has been shown to have a detrimental effect on health (e.g., Hislop, 1991; Seyle, 1982), both of these stressors will now be examined separately.

Acculturative Stress

Cross-national migration has been shown to be associated with high levels of stress, regardless of immigrant group. However, each group faces a unique combination

of stressors upon immigration, and immigrants from the former Soviet Union are no exception. They are not only faced with the challenge of learning a new language and a new set of cultural norms, but must also deal with the cultural clash of values and attitudes that are an inevitable consequence of going from a communist, totalitarian regime to the individual-centered, democratic United States. Research suggests that factors such as anti-immigration sentiments, poor language fluency, and involuntary migration, as well as differences between the Soviet and U.S. cultures, including those in religion, family life, and socioeconomic status (SES), may result in higher levels of stress following migration (e.g., Mydans, 1993; Rogler, 1994). The acculturative stress resulting from these factors is important to understand, because, as the following sections will demonstrate, it directly increases the risk of mental health difficulties for immigrant populations.

Anti-immigration sentiments and prejudice. While negative attitudes and anti-Semitism in the country of origin may have forced immigrants from the former Soviet Union to migrate against their will, the attitudes of the people in the host country are also important, as anti-immigration sentiments, prejudice, and even racism play a substantial role in immigrants' mental health. Recent immigrants to the United States arrived at a time of widespread economic insecurity (Rogler, 1994), and in contrast to the immigration policy, Gallup polls have indicated that from 1965 to 1993, the percentage of people in the U.S. believing that immigration should be decreased rose from 33% to 61% (Mydans, 1993). These negative sentiments, though often subtly displayed, can lead many immigrants to develop a distrustful and hostile attitude toward members of the host

culture. In addition to directly increasing risk of heart disease and premature mortality (see Adler et al., 1994), hostility can also indirectly effect mental health by cutting off potential friendships and associations with members of the host culture. Since these associations are often important sources of social support, their loss can result in isolation. The effects of racism are even more extreme, as low self-esteem, identity problems, learned helplessness, and depression have all been attributed to prolonged exposure to a racist society (Fernando, 1984). Thus, immigrants facing a hostile culture are at risk for both physical and psychological problems.

Language fluency. Another critical factor in immigrant adjustment is language fluency. This factor is negatively correlated with stress (Berry, Kim, Minde, & Mok, 1987). In addition, it is also directly connected to fewer and less desirable employment opportunities, which, may lead to financial concerns, as well as other problems associated with low socioeconomic status (SES). This is particularly true for older Soviet immigrants, who, because of language difficulties, often choose to remain unemployed even though they may not have reached retirement age. Language fluency is also important, because it is one of the main determinants of whether or not immigrants utilize health services and the formal support network provided by immigration agencies (Persidsky & Kelly, 1992). In addition, poor language ability adds stress to every-day experiences, such as shopping, paying bills, and communicating with others, and in general gives people less control over their environment than they would have otherwise.

Surveys of elderly Russian immigrants in New York City indicate that lack of language skills is a widespread problem. According to Gelfand (1986, as cited in

Persidsky & Kelly, 1992), only 1% of the elderly respondents in New York City (N = 259) could speak English well, and only 4% could read it well, while 49% could not speak it at all and 29% could not read it at all. Furthermore, language fluency appeared to be particularly problematic for older immigrants, as people aged 50 and over had lower fluency rates in reading, writing, and speaking English than younger people, both at the time of arrival and at the time of the survey (Persidsky & Kelly, 1992).

Involuntary migration. Another important migration-related stressor that, for the most part, has been ignored in the literature is involuntary migration (e.g., refugees). Berry et al (1987) found that "push" factors (i.e., factors related to a desire to escape from unpleasant situations caused by personal, economic, political, and/or familial problems) significantly and positively correlated with stress r = .54). They suggest that the stress is brought on by the resentment that some persons experience when they are forced to leave their home country (Berry et al., 1987).

In addition to "push" factors, involuntary migration can also occur when all family members are not equal participants in the decision-making process. For example, some migrants, most notably children and elderly persons, are passive participants in a decision reached by others (Shuval, 1982). As with refugees, this type of involuntary migration implies a lack of control, which has been shown to be linked to both physical and mental health problems. For example in research with both animals and people, Seligman and his colleagues found a wide range of physical and psychological symptoms associated with perceived lack of control, which he called "learned helplessness." These symptoms included passivity, cognitive deficits, drop in self-esteem, sadness, anxiety, hostility, loss

of appetite, sleep problems, and reduction of motivation (Rosenham & Seligman, 1989), as well as depression (Peterson, Maier, & Seligman, 1993). Individuals who are forced to leave their friends and family and migrate to another country where they are "strangers in a strange land," unable to speak the language, and ignorant of even the most basic social customs, are clearly at risk for developing learned helplessness, particularly in a country that places such a high premium on self-determination. As Rogler summarized, "in the context of a host society suffused with egalitarian ideals, the denial of control of the self creates risk" (Rogler, 1994).

Prior to the collapse of the Soviet Union, most Jewish immigrants from the former USSR were considered refugees in the United States. However, unlike the majority of refugees from other nations, Soviet Jews were not considered to be an ethnic minority group and, therefore, could not use the benefits of minority status (Persidsky & Kelly, 1992). Moreover, although the family's decision to emigrate is often made collectively, it is the adult children who are typically the instigators of migration (Althausen, 1993). As a result, many older adults in the former Soviet Union migrated involuntarily, joining their children so that the family would not become separated (Mirsky & Barasch, 1993; Persidsky & Kelly, 1992). Thus, while many Soviet immigrants may be considered involuntary due to their refugee status, the risks associated with forced migration are probably most salient for the elderly.

Religious/ethnic identity. While many immigrants face some identity issues (e.g., immigrant status, minority status), Jews from the former Soviet Union are also confronted with a new ethnic identity, as upon arrival to the United States, they find themselves

referred to as "Russians" by Americans who assume that they are ethnically Russian people who practice the Jewish religion (Birman, 1994). In reality, as discussed earlier, Soviet Jews, while keenly aware and proud of their Jewish identity, are typically religiously nonobservant and generally uninformed about the Jewish traditions (Flaherty, Kohn, Golbin, Gaviria, & Birtz, 1986). Historically, this secularism frequently alienated the American Jewish community (a community from which many elderly Soviet immigrants expected to receive support), which tended to view them as "aggressive, pushy, manipulative, and ungrateful" (Flaherty et al., 1986, p.150). Thus, for Soviet-Jewish immigrants, this tension around religious/ethnic identity may provide additional stress not experienced by other immigrant groups.

Family life. While familial relations are often a source of support, they can also be a significant source of stress, particularly when new cultural values clash with old traditions, which is what often occurs following immigration. The Soviet Jewish family, was characterized by strong parental authority and control (Althausen, 1993). For example, Soviet couples often believed that they must obtain parental permission before they could marry (Detzner & Sinelnikov, 1994). Parental authority was especially salient, because the average Russian family typically consisted of three generations, all living under one roof (Hulewat, 1981). In fact, almost 60% of all couples began their married life in the cramped apartment of one spouse's parents, even though more than 75% of the young couples polled indicated that they would prefer to live independently (Detzner & Sinelnikov, 1994). This living arrangement stemmed partly from necessity due to the extreme shortage of housing, as it sometimes took years to get off a waiting lists for an

urban flat, which often consisted of two or three rooms, with a communal bathroom and kitchen outside the living area (Danes, Doudchenko, & Yasnaya, 1994; Detzner & Sinelnikov, 1994). However, the high degree of mutual dependence caused by the poor economic situation and the "atmosphere of distrust and suspicion" of outsiders which permeated and continues to permeate Russian society (Althausen, 1993) also contributed to the shared living arrangement. For example, since child day-care services were often either absent or inadequate (Althausen, 1993; Zimmerman, Antonov, Johnson, & Borisov, 1994), this role was typically filled by the parents of the young couple. In addition, the couple's parents often performed housekeeping and "hunted" for scarce groceries, while their children, in turn, were expected to take care of them in their old age, as services for the elderly (e.g., nursing home care) were practically nonexistent (Althausen, 1993).

This generational interdependence, which was so adaptive in the old country, was usually challenged almost immediately after migration. As Althausen (1993, p. 66) noted, "the newly-arrived Russian immigrant family usually gets its first introduction into the American values of differentiation and independence of family units when, only days after their arrival, the resettlement agency begins to treat them as two separate families: the grandparents get their own check and benefits, the adult children get theirs." Nonetheless, many Russian-Jewish immigrant families initially continue to live in a multi-generational household until the working-age adults establish themselves economically and culturally and begin the suburban migration. Sometimes their elderly parents go with their children, but, just as often, they remain in the city, where they can

live independently (they typically do not drive and are not fluent with the English language) as part of the Russian-Jewish community (Orleck, 1999). Thus, although the separation from their family may be a healthy source of pride for many older immigrants, it is important to note that it also deprives them of the mutual caretaking relationships that have long been traditional in Soviet-Jewish families.

Socioeconomic status (SES). Along with family relations, another change experienced by many immigrants is their socioeconomic status (SES). In nonimmigrant populations, the positive relationship between SES and health has been extensively documented (e.g. Dohrenwend et al., 1992; Neugebauer, Dohrenwend & Dohrenwend, 1980; Holzer et al., 1986). More specifically, SES has been shown to be inversely related to smoking, obesity, lack of physical activity, depression, hostility, and stress (see Adler et al., 1994), all of which contribute to risk of morbidity and mortality.

For immigrants, the connection between SES and health is more complex. The complexity stems from the fact that immigrants must frequently accept employment that is below their level of education, which sometimes results in a lower standard of living than they were accustomed to prior to migration (Rogler, 1994). This drop in SES may lead to low self-esteem, depression, and demoralization (Ritsner et al., 1993). On the other hand, for many immigrants, the previous experience of a higher SES drives them to achieve economic success in the new culture. This drive may influence many different aspects of their behavior, including work habits, saving/spending, and child rearing. Furthermore, the previous exposure to a higher status (e.g., high education) may affect an immigrant family's values and behaviors, thus protecting them from some of the poor

outcomes associated with low SES.

Perhaps the most interesting finding concerns the effect of acculturation on the relationship between SES and mental health. In their meta analytic study of acculturation and adjustment, Moyerman & Forman (1992) concluded that in all cases where SES was an important predictor for poor outcomes (i.e., addictions, career conflict, anxiety/stress), lower SES samples showed sharp increases in symptomatology as they acculturated. According to the study's authors, this can be understood through the application of the social inequality theory. That is, when low SES immigrants migrate to the United States, they are likely to use individuals from their country of origin as the basis for social comparisons, but as they acculturate to the United States, they begin to perceive more inequality in class, power, and social status in comparison to others in the host country. Moyerman & Forman (1992) suggest that these low SES individuals probably experience psychological symptoms as a result of their growing dissatisfaction with their social conditions.

While low SES is a risk factor for some immigrants, for others it is the drop in SES that is most salient. This is especially true of Soviet immigrants, who often had to forfeit their pension and life savings when they left their homeland. The drop in SES is further exacerbated by the fact that although Soviet-Jewish immigrants tend to be highly educated, they often struggle to find comparable employment due to language difficulties or differences in training requirements (Ben-David, 1995; Ritsner et al., 1993). This is an issue for both men and women, as the economic conditions in the ex-Soviet nations, both before and since the collapse of the Soviet Union, necessitated that both sexes participate

in the labor force. In fact, since 1970, fewer than 10% of able-bodied Soviet women have engaged in full-time homemaking, mostly because it became impossible for most families to live on a single salary (Boss & Gurko, 1994; Danes et al., 1994). In addition, as evidenced by a Moscow study of 418 women, virtually all women (98%) work full-time, even if they are mothers of small children (Danes et al., 1994). Moreover, although they were still more likely than men to have less prestigious and lower paying jobs, the Soviet work environment was, at least in principle, egalitarian. For example, in 1988, women comprised 40% of all scientists, 36% of all engineers, and 50% of those working in the arts (Boss & Gurko, 1994). Furthermore, in 1984, women comprised 34% of the USSR Supreme Soviet (main legislative body) and about 50% of local Soviet governmental bodies (Boss & Gurko, 1994). Thus, like men, women in the Soviet Union may have derived part of their self-identity from their career. They may still be mourning this loss following arrival and, like men, may feel pressure to find comparable work in the United States and may feel shame and worthlessness if they are unable to do so.

Age-Related Stress in Elderly Immigrants

The relationship between stress and health is particularly salient for older immigrants, because while stress is not an inevitable consequence of old age (Foster, 1997), the combination of age-related (e.g., health, death of loved ones) and migration-related (e.g., language difficulties) stressors can cause many elderly immigrants to experience high levels of stress. For example, studies of different ethnic groups (e.g., Indochinese, Korean) have found that elderly immigrants report higher rates of psychological distress than their non-immigrant counterparts (Browne, Fong, & Mokuau,

1994; Kiefer et al., 1985). More specifically, stressful life events and immigration after age 20 have been linked to a variety of negative mental health outcomes in elderly immigrants (Ruskin et al., 1996). While few studies have examined stress and adjustment in elderly samples of immigrants from the former USSR, existing studies have largely supported the notion that elderly immigrants experience considerable difficulties making the adjustment to the new culture. Because of the tremendous influx (roughly 500,000 between 1989 and 1993 alone) of Soviet-Jewish immigrants into Israel (Ritsner et al., 1993; Zilberg, 1995), the vast majority of research with this immigrant group took place there. However, the few existing U.S. studies found that Soviet immigrants tended to have unrealistic expectations for life in the new country (Brodsky, 1988; Goldstein, 1979) and were also more likely to be unhappy and experience depression, somatization, and demoralization than nonimmigrants (Flaherty et al., 1986; Kohn et al., 1989).

These studies suggest that, although elderly immigrants do not necessarily have the worst mental health within their own ethnic group (Browne et al., 1994), immigration may provide a unique set of stressors for elderly people. For example, elderly immigrants are typically less flexible than their younger counterparts in adjusting to a new culture (Mirsky & Barasch, 1993) and generally find it more difficult to learn a new language and adopt new behavioral norms and values (Mirsky & Barasch, 1993; Tran, 1992). These are critical tasks, as difficulties with language and cultural norms may cause the elderly to experience stress in every-day activities (e.g., shopping), important endeavors (e.g., receiving medical services), and even family relationships (e.g., conflict over child-rearing).

It is also important to recognize that non-cultural stressors may be particularly stressful for elderly immigrants. Two stressors in particular: age-related health issues and the death of loved ones are common for elderly individuals (Solomon, 1996) and merit a closer examination.

The association between physical and psychological health has been well documented in the elderly. For example, a study of over 5000 non-institutionalized Dutch persons between the ages of 57 and 84 years found that hearing impairment, neurological disease, vision impairment, and lung and heart disease were strongly associated with psychological distress (Ormel et al., 1997). Similarly, health related stress and limitations were deemed to be a central issue for elderly foreign residents in Germany (Goldberg, 1996). Elderly patients with physical problems are at particularly high risk for developing depression, which has been associated with frequent and severe headaches, skin infections, respiratory illnesses, ulcers, hypotension, and diabetes (Katz, 1996). As Gelfand and Yee (1991) point out, elderly immigrants frequently suffer from depression, because they have limited resources to deal with physical losses and stressful life events. However, depression is not the only mental health symptom that elderly immigrants experience. Because of their high rates of physical illnesses, the elderly are also at increased risk for several other psychological syndromes. More specifically, physical illness, along with the medication that is used to treat it, has been shown to not only cause mood disorders, but also psychotic and anxiety disorders (Marsh, 1997).

In addition to the loss of physical health, the loss of a loved one has also been shown to lead to prolonged periods of distress and disability, including a reduction in

cognitive effectiveness and problem-solving capacity, a deterioration of the person's self-concept, and higher rates of adjustment disorders and chronic psychopathology (Caplan, 1990). Furthermore, an analysis of a national random sample of 503 elderly people who were widowed in 1979 revealed significantly higher mortality rates for men over age 75 in the first six months of bereavement (Bowling & Windsor, 1995).

Soviet elderly before migration. In the former Soviet Union, older adults were characterized by the prevalence of the common diseases of old age, such as arthritis and cardiovascular disease (Persidsky & Kelly, 1992). Furthermore, health problems (e.g., accidents, injury, chronic disease) were the major cause of the impaired functional abilities of the urban (Persidsky & Kelly, 1992), and life expectancy (62.7 years for men, 72.7 years for women) was, and continues to be, considerably shorter compared to other industrialized nations, including the United States, France, England, Japan, and Germany (70.7 years for men, 77.7 years for women) (Ryan, 1991, cited in Giarchi, 1996).

Part of the reason for the relatively low life expectancy was that, despite the fact that approximately 65% of the Soviet citizens' income went to the government as taxes (Danes et al., 1994), health care and other social benefits in the Soviet Union were largely inadequate. While many of the services, such as child care and housing, which U.S. families pay for out of pocket, were provided free of charge, there was no guarantee that they would actually be available or adequate, and, in fact, as described earlier, they often were not. Health services, in particular, were (and still are) primitive by U.S. standards (Althausen, 1993; Danes et al., 1994). For example, there was typically an inadequate supply of medications and about half of the medical institutions did not have hot water

and sewerage (Giarchi, 1996). Furthermore, many of the health practitioners (e.g., doctors, nurses) were undertrained and hospitals were overcrowded and understaffed, requiring family members to come to the hospital to assist the scarce and overworked nursing staff (Althausen, 1993; Giarchi, 1996). Additionally, many Soviets perceived the health care system as corrupt and bureaucratic and often brought money or hard-to-get items (such as chocolate) to health care staff to ensure that their family members got adequate treatment (Althausen, 1993).

Mental health services, including cognitive, behavioral, and role-playing techniques, were also available in the Soviet Union[2], but like other types of therapy, they were considered the prerogative of the physician, and nearly all approaches to psychotherapy were based on the medical pathological model (Lauterbach, 1984). Apart from receiving therapy from a physician, there were few other options for the mentally ill (Lauterbach, 1984). For example, according to Zeigarnik (1975, cited in Lauterbach, 1984), in 1973, there were 20,600 neuropathologists in the Soviet Union, 17,500 psychiatrists, and an estimated (there was no official listing) 250 clinical psychologists. Moreover, patients were typically unable to choose their psychiatrist or psychoneurological outpatient clinic, although it was the practice of some physicians and psychiatrists to, for a fee, make unofficial house-calls outside their working hours (Lauterbach, 1984). In addition, there was also a lot of corruption, and it was widely known that psychiatric hospitals were often misused in the former USSR to punish non-

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[2] Psychotherapy in the Soviet Union was not as heavily influenced by Freud as it was in Europe and the United States (Babaya & Shashina, 1985).

conformists (Giarchi, 1996).

Soviet elderly in the U.S. Despite the fact that they are currently in the United States, the beliefs and attitudes of elderly Soviet immigrants toward health care in general and mental health, in particular, were developed under the Soviet political, cultural, and economic system. In the Soviet Union, despite the inadequate quality of care, about 90% of the elderly made frequent and extensive use of the health care system. More specifically, they averaged 6 to 12 home visits by a doctor or nurse per elderly individual per year and an average hospital stay of 30 to 60 days per person per year (World Health Organization, 1983, described in Persidsky & Kelly, 1992). As a result, they are often frustrated by the U.S. health care system, which, because of the associated costs, they cannot utilize as often as they are used to. At the same time, because of their experiences in the Soviet Union, many immigrants are distrustful of health professionals and medical treatment. Thus, elderly Soviet immigrants are, at best, ambivalent about health care services and are often reluctant to seek treatment (Persidsky & Kelly, 1992). If anything, elderly immigrants' use of mental health services is even more dismal. Prior to emigrating, Soviet Jews typically had very negative attitudes regarding mental illness, were distrustful of mental health care providers, and resisted seeking mental-health services in the Soviet Union at all costs (Persidsky & Kelly, 1992), Thus, only a few are willing to even consider psychological treatment in the United States unless they are severely ill. Finally, it is also important to note the different attitudes toward terminal illnesses in the Soviet Union and the United States. Unlike U.S. physicians, Soviet physicians cannot tell patients the truth about approaching death, a decision that has to be

made by family members (Persidsky & Kelly, 1992). As a result, the elderly immigrants and their families are often resentful of U.S. health professionals who bring them the unwelcome news.

In summary, immigrants in general and elderly Soviet-Jewish immigrants in particular are exposed to a number of acculturative stressors, which place them at higher risk for a wide range of mental health problems, including depression, anxiety, demoralization, and low self-esteem. Nonetheless, levels of stress alone do not completely explain the development of mental health problems. This is because, while there is a clear link between stress and disease (e.g., Hislop, 1991; Seyle, 1982; Strausser, Belisle, & Fiore, 1984), there is also evidence that individuals are born with varying predispositions to different psychological and physical health problems. This predisposition concept is at the core of the diathesis-stress model, which is currently the most accepted theory of the relationship between stress and illness. According to the diathesis-stress model, in order to develop and/or maintain a disorder, an individual must first have a biological or psychological predisposition to it and then be subjected to an immediate form of psychological stress (Comer, 1995). If an individual has a strong predisposition, very little stress is needed to trigger the illness. However, if extreme amounts of stress are experienced, even individuals who are constitutionally strong may develop the disorder (Rosenham & Seligman, 1989).

The diathesis-stress model is most often used to explain the development of schizophrenia, where adoption and twin studies show both a clear genetic vulnerability (diathesis) and a strong environmental component (stress) (Gottesman, 1991, van-Os &

Marcelis, 1998). However, the diathesis-stress model has also been used to explain the etiology of a variety of other physical and mental health problems, including child depression (Burke & Elliott, 1999), adult depression (Boekamp, Overholser, Schubert, 1996), anxiety disorders (Paris, 1998), obsessive-compulsive disorders (Turner, Beidel, & Nathan, 1985), and musculoskeletal pain (Flor & Birbaumer, 1994).

While the diathesis-stress model provides a useful framework for understanding the etiology of many mental health problems, it falls short of explaining the relationship between stress and mental health outcomes. This is because while stressors are risk factors for health problems, several other factors can protect people from the effects of those stressors or have a direct positive influence on mental health. In particular, general population studies show that social support can be a buffer against the effects of stress and immigration studies have found that higher levels of involvement in the traditional and/or host culture tend to be associated with better mental health. Consequently, the impact of these two factors on the relationship between stress and mental health will now be discussed. I will begin with social support.

The Benefits of Social Support

Social support typically refers to resources provided for an individual by significant others such as family, friends, co-workers, and acquaintances. It is an important concept in health psychology, as there is general consensus that individuals who receive social support from friends and relatives are better able to avoid illness and recover more quickly when ill than do those who remain isolated from others (see Cohen & Wills, 1995). Even the mere perception of support on the part of the recipient can lead

to positive outcomes. In fact, several researchers (e.g., Henderson & Moran, 1983; Sarason, Levine, Basham, & Sarason, 1983) have observed that the perception of social support may be more critical than an objective determination of social support availability (i.e., social network size). However, social support is hardly a panacea. As Cohen & Syme (1985) note, a number of different factors may be critical for a valid assessment and a successful intervention. These factors, which include the support source, support target, support type, and support duration will be discussed next.

Support source: Who is providing the support? The issue of who provides the support is critical, as the same resource may be accepted from one giver but rejected from another (Cohen and Syme, 1985). Pearlin (1985) examined the most basic sources: networks, group affiliations, and interpersonal interactions. According to Pearlin, the network includes "the entire web of relationships of which individuals are a direct or indirect part" (Pearlin, 1985, p. 44). Although people are unlikely to call on all of their network's resources at any one time, the network is a useful concept, because it draws attention to the institutional and organizational resources that are available to the individual. As Pearlin noted, this is not merely a way of identifying societal resources, because like wealth and power, support resources that are available to individuals are unequally distributed in society across different socioeconomic strata.

Nestled within networks are group affiliations, which are groups to which individuals have active affiliations (Pearlin, 1985). While networks are a good indication of which supports individuals can potentially call on, group affiliations represent the sources of support to which individuals are most likely to turn. Group affiliations include

relatives, friends, colleagues, and associates, with relationships that are most direct, active, and intense usually representing the most viable sources of support (Pearlin, 1985). However, it is important to note that sociocultural factors often influence whether support is sought out or accepted. For example, there is evidence that, in some cultures (e.g., the United States), individuals prefer to receive support from older sisters than from younger brothers (Searcy & Eisenberg, 1992), presumably because older sisters are traditionally nurturing. In addition, social comparison researchers have found that different emotional states affect an individual's affiliative behavior. For example, a fearful situation (e.g., waiting to receive an electric shock) evoked, in most study participants, the desire to wait with someone else, but only with individuals in the same situation, while anxiety, embarrassment, and the presence of strong emotions (e.g., experienced by workers searching for body parts following an airplane crash) all led to decreased affiliation (see Buunk & Hoorens, 1992). Studies with different populations (e.g., cancer patients, people in stressful marriages) have also found that individuals under stress tend to prefer to receive support from those who are similarly or better off than they are (see Buunk & Hoorens, 1992).

The last category of support-givers (termed "interpersonal interactions" by Pearlin), consists of relationships marked by trust and intimacy. These are relationships that are "important to people for noninstrumental reasons, are nonspecialized and continuous, and encompass broad areas of interest and concern" (Pearlin, 1985, p. 45). While these qualities are typically found in a marital relationship or an intimate friendship, the receivers of support from these relationships may be entirely unaware that

they are, in fact, receiving support. This is evidenced by Brown (1978), who found that people in such relationships consider themselves entirely self-reliant, suggesting that support from these relationships is not actively sought out or consciously accepted or rejected.

For immigrants and other foreign born individuals, the source of support may also be important in respect to which culture it comes from. That is, support from individuals from one's country/culture of origin may have a different impact than support received from members of the host culture. This theory, which has become known as the "ethnic density hypothesis," states that there may be an inverse relationship between the incidence of mental illness in a particular ethnic group and its size relative to the total population (Cochrane & Bal, 1988). Although no studies have tested the ethnic density hypothesis directly, studies in Singapore, England, and Canada have shown a strong inverse correlation between the size of the ethnic group and the incidence of a variety of disorders, including psychosis and suicide (Murphy, 1977). Nonetheless, there have not yet been any studies that have actually compared cultural sources of support, and the impact of receiving support from one culture vs another is not currently known.

Support target: Who is receiving the support? The characteristics of the individual receiving the support may determine both whether the support is given and whether it is effective. Evidence for the former point can be found in the large literature on prosocial behavior, which shows that helping behavior is more likely to occur if the individual who needs help is judged to be attractive (Benson, Karabenick, & Lerner, 1976) and not responsible for his/her circumstances (Weiner, 1980). While these

characteristics are most salient for strangers or acquaintances, other studies show that the more a person is liked, the more likely they are to receive help (Clark, Ouellette, Powell, & Milberg, 1987). Ironically, the same characteristics that cause the helper to help may lead the recipient to reject it. According to Fisher, Nadler, & Whitcher-Alagna (1982), an individual suffers a loss of self-esteem when he/she receives help from a friend or similar person, which leads to a dislike of the helper and a high tendency to refuse the help. However, it should be noted that some sources of support are probably less influenced by the characteristics of the recipient than others. As Cohen and Syme (1985) suggest, an individual's personality probably plays a larger role in forming and maintaining friendships than in maintaining family ties, since support from family is often regarded as an obligation of the relationship. That is, the characteristics of the recipient may be important in determining whether or not support is given by friends but may not matter when it comes to family members.

Support type: What kind of support is provided? Different situations and different personality types require different types of support. For example, a monetary loan may be helpful during temporary unemployment but useless during a break-up of a romantic relationship. Similarly, some people may desire information during a financial crisis, while others may need to be reassured about their ability to support their family. There may be an unlimited number of ways individuals can support one another. However, it is possible to group similar types of support into broad categories. For example, Thoits (1986), described three categories: instrumental aid (e.g., financial help, grocery shopping), socioemotional aid (i.e., demonstrations of love, caring, empathy, and

group belonging), and informational aid (i.e., advice or information designed to address the problem). However, Pearlin (1985) cautioned that although such categories may provide a useful structure for conceptualizing different types of support, people usually have multiple problems, each requiring different types of support from varying combinations of people. Furthermore, the same problem may require different supports at various stages (Pearlin, 1985). For example, when an individual is hospitalized, he/she typically first requires substantial medical attention from medical professionals, followed by emotional support from family members after stabilization, finally instrumental (i.e., gifts) and informational support from friends and work colleagues upon returning home.

Support timing: When is the support provided? According to Cohen & Syme, (1985), social support that is effective at one point may be useless or even harmful at another. For example, factory workers who lose their job when the plant closes may initially attribute the unemployment to the economy or poor plant management. Thus, during this time, support for self-esteem would be of little use. However, those workers who are still unemployed several months later may begin to question their competency. At this point, support for self-esteem may be crucial.

Support duration: For how long is support provided? Social networks, as well as support organizations (e.g., Red Cross) can often provide ample short-term support but are unable to sustain the support for extended periods of time. In cases of acute stressors, short-term support may be sufficient, but individuals experiencing long-term stress, such as chronic illness, typically require prolonged support. Support duration is particularly salient for the elderly, as over a third of them require some degree of long-term

instrumental support (Minkler, 1985).

In summary, the positive effects of social support are well documented, and much is known about the impact of different elements of support. However, the process through which social support works is still under scrutiny and requires a brief discussion.

The Social Support Process

Cohen & Wills (1985) examined two different models through which social support could have a beneficial effect on well-being. One model, termed the buffering model, posits that support buffers or protects persons from the negative impact of stressful events. This model proposes that support is related to health only (or primarily) for persons under stress. The alternative (main-effect) model, on the other hand, proposes that social support has a beneficial effect irrespective of the amount of stress experienced. In their review of the literature through 1983, Cohen & Wills (1985) concluded that both models of social support are valid but represent a different process through which social support may affect well-being. Thus, each will now be reviewed.

Main-effect model. Epidemiological community studies have established a clear relationship between social support and health. For example, a nine-year follow-up of adults (Berkman & Syme, 1979) and a 30-month follow-up of an elderly sample (House, Robbins, & Metzner, 1982), both found that mortality from all causes was greater in persons with lower levels of social support. Furthermore, social support has also been shown to have beneficial effects for individuals suffering from depression (e.g., Komproe, Rijken, Wynard, & Winnubst, 1997; Li, Sletzer, & Greenberg, 1997) and other psychological distress (e.g., Baider, Kaufman, Ever-Hadani & De-Nour, 1996).

Buffering model. Although the direct effects of social support are compelling, there is also a preponderance of evidence suggesting that social support protects individuals from the negative effects of stress. That is, several studies have found that social support only has positive effects when individuals are experiencing high levels of stress. For example, although exposure to stress (i.e., unstable social conditions) led to suppressed immune system responsiveness in male monkeys, the monkeys that were the most affiliative showed an enhanced immune response (Cohen, Kaplan, Cunnick, Manuck, & Rabin, 1992). Similar findings emerged in studies with people who experience a traumatic experience (e.g., Pennebaker, Hughes, & O'Heron, 1987; Costanza, Derlega, & Winstead, 1988). For most people, immigration is indeed a traumatic experience, and the ethnic density hypothesis discussed earlier suggests that support from the ethnic community may be especially important in buffering the effects of stress and low SES for some individuals, particularly immigrants. As a result, the buffering model seems most appropriate with immigrant populations.

Social Support in the Elderly

The relationship between social support and health is no different for the elderly compared to other age groups (Minkler, 1985). Indeed, as in general population samples, there is overwhelming evidence that emotional support from family members and other relationships is positively associated with both physical and psychological health in elderly immigrants. For example, a study of 4734 adults age 65 and over found that physical impairment, depression, and decreases in life satisfaction were all associated with less perceived belonging support and less perceived tangible aid (Newsom & Schulz,

1996). Moreover, a review of 83 studies (56 of which were judged to be methodologically satisfactory) led the authors to conclude that, regardless of the disease or illness type, a positive perception of family support is consistently associated with a more favorable outcome (Kriegsman, Penninx, & van Eijk, 1995).

Studies with elderly immigrant populations also showed a significant relationship between social support and health. For example, Korean elders in the U.S. who had more close persons and more frequent contact with the close persons exhibited fewer depression symptoms (Lee, Crittenden, & Yu, 1996), and elderly Chinese immigrants who were satisfied with help received from family members received lower scores on a geriatric depression scale (Mui, 1996). In fact, a recent cross-cultural study examining the influence of social support on subjective well-being suggests that the benefits of social support may be similar across cultures, as a comparison of elderly persons in the United States and India found no differences across the two samples, despite a combined sample of 773 (Venkatraman, 1995). Cultural differences do, however, exist regarding which family members are viable sources of support. For example, in a multi-ethnic study of the elderly in Canada, 37% of British respondents reported confiding in peer family members (e.g., siblings, cousins), compared with 24% of French, 22% of Jewish, 20% of German, and 8% of Ukrainian/Russian respondents, a statistically significant difference (Penning & Chappell, 1987). The same study also found that the type of support that is provided by the family also varies from culture to culture, with Jews more likely to report receiving advice and financial aid than the other ethnic groups. Nonetheless, many elements of support have a similar impact for the elderly across

cultures. Of these, two factors appear to be particularly salient: the size of the support network (amount of support) and who is in it (source of support).

Amount of support: network size. Several longitudinal studies have shown that, despite the prevalent notion that social networks shrink in size with advancing age, age differences in the size of networks and frequency of contact are relatively small (Antonucci, 1990, cited in Atchley, 1994). Moreover, contrary to popular myth, the elderly are generally not isolated from or neglected by their adult children, especially when they need assistance (Minkler, 1985; Atchley, 1994). However, for the very old (e.g., over age 80), death, health problems, and relocation are not only sources of stress but can also decrease the size of the supportive network (Minkler, 1985). For example, a longitudinal study of 640 elderly over age 85 showed that almost 50% of participants had a smaller network 2.5 to 3 years later than during the original interview, with 19% having fewer relatives in their networks, 30% having fewer friends, and 26% also having fewer confidants (Bowling, Grundy, & Farquhar, 1996).

Loss of support in old age appears to be particularly problematic for men over age 70, who report having fewer friends than do women (Pogrebin, 1987). This gender difference is likely due to a variety of socialization factors. For example, men are used to having friendships develop around their work and interacting with friends around an activity. Thus, the less they are physically able to do, the more difficulty they have forming new friendships and maintaining old ones (Pogrebin, 1987). Men who have no friends typically rely on their wives for support, but such an over-reliance on one person does carry a risk, as men who categorized their wives as their best friends suffered the

most mental illness after their wives died (Pogrebin, 1987).

Source of support: Friendships and families. Loss of friendships is especially disturbing, because friends may be more important than ever to the elderly's health and well-being. In fact, Pogrebin (1987, p. 223) suggests that, contrary to popular opinion, "elderly people, like the rest of us, prefer friends of their own age.... And, believe it or not, a majority of old people say they think it's more important for them to have age-mates than family as their intimates."

Not only is it important to have friends in old age, as in adolescence, it is also beneficial to be part of a peer-group. Although it is unusual to find "old men running in packs" or "old women going to the theater as a group," being part of a clique has been found to be much more beneficial than one-on-one friendships (Pogrebin, 1987, p. 359). The clique, according to Pogrebin, gives old people a sense of belonging and an opportunity to share resources and help each other adapt to the aging process. As a result, Pogrebin (1987) suggests that living in retirement communities or in other age-segregated housing may be associated with the best outcomes for the elderly:

> "When the old are dispersed among families or singles, they tend to be the most isolated from each other and detached from the larger society.... In communities organized especially for the aged, on the other hand, old people can be independent yet know there is help at hand; their social life is part of their daily life. And when there are no younger people around, they fill the authority roles denied to them in an age-integrated society. They feel useful and appear competent in the eyes of their friends."

Unfortunately, the research examining social support in retirement communities is not concordant. In her review of this literature, Potts (1997) found three disparate views that have received empirical support: (a) social interaction in retirement communities are

frequent and intimate, (b) social interactions are frequent but superficial and lacking in intimacy, and (c) despite routinely engaging in activities with others, many elderly residents view themselves as isolated within both their environment and the larger community. In her own study of a retirement community, Potts (1997) found that although social support from friends within the community was high, unlike social support from friends living elsewhere, it failed to have a significant effect of depression. These findings underscore the importance of having multiple sources of support. As Potts (p. 358) concluded, the two different types of friends "undoubtedly meet different needs and the social support derived from them is undoubtedly associated with different aspects of well-being.

As with so many other things, it is also important to remember that in our pluralistic society, there is tremendous cultural (not to mention individual) variation in both attitudes and behaviors regarding family and friends. Indeed, certain types of support (e.g., long-term, instrumental support) are more likely to be provided by family members (Minkler, 1985), regardless of culture or ethnicity. Moreover, many elderly need to be needed and receive pleasure from providing both emotional and instrumental support for family members (Atchley, 1994), while for some elderly persons (e.g., those with a Japanese background), the family is the only acceptable source of support (Koyano, Hashimoto, Fukawa, & Shibata, 1995).

For Soviet-Jewish families, providing support for family members remains a priority long into old age. For example, a survey of 1400 men (ages 60-63) and women (ages 55-58) shortly after they became eligible for retirement indicated that the vast

majority of the elderly continued to provide financial, domestic work, and child-care assistance for their adult children after retirement. Overall, only 6% of the sample indicated that they gave no assistance whatsoever to their adult children (Detzner & Sinelnikov, 1994). Finally, this study also confirmed other research findings on mutual aid imbalances in the Soviet Union, as older adults were three times more likely to provide help to their children than they were to receive help, with the greatest imbalance in the area of financial support (Detzner & Sinelnikov, 1994).

Acculturation

While the benefits of social support have been examined in both immigrant and non-immigrant populations, studies with different immigrant groups suggest that, for immigrants, acculturation strategies may also serve a protective function. In fact, one major hurdle in trying to determine the impact of immigration-related stressors on mental health is that immigrants do not all respond the same way when they make contact with the new culture. Some individuals, for instance may continue to identify with and maintain the values, attitudes, and tastes of their traditional culture, whereas other immigrants (even those that are quite old) may subscribe to the "When in Rome..." philosophy and try to blend into the new culture as much as possible. These attitude and behavior differences toward the host culture are called acculturation styles.

Acculturation is an anthropological term that has been defined as "those phenomena which result when groups of individuals having different cultures come into continuous, first hand contact with subsequent changes in the original pattern [of behaviors, attitudes, etc] of either or both groups." (Redfield, Linton, & Herskovits, 1936,

p. 149). While, in principle, change can occur in either or both of the two cultural groups, in practice one culture typically dominates the other (Berry, 1980).

While anthropologists coined the term to describe what happens to groups, psychologists have adopted it to describe the extent to which the individual is involved in the traditional and new cultures and the process of individual change and adaptation that results from such involvement. The second half of this chapter will discuss the relationship between acculturation styles and mental health among members of different ethnic groups in the United States. However, since the concepts of culture, ethnicity, and nationality, are still often used interchangeably (Betancourt & Lopez, 1993), it is first necessary to examine each of these concepts in more detail.

Rohner (1984) reviewed the elements found in anthropological and psychological literature and proposed a definition of culture as a "highly variable systems of meanings which are learned and shared by a people or an identifiable segment of the population....[and] transmitted from one generation to another." Triandis et al. (1980) proposed a more practical definition for the purpose of examining psychological research. Triandis distinguished between the physical culture which includes objects such as buildings and tools, and the subjective culture which includes elements such as social norms, roles, beliefs, and values. More specifically, familial roles, communication patterns, affective styles, and values regarding individualism, collectivism, spirituality, and religiosity all comprise Triandis's conception of subjective culture.

The concept of ethnicity is particularly confusing, because as Birman (1994) pointed out, it has been used to represent at least three conceptually different constructs:

ethnicity (the collective culture of a minority group cultural group within a larger society), ethnic origin (a classification system based on one's biological ancestors), and ethnic identity (the extent to which an individual chooses to incorporate a particular ethnic classification into their sense of self). The issue of definition is sometimes made more complex when religion is involved. An example of such complexity may be found in the case of Jewish immigrants from the former Soviet Union who, upon migrating to the United States, find themselves referred to as "Russians" by people from the U.S. who perceive them as ethnically Russian people who practice the Jewish religion (Birman, 1994).

However, neither of these acculturation styles appear to be optimal for adequate emotional adjustment. For example, high acculturation has been shown to be associated with higher lifetime prevalence of phobia, depression, dysthymia, and alcohol and drug abuse and dependence (Burnham, Hough, Karno, Escobar, & Telles, 1987), as well as both suicide ideation and attempts (Sorenson & Golding, 1988). Furthermore, there is evidence linking high acculturation with difficulties in parent-child relationships and low levels of adjustment in children (Szapocznik, Kurtines, & Fernandez, 1980; Charron & Ness, 1981). Rumbaut's (1991) study of Indochinese adolescents in the United States provides another example of the deleterious effects of high levels of acculturation. According to his study, youngsters from these sociocultural groups who overidentify with the American culture tend to be proportionately less successful academically than their less acculturated peers.

An impressive body of evidence similarly links low levels of acculturation to

psychological distress in adults. A variety of symptoms, including depression, withdrawal, somatization, PTSD, and obsessive-compulsive behaviors, have been associated with low adult acculturation in a variety of immigrant populations (Westermeyer, Bouafuely, Neider, & Callies, 1989; Escobar et al., 1983). In addition, low acculturation was also found to negatively affect immigrants' subjective self-appraisals. For example, Yu and Harburg (1981) found a positive relationship between low acculturation and both life dissatisfaction and the number of negative life events such as divorce, hospitalizations, and death in a study of Chinese immigrants.

Berry (1980; 1986) expanded the concept of acculturation. In addition to high acculturation (which Berry called Assimilation) and low acculturation (Berry's term is Separation), he identified two additional styles of dealing with a new culture: integration and marginalization. Integration, also known as biculturalism, is the identification with the new culture while maintaining traditional cultural identity, while marginalization (or deculturation) is characterized by the rejection of both the new and the traditional cultures (see figure 1).

The handful of studies which have examined these constructs indicate that biculturalism is usually associated with the best levels of adjustment in adults. For example Lang, Munoz, Bernal, & Sorenson, (1982) found that bicultural Hispanic adults reported higher life quality, better emotional stability, lower levels of depression, and higher psychological adjustment than those who were either monoculturally Latino (separated) or monoculturally U.S. mainstream (assimilated). Similarly, the same researchers noted that drug abuse was much more prevalent in monocultural individuals,

specifically in over-acculturated youths and under-acculturated mothers of Cuban families (Lang et al., 1982). Biculturalism was also found to be optimal in a study comparing the satisfaction and acculturation of Southeast Asian and Hispanic adults. In that study, biculturalism was found to be the most satisfactory form of acculturation, followed by assimilation and then separation (Wong-Rieger & Quintana, 1987). A study of Indochinese adults (Rumbaut, 1991) yielded similar results. However, as Szapocznik et al. (1980) caution, it is not the retention of the old culture or the adaptation of the new culture that is in itself pathological. Rather it is the lack of biculturality that is maladjustive because it makes these individuals inappropriately monocultural in a bicultural context. In fact, there is evidence that in some circumstances, it may be more adaptive for immigrants to either assimilate to or separate from the host culture (Berry et al., 1989).

Researchers have had a difficult time trying to integrate all of the studies examining acculturation styles, as the findings are often inconsistent, even when comparing studies of elderly immigrants. For example, a study of elderly Chinese immigrants in the U.S. found that low levels of acculturation (i.e., separation) was associated with more depressive symptoms (Lam, Pacala, & Smith, 1997), while a study of elderly Korean immigrants found no significant relationship between acculturation and depression (Lee, Crittenden, & Yu, 1996). Even meta analytic studies have not been able to provide a clear picture. For example, a meta analysis of 30 studies of acculturation and mental health among Hispanics yielded an inconsistent overall pattern of direct and indirect relationships (Rogler, Cortes, & Malgady, 1991). There are two possible

explanations for the lack of consistency. Rogler (1994) argued that it is due to the fact that researchers often fail to account for many of the variables discussed earlier, such as drop in SES and social support. An alternate explanation is that the authors of the meta analysis failed to recognize that the various Hispanic groups were all different from one another and should, therefore, be broken down into individual ethnic groups (e.g. Puerto Rican, Cuban) prior to analyses.

There is evidence that both explanations are valid. As pointed out earlier, the literature suggests that migration-related stressors and buffers such as SES and social support are extremely important and must be integrated with acculturation styles in future research. In addition, the importance of treating each immigrant group separately due to the large differences found among the various immigrant groups in the United States (Baca Zinn, 1989) is also recognized.

In summary, researchers have identified the unique stressors associated with immigration, established the link between stress and mental health, and explored the benefits of different types of social support. In addition, studies with different immigrant groups have demonstrated that the individual's acculturation style is associated with various outcomes, including mental health and quality of life. However, because most acculturation studies typically focused directly on mental health outcomes, the impact of cultural involvement on variables such as social support is still not clear, despite many studies attesting to the benefits and protective nature of support. Moreover, it is still not known whether receiving social support from individuals in one culture (i.e., from the traditional vs. the host culture) may be more important than from those in another.

In addition to the need to address the issues above, it is also important to continue to expand the acculturation literature base to previously understudied immigrant groups, particularly since acculturation studies with one immigrant group are often not generalizable to other groups. At this point there have not been any studies examining the acculturation process in Soviet-Jewish immigrants, and because most of the acculturation studies are done using child and adult samples, it is also not clear whether cultural involvement, particularly in the host culture, continues to be a significant predictor of mental health in elderly immigrants.

The goal of the present study was, therefore, to begin to simultaneously address the lack of acculturation research in both Soviet-Jewish immigrants and elderly immigrants by focusing on the impact of cultural involvement on psychological adjustment and social support in a sample of elderly immigrants from the former Soviet Union who are currently residing in the United States. More specifically, the purposes of the study were (a) to develop a culture-specific measure of acculturation for immigrants from the former Soviet Union, and (b) to test the model of the relationship between acculturation, stress, social support, and mental health, in which acculturation style is associated with better mental health and increases the immigrants' perception of social support, which, in turn, moderates the relationship between stress and mental health. In addition, the final aim of this study was to go beyond the current understanding of cultural involvement and determine whether particular types (i.e., factors) of cultural involvement are associated with mental health outcomes and not others.

Study Hypotheses and Questions

Based on previous studies of acculturative stress and social support, it was hypothesized that (1) elderly immigrants reporting more stressful life events would show poorer psychological adjustment, and that (2) perceived social support would moderate the effects of stressful life events. Furthermore, it was also hypothesized that cultural involvement would also predict successful adjustment. Specifically, (3) respondents reporting higher levels of involvement in both the U.S. and Soviet/Jewish cultures were hypothesized to report fewer psychological problems. Finally, because people often rely on multiple sources for support, and because involvement in the U.S. culture and in the Soviet-Jewish culture are assumed to be associated with different types of social support, it was hypothesized that (4) higher involvement in both the Soviet-Jewish and U.S. cultures would be associated with higher levels of support. Moreover, while no demographic differences were hypothesized, it was possible that these variables could mask the hypothesized effects. Thus, the above hypotheses were also tested after statistically controlling for all demographic variables (among gender, age, and time in U.S.) that were significantly correlated with the outcome variable in each hypothesis.

Because it was not possible to predict whether the acculturation scale would yield multiple factors or identify what those factors might be, hypotheses regarding the differential benefits of specific types of cultural involvement were not generated prior to data analysis. However, a final purpose of this study was to determine which particular types or factors of cultural involvement were most strongly associated with mental health and social support outcomes.

Chapter 3

METHOD

Participants

Russian-speaking immigrants, age 50 and older, who were born in the former Soviet Union or in one of its successor states (e.g., Russia, Ukraine) were eligible to participate in this study. This relative young cutoff was used to select the "elderly" sample for three reasons: 1) life expectancy in the Soviet Union is 7-9 years lower than in the United States and other industrialized nations (Giarchi, 1996), 2) older adults in the Soviet Union are characterized by diseases of old age, such as arthritis and cardiovascular disease (Persidsky & Kelly, 1992), and 3) all of the older adults in the sample were retired. Thus, despite the young cutoff, this sample of older adult immigrants has many characteristics in common with U.S.-born elderly. However, to avoid confusion, the study participants will, hereafter, be described as either "older adults" or "retired adults."

Study participants were recruited from "English as a Second Language" (ESL) classes in Chicago and were, therefore, comprised of mainly recent immigrants. The average class consisted of 18 students, with a total enrollment of 157. A total of 151 students (6 were absent) were asked to participate. Four students declined and three others did not finish filling out the questionnaires. Thus, data collection yielded a 95% participation rate, for a total sample of 144. Power analyses indicate that this sample size

is sufficient to detect medium, but not small effect sizes, at Power = .80 and p = .05 (Cohen, 1992).

The older adult sample was 59.7% female and 40.3% male, ranging in age from 50 to 86 (mean age = 67.3, SD = 6.7). The time in the United States ranged from 1 month to 167 months (mean time = 51.9 months, SD = 25.5). Although 32.6% of the respondents were below retirement age, none were working full time and only two had part-time employment. All 144 respondents were receiving government aid and 71.5% were living in government subsidized apartments. The majority of respondents (54.3%) reported a "somewhat higher" or "much higher" standard of living now compared with how they lived just prior to migration. However, a considerable minority (31.7 %) reported a "much lower" or "somewhat lower" standard of living now than prior to migration.

Almost all (87.8%) of the respondents were Jewish. However, 39.9% indicated that they were not at all observant and only 4.2% rated themselves above the mid-point on a 5-point religiosity scale. Sixty-nine percent of the respondents were married. Of the remainder, 22% were widowed, 4% were divorced, and 3% were never married. Over two thirds (69%) lived with their spouse, and most of the rest lived alone (22%). However, 12% of all the respondents (i.e., including those who lived with their spouses) lived with an adult child.

Procedures

Older adult immigrants from the former Soviet Union were recruited from nine ESL classes held at various locations (e.g., public library, college classroom) in Chicago.

Permission was obtained from the instructors for the researcher to recruit study participants at the beginning of the scheduled class period. At that time, all potential participants were informed about the purpose of the study, the time commitment required of participants, and information about the administration of the measures. The confidential nature of the study was explained, and it was made clear that there was no penalty for not participating. The eligible ESL students who agreed to participate in the research then completed the group-administered self-report questionnaires, immediately following the regular class period. Two to four (depending on group size) Russian-speaking assistants who were familiar with the instruments were present in order to answer questions and facilitate the completion of the instruments (e.g., read items aloud to respondents having trouble reading the small print).

All respondents were asked to fill out, under the interviewers' supervision, the Immigrant Demographic Questionnaire (ID-Q), the Soviet-Jewish Acculturation Scale (SAM; Lyubansky & Shpungin, 1998), the Hassles and Uplifts Scale (Delongis, Folkman, & Lazarus, 1988), the Brief Symptom Inventory (BSI ; Derogatis & Spencer, 1982), and the Social Support Survey (Sherbourne & Stewart, 1991). Respondents were given a choice between Russian and English versions for all the instruments. However, all of the participants chose the Russian version. All of the measures were translated from English into Russian through the commonly employed (e.g., Flaherty et al., 1986; Hurth & Kim, 1990; Hovey, 2000) back translation technique. Thus, the instruments were translated into Russian by one translator and then translated back into English by a second translator to ensure that the meaning and nuances of the original questionnaires were retained.

Measures

Demographics. The Immigrant Demographic-Questionnaire (ID-Q) was used to collect pertinent demographic data, including gender, age, marital status, education, occupation (prior to retirement), income, employment status, reason for migration, length of time in the U.S., religion and religiosity, type of housing (e.g., apartment, house), living arrangement (e.g., alone, with child or child's family), and language ability.

Acculturation. The Soviet-Jewish Acculturation Measure (SAM; Lyubansky & Shpungin, 1998) assessed the individual's level of involvement in both the Soviet-Jewish culture and the U.S. culture, in order to determine his/her acculturation style. The development of the SAM was guided by the theoretical framework of Berry and his colleagues (e.g., Berry et al., 1989; Dona & Berry, 1993), which proposed that immigrants entering a new society can interact with the host culture using four, previously discussed, styles (i.e., Assimilation, Integration, Separation, or Marginalization). Like the scales developed by Berry and his colleagues (e.g., Berry et al., 1989; Dona & Berry 1993), the SAM consists of items that measure the attitudes of the respondents toward different elements of both the traditional and the host cultures. However, the SAM differs from these scales in two important ways. (1) In addition to the attitude items, the SAM also includes items addressing preferences and behaviors (e.g., food preferences, organization involvement); and (2) Since each culture has its own customs and values, the items on the SAM were developed specifically for the Soviet-Jewish population using the following procedures described by Dona & Berry (1993) and Nguyen (1995).

Review of the literature and consultation with members of the Soviet Jewish community were used to generate 35 topics that reflect the most relevant themes for the Soviet Jewish community (e.g., food and music preferences, community involvement). Two items were then developed for each topic, forming two 35-item scales measuring the level of involvement in the two cultures (i.e., involvement in the Soviet-Jewish culture [ISJ] and involvement in the U.S. culture [IUS]). Respondents were asked to rate on a 4-point Likert scale the extent to which they agree/engage in these various attitudes and behaviors.

Following procedures outlined by Tabachnick and Fidell (1996), all items were tested for normality, and a total of six items (ISJ items 32, 46, and 62 and IUS items 47, 55, and 61) were dropped because they did not meet the criteria for a normal distribution (i.e, skewness >2 or <-2; kurtosis >4 or <-4). These items were excluded from both the factor analyses and the computation of the overall involvement (i.e., ISJ and IUS) scales . In addition, two items (52 and 56) were dropped from the ISJ scale and three items (3, 53, and 67) were dropped from the IUS scale due to low correlations ($\underline{r}$s<.15) with the total scale scores. However, since it was possible for these last 5 items to correlate highly with a factor but not the overall scale, they were not excluded from the factor analyses or conceptual groupings.

Two separate common factor analyses were used to determine potential groupings of the remaining 32 items in each of the ISJ and IUS scales. None of the squared multiple correlations (SMCs) of factor scores were close to one, so multicollinearity and singularity were not a threat in either case. Correlations among both sets of 32 items

revealed numerous correlations in excess of .30, indicating that a pattern in responses to variables was likely (Tabachnick & Fidell, 1996).

A combination of Kaiser's criterion, the scree plot, and conceptual relevance were used to identify the number of factors for both the ISJ and IUS scales. As a result, one- to six-factor solutions were interpreted for both involvement scales. For each solution, the factor correlation matrices were examined in order to make a decision between orthogonal and oblique rotation. Since many of the factor correlations exceeded .32 (a 10% overlap in variance), oblique rotation was determined to be most appropriate in all cases (Tabachnick & Fidell, 1996). All factor loadings were determined from the rotated pattern matrices, using a cutoff point of .35. This relatively low cutoff was used, because the homogeneity of scores in the sample warrants an interpretation of lower loadings, and the rule of thumb is that only variables with loadings of .32 and above are interpreted (Tabachnick & Fidell, 1996).

For the ISJ scale, the 6-factor solution was not conceptually relevant (i.e., it was not possible to find a common theme in several factors). The 5-factor solution made conceptual sense but was deemed unsatisfactory because of the high inter-factor correlations (i.e., half [5/10] of the $\underline{r}$s were greater than .3 and two were greater than .4), suggesting that a more parsimonious solution was likely. The 4-factor solution was also conceptually sound but high inter-factor correlations (half [3/6] of the $\underline{r}$s were greater than .3, one was greater than .4) caused this solution to also be rejected. The 3-factor solution could not be conceptually interpreted, while the 2-factor solution was conceptually fine but was rejected due to the high correlation $\underline{r}$ = .44) between the two factors.

Because the factor analysis did not yield a satisfactory solution, the 32 ISJ items were conceptually grouped into factors based on the acculturation literature. In his review of acculturation measures, Zane (1998) found six domains that were commonly assessed. These domains were language, social affiliation tendencies, attitudes toward cultural participation, family socialization, communication style, and prejudice. There were no prejudice items on the ISJ, and only one item that referred to communication style. However, items were grouped together using the other four domains identified by Zane, and Cronbach's alphas were then computed for each of these factors to determine their internal consistency. All four groupings were found to have decent internal consistency, with a high alpha of .71 on the language factor and a low alpha of .61 on the social affiliation factor. However, like the factors generated by the factor analyses, these four factors were significantly intercorrelated (all rs >.3) and were, therefore, also rejected in favor of a 1-factor solution.

On the IUS, like the ISJ, the six-factor solution was not conceptually relevant. Neither were the five-factor or four-factor solutions. The three-factor solution was conceptually valid, but two of the factors had a correlation coefficient of .44, indicating that they were likely measuring the same construct. The two-factor solution was more satisfactory. It was both conceptually sound and parsimonious, with an inter-factor correlation of .27. The two factors were named U.S. Values and U.S. Behavior Preferences, but as with the ISJ, the four domains identified by Zane (1998) were tested before the factor analysis results were accepted. Following the procedure described for the ISJ, Cronbach's alphas were computed for each of the four domains to determine their

internal consistency. Only the language factor (alpha = .79) had an adequate internal consistency. The internal consistencies of the other factors (social affiliation alpha = .48, family socialization alpha = .53, and cultural attitudes alpha = .54) were well beneath the accepted level. Since all seven of the items on the language factor matched the behavior preferences factor from the factor analysis, the original two factors from the factor analysis were retained (see Table 1).

In summary, a single factor emerged for the ISJ scale, while the IUS scale yielded two factors (U.S. Behavior Preferences and U.S. Values). The implications of these solutions will be discussed later. However, a one-factor solution for the ISJ and a two-factor solution for the IUS were deemed appropriate, because cultural involvement may have a different factor structure depending on whether it is a minority or majority culture for the respondent. That is, while cultural values and behaviors may factor separately for the majority culture, they may form a single factor for the minority (i.e., immigrant) culture.

All the different cultural involvement scales (i.e., ISJ, U.S. Values, U.S. Behaviors), were treated as continuous variables, rather than as categorical (i.e., acculturation styles), as a lack of norms for this instrument prevented a classification of respondents into acculturation styles (i.e., assimilated, bicultural, separated, marginalized).

Internal consistency. The two original culture-involvement scales show strong internal consistency, with Cronbach's alphas of .84 and .82 for the ISJ and IUS scales, respectively. The alphas for the two IUS factors are also acceptable (.84 and .66 for the

U.S. behavior preferences scale and the U.S. values scale, respectively). The SMCs also indicate that all of the factors were internally consistent and well defined by the variables (the lowest SMC was .81). It is necessary to note the high number of variables (nine and eight, respectively for the ISJ and IUS scales) that failed to load on any of the factors (despite the relatively low cutoff of .35). This suggests that the variables as a group were not very well defined by this factor solution. However, this "loss" of items was expected given that this is the initial use for this instrument. In fact, this factor solution will be used to refine the ISJ and IUS scales for future use.

Criterion validity. Measurement of the ISJ's criterion validity was not possible. However, correlations with language ability and U.S. (i.e., non-Russian) social support indicate acceptable criterion validity for the U.S.-involvement scales. Specifically, the U.S. behavior-preferences scale is significantly correlated ($ps<.05$) with both respondents' self-report of English ability and with higher social support scores from non Russian speakers in the U.S. ($rs = .24$ and .36, respectively).

Divergent validity. To verify that the SAM was measuring acculturation, rather than a related variable, the two cultural involvement scales (ISJ and IUS) were correlated with language ability and time in the United States. In addition, the involvement scales were also correlated with a measure of physical health, in order to determine that involvement was not confounded with physical ability. Results show a clear lack of relationship between time in U.S. and IUS $r = .02$, $p > .05$) and between time in U.S. and ISJ $r = .02$, $p > .05$). Language ability was also found to not be significantly correlated with ISJ $r = .03$, $p > .05$) and to have a significant but small correlation with IUS $r = .24$, p

< .05). Finally, physical health was not significantly correlated with either the ISJ r = .07, p > .05) or the IUS r = .10, p > .05) scales.

Divergent validity was also examined for the two IUS subscales (i.e., factors). Correlation coefficients were calculated to determine if the subscales were differentially associated with various outcome variables, which included the total hassles, and the total psychopathology (BSI) scores. No differences were found for the hassles score. However, U.S. Values r = -.23, p < .05), but not U.S. Behavior-Preferences r = -.03) were significantly negatively correlated with total BSI scores.

Stress. The hassles half of a revised version of the Hassles and Uplifts Scale (Delongis et al., 1988) was used to assess stress. The revised Hassles Scale consists of 53 items. For each item, study participants were asked to rate both how much of a hassle it was for them that week using a 4-point scale, where 0 = none or not applicable, 1 = somewhat, 2 = quite a bit, and 3 = a great deal. Total hassles scores were obtained by summing across ratings given to all non-health-related items.

Seven items (11-17) were dropped from the Hassles scale, because they were related to employment, and were, therefore, not applicable for this sample. In addition, because of the reliability issues inherent in using a measure with a different population than for which it was designed, frequency distributions were examined for all the remaining items on the Hassles scale and Cronbach's alpha was computed using the elderly immigrant sample. As on the SAM, items were dropped if they yielded a low correlations (rs<.15) with the total Hassles scale. Four items (2. "your parents or parents-in-law," 23. "investments," 24. "smoking," and 28. "contraception") met this criterion

and were, therefore, dropped as well. Finally, items were also dropped if 85% (or more) of the responses fell on adjacent points (i.e., 3 and 4) on a 4-point Likert scale and if Cronbach's alpha for the scale was higher without these items. Two items (7 and 42) met these criteria. This left the Hassles scale with a total of 40 items.

Test-retest correlations for the total scores for one month and four months in the standardization sample are .82 and .72, respectively (Delongis et al., 1988). In addition, the Hassles scale has been shown to have good predictive validity. For example, it was shown to be a more powerful predictor of psychological symptoms than major life events (e.g., divorce, relocating), another common way of measuring stress (Kanner, Coyne, Schaefer, & Lazarus, 1981). Cronbach's alpha of .91 for the 40-item Hassles scale showed strong internal consistency in the elderly immigrant sample.

Mental health. The Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982) was used to assess the immigrants' mental health. The BSI is a shortened version of the widely-used Symptom Checklist-90 (SCL-90, Derogatis, 1977; 1983), and is designed to assess the symptom patterns of psychological and medical patients as well as community non-patient respondents. It is a 53 item self-report inventory in which subjects indicate how much they were distressed by each item in the past seven days, using a five-point Likert scale, where 0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit, and 4 = extremely. In addition to the 53 individual items, nine interpretable factors were derived from a varimax rotation of the principal components (Derogatis, 1993). The nine factors, or dimensions, are Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism.

Scores for these dimensions are determined by calculating the sum of all the items in each dimension. In addition, the BSI yields a global measure of psychological status, which is derived from the total of all 53 individual items.

All 53 items were deemed to be relevant to the immigrant sample. However, as with the Hassles scale, items were dropped if 85% (or more) of the responses fell on adjacent points on the 5-point Likert scale and if Cronbach's alpha for the scale was higher without these items. Two items (40. "having urges to beat, injure, or harm someone" and 53. "the idea that something is wrong with your mind") met both criteria, indicating that they were unreliable with this sample. These two items were, therefore, excluded from all dimension and total-problem scores. Correlations among the nine dimensions in the Russian immigrant sample ranged from .39 to .79, with only correlations involving Somatization being less than .50).

Previous studies with the BSI indicate that the instrument has excellent psychometric properties. For example, the BSI has been shown to have impressive convergent validity with the MMPI, and there are over 200 published reports documenting the predictive validity of the BSI in many different samples, including the elderly (Derogatis, 1993). Furthermore, the test-retest reliabilities across a two-week interval, for all nine dimensions of the BSI, range from a low of .68 to a high of .91 (total BSI test-retest =.90), while internal consistency coefficients range from .71 to .85 (Derogatis & Melisaratos, 1983). A test of the internal consistency coefficients in the elderly Soviet immigrant sample yielded similar alphas (range = .71 to .87), except for the 5-item Paranoid Ideation scale which had an alpha of .63.

Social support. The Medical Outcomes Study Social Support Survey (Sherbourne & Stewart, 1991) was employed as the measure of social support. The Social Support Survey is a 20-item self-report scale consisting of one structural support item asking about the respondent's number of close friends or relatives and 19 items comprising five predetermined categories of social support: tangible, affectionate, positive social interactions, emotional, and informational support. Factor analysis was performed on the 19 items using a sample of 2987 individuals who had screened positive for at least one medical condition. The results confirmed four of the five factors (emotional and informational support items were grouped together), so four subscales were derived (McDowell & Newell, 1996). Subscale scores sum the responses checked for the relevant items and rescaled to a 0 to 100 range, with higher scores indicating more support. In addition, a total support score is calculated from the mean of the subscale scores (McDowell & Newell, 1996). None of the items failed to meet the reliability criteria outlined earlier. Thus, no items were dropped from the social support scale. The correlations among the four subscales ranged from .64 to .81 in the Russian immigrant sample.

For the standardization sample, the internal consistency for the overall scale was high (alpha = .97), as were the alphas for the subscales (range = .91 to .96) (McDowell & Newell, 1996). The alphas were similarly high for the elderly Soviet immigrant sample (overall alpha = .96, subscale alphas = .81 to .92). The stability of the Social Support Survey was also tested, and the one-year test-retest correlation was .78 (.72 to .76 for each subscale). Lastly, the Social Support Survey is significantly correlated with loneliness,

(rs = -.53 to -.69), marital and family functioning (.38 to .57) and mental health (.36 to .45) (McDowell & Newell, 1996).

The original MOS Social Support Survey did not assess the source of social support (i.e., what population the social support was coming from). However, because the source of social support was a primary interest of this study, respondents were also asked to indicate, for each of the 19 items, whether they received that type of support from A "American" or R "Russian-speaker." Responses were then coded (0 = no support on that item from that source, 1 = support present on that item from that source) for both of the social-support source scales. The two scales: American Support and Russian Support, therefore, each could have a theoretical range of 0 to 19. However, the means and standard deviations for the two scales (American $\bar{x}$ =1.22, SD=3.14; Russian $\bar{x}$ = 18.24, SD=1.69) suggest that there is little variance for these two scales, with study participants reporting that almost all of the social support comes from other Russian-speakers. An examination of the distribution of the two sources of support are also problematic, as both the American Support and Russian Support scales showed unacceptable levels of skewness (3.7 and -3.8, respectively for American and Russian speakers) and kurtosis (15.5 and 20.1, respectively), making it impossible to examine the impact of social support source using these data.

Chapter 4

RESULTS

Stress and Mental Health. The results indicate that many elderly Soviet/Jewish immigrants experience a number of stressors. For example, 24 of the 40 Hassles items were endorsed by at least 1/3 (N = 47) of the sample. The most frequently endorsed hassles were "personal health" and "physical abilities," which were rated at least somewhat stressful by 76% and 71% of the sample, respectively. "Personal health" (24%) and "health of family member (15%) were considered to be the most severe sources of stress, as indicated by ratings of "extremely stressful," the most severe rating.

To determine whether elderly Soviet/Jewish immigrants who report more stressful life events have poorer psychological adjustment (H^o1), the Hassles total score was regressed onto the total BSI score, using a linear regression model. The results indicated that Daily Hassles are a significant predictor of mental health, as measured by the total BSI score (Std $\beta = .40$, $p < .05$).

To ensure that gender or age differences were not accounting for the significant effect, correlation coefficients were calculated between these variables and the total Daily Hassles score. These analyses yielded no significant correlation between gender and Daily Hassles ($p > .05$). However, a significant age effect emerged $r = -.17$, $p < .05$), indicating that the younger elderly reported significantly more hassles than the older

elderly. Because of the significant relationship between age and Daily Hassles, age was added to the regression model so that its effects could be partialled out. This yielded a significant age X hassles interaction (Std β =1.31, $p<.05$). Since the Hassles were the independent variable of interest, the interaction was further examined by taking the median age (68) and running two separate regressions of Hassles onto the total BSI score for immigrants who were under the age of 68 and for those who were over the age of 68. These analyses indicated that daily hassles predicted mental health problems in the older elderly (i.e, above the median age of 68) but not in the younger elderly (i.e., below age 68).

Social support and mental health. To determine whether perceived social support is a buffer against the negative effects of stress (H°2), the Hassles X Social Support interaction was tested via multiple regression, with the overall social support score as the predictor variable and the total BSI as the criterion. Since a significant age X Hassles interaction was found in prior analyses, age was also included in the model. This resulted in a significant age X social-support X Hassles interaction ($p<.05$, R^2 =.256). A break-down of this interaction using the methodology described in the previous paragraph indicated that social support was a significant buffer against stress for the older elderly (i.e., above the median age of 68), but not for the younger elderly.

Given that social support was shown to buffer some elderly immigrants against the effects of stress, it was also important to determine whether the source of the support (i.e., from Russian speakers vs non Russian-speakers) had any influence on the relationship. To test the potential impact of the source of support, separate regression

models were to be run, first partialling U.S. support and then Russian support from the interaction model testing the buffering hypothesis. However, as described in the Methods section, the skewed distribution of the two sources of support made it impossible to examine the impact of social support source using these data.

Cultural involvement and mental health. To determine whether greater involvement in the Russian-speaking community and/or the mainstream U.S. culture is beneficial for elderly immigrants (H°3), the two subscales measuring involvement in the U.S. culture (IUS) and the Soviet/Jewish Involvement scale (ISJ) were first regressed separately onto the criterion variable, consisting of the BSI total problem score. Then, to determine whether the two cultural involvement scales provide additional predictive value beyond respondent's age and time-in-U.S., these two variables were added to the model and partialled from the cultural involvement variables.

Results indicated that neither the ISJ scale nor the U.S. Behavior-Preference scale significantly predicted BSI scores (ps>.05). However, lower scores on the U.S. Values scale were found to significant predictor higher BSI scores (Std β = -.23, $p<.05$), even after both age and time (months) in U.S. were partialled out (Std β = -.22).

Cultural involvement and social support. Because it was possible that cultural involvement affected mental health indirectly (by way of social support), I tested whether higher involvement in both the Soviet-Jewish and U.S. cultures would be associated with higher levels of support (H°4). Thus, the two subscales measuring involvement in the U.S. culture (IUS) and the Soviet/Jewish Involvement scale (ISJ) were regressed separately onto the criterion variable, the total social support scale, with age and time in U.S. as the covariates. In addition, since people often rely on multiple sources for

support, and because involvement in the U.S. culture and in the Soviet-Jewish culture are assumed to be associated with different types of social support, we also tested whether higher involvement in the Soviet-Jewish and U.S. cultures would be associated with higher levels of support from that particular culture. Thus, the regressions described above were redone with U.S. Support and Russian Support as the criterion variables, in order to determine whether higher involvement in the Soviet-Jewish culture would be associated with more social support from Russian-speakers, and whether higher involvement in the U.S. culture would be associated with more support from the "American" community.

Involvement in the Soviet/Jewish culture (ISJ) again failed to predict the criterion variable. The same was also true for the U.S. Values scale. However, the U.S. behavior preference scale significantly predicted total social support (Std $\beta = .17$, $p<.05$), with more U.S. Behaviors associated with greater social support. As with previous analyses, the distribution of the data did not permit an examination of the social support source (i.e., U.S. support, Russian support).

Chapter 5

DISCUSSION

The purpose of the study was to test a model of the relationship between acculturation, stress, social support, and mental health. To do this, a measure of acculturation for Jewish immigrants from the former Soviet Union was developed. The model contained four separate hypotheses regarding the relationship between the four constructs.

Summary of Findings

Stress and mental health. The literature reviewed in Chapter 2 suggests that immigration is associated with many different stressors. Unfortunately, the lack of norms for the older elderly (over age 64) on the revised Hassles scale (Delongis et al., 1988), as well as the lack of norms for Russian-speaking elderly prevents a determination of whether or not this sample of elderly Russian-Jewish immigrants is experiencing more stress than non-immigrant Russian-Jewish elderly. However, the results indicate that this sample is experiencing a large number of stressors, particularly in the area of health and physical abilities, which is consistent with previous studies of Soviet elderly prior to migration (Persidsky & Kelly, 1992), as well as with studies of foreign-born elderly (e.g., Goldberg, 1996).

It was hypothesized that elderly immigrants reporting more stressful life events

would show poorer psychological adjustment. There was support for this hypothesis, as Daily Hassles were found to be significant predictors of mental health, with higher scores on the hassles scale associated with more psychological complaints. This finding is consistent with previous studies, as the relationships between both immigrant stress and psychological health (e.g., Ruskin et al., 1996) and between physical and psychological health (e.g., Ormel et al., 1997) have been well documented.

When age was added to the model, a significant age X hassles interaction emerged, which indicated that daily hassles predict mental health problems in the older elderly but not the younger elderly. Since such a trend has not been reported in the literature, it was hypothesized that a different variable may be masking the relationship between stress and mental health for the older elderly. Since, by definition, this variable would have to be correlated with age, the correlation matrix between age and other demographic variables was examined to identify the potential masking variables. Three variables (time in U.S., lives with child, and lives alone) were thus identified and tested for masking effects via partial correlations (i.e., the effects of each of these variables were partialled from the formerly nonsignificant stress X mental health correlation). However, the partialling of all three of these variables failed to produce a significant stress X mental health correlation, indicating that none of the three are masking the relationship between stress and mental health for the older elderly. In addition to the demographics, the relationship between stress and mental health in the older elderly may have also been masked by social support, as studies have shown that even while the size of their social circle decreases, the importance of friends actually increases (Pogrebin, 1987). Thus,

using the same procedures as with the demographic variables, the possibility of social support being a masking variable was statistically tested. Like the demographic variables, social support was also not found to be a masking variable.

Since a masking variable could not be identified, the next step was to draw some conclusions based on the significant negative correlation between age and Daily Hassles ($p<.05$). The negative correlation suggests that either the older elderly are actually experiencing fewer Daily Hassles than their younger counterparts, or they are experiencing comparable Hassles but are less likely to report them. While it is not possible to determine if either of these explanations is valid, Lazarus & Delongis (1983) suggest that the latter may be more likely. They propose that changes in perceived stress are the result of an age-related shift in the person's appraisal of the same stimulus rather than a change in the stimulus itself. That is, because health expectations decline with age, the same condition (e.g., shortness of breath) is more likely to be a source of stress for the younger elderly than the older elderly.

Social support and mental health. It was also hypothesized that perceived social support would moderate (i.e., buffer) the effects of stressful life events. The findings indicated that social support was a significant buffer against stress for the older elderly but not for the younger elderly. Considering that stress turned out to only predict mental health for the older elderly, this finding is not surprising. Interestingly, although it is not clear whether the author tested for interaction effects, a study of social support and mental health in elderly Soviet-Jewish immigrants in Israel did not find significant age differences for either outcome variable (Litwin, 1995). On the other hand, while the

Israeli study did not test the buffering hypothesis, it also found that higher levels of social support were associated with better mental health (Litwin, 1995). Indeed, both Orleck (1999) and Litwin (1995) suggest that social support is the primary reason most elderly Soviet-Jewish immigrants are able to make a successful adjustment to the new culture.

Because support from members of one culture could potentially have greater impact than support from members of another, it was deemed important to test whether the source of social support made any difference in the relationship between social support and mental health. Unfortunately, the lack of variance in the source of social support (e.g., 101 of 144 respondents indicated that all 19 of the support items on the scale were provided by Russian-speakers) resulted in a skewed distribution, which did not permit statistical analysis. This was likely a function of the lack of contact that retired immigrants with limited English ability are likely to have with non-Russian speakers. Studies which sample a wider age-range of immigrants are more likely to have a more balanced distribution, which would allow a test of this hypothesis.

Cultural involvement and mental health. Finally, it was hypothesized that acculturation style (i.e., levels of involvement in the U.S. and Soviet/Jewish cultures) would also predict successful adjustment. Specifically, after controlling for age and time in U.S., respondents reporting higher levels of involvement in each culture were hypothesized to report fewer psychological problems. As predicted, higher scores on the U.S. Values scale were associated with lower BSI scores. However, neither the ISJ scale nor the U.S. Behavior-Preference scale significantly predicted mental health.

The significant finding for U.S. Values but not U.S. Behaviors suggest that only a

particular type of involvement (i.e., cultural values) is associated with mental health. This is particularly important given the relatively low correlation r = .27) between the two U.S. involvement scales, making it necessary to assess cultural values directly, rather than relying on cultural behaviors, which are much more easily observed and measured. The differential findings for the two scales may also suggest that cultural values reflect a deeper, stronger involvement than do cultural behaviors, which may be more influenced by convenience and language ability. Thus, it is possible that the reason U.S. behaviors fail to predict mental health outcomes is that they may not be as strong an indicator of cultural involvement as are values.

Unfortunately, despite a growing number of different acculturation scales developed for a variety of immigrant and even non-immigrant groups, almost all of the scales focus on language use (17 of 18 acculturation scales) and daily habits/behaviors (13 of 18 scales). In fact, in his review of 18 acculturation measures, Zane (1998) found that only three scales measured cultural values, and a search of the PsycLIT database from 1977 to 2000 revealed that the six acculturation studies that measured cultural values were all done with either African Americans or Asian Americans and none of the six sampled the elderly. Considering the prominence of cultural values in this study, more research examining the psychological impact of cultural values in immigrants across the lifespan is sorely needed.

Turning back to involvement in the Soviet-Jewish culture, it is not clear why this scale was not significantly associated with mental health outcomes. One possibility was that the lack of a significant effect for the ISJ scale was due to the homogeneity of the

study sample in regard to this variable. That is, since this was on older adult sample, it was possible that study respondents tended to uniformly endorse responses that indicated high involvement in the Russian-Jewish culture. Indeed, several authors have noted the tendency for elderly Russian-Jewish immigrants to be highly involved with both the Russian-speaking (e.g., Litwin, 1995; Orleck, 1999) and Jewish communities (Simon, 1997). However, while this was true for some items (see Table 4 for sample item and response percentages), the ISJ scale was normally distributed and had almost the same standard deviation (11.55) as the IUS scale (11.49), indicating that homogeneity of variance was not a problem.

Cultural involvement and social support. Because people often rely on multiple sources for support, and because involvement in the U.S. culture and in the Soviet-Jewish culture are assumed to be associated with different types of social support, it was hypothesized that higher involvement in both the Soviet-Jewish and U.S. cultures would be associated with higher levels of total support. Involvement in the Soviet/Jewish culture (ISJ) again failed to predict the criterion variable. The same was also true for the U.S. Values scale. However, the U.S. Behavior Preference scale significantly predicted total social support, with higher involvement scores associated with greater social support.

Together with the analyses examining cultural involvement and mental health, these findings suggest that cultural involvement is a multi-dimensional construct with different types of involvement (e.g., values, behavior preferences) being associated with different outcomes. In addition, since the findings indicate that involvement in the U.S.

culture but not involvement in the Russian-Jewish culture is associated with better mental health and greater social support, it appears that, for older adult immigrants from the former Soviet Union, assimilation and biculturalism are the acculturation styles associated with the best outcomes.

Testing the Model

The present findings call for several revisions to the proposed model: (a) The source of social support (i.e., Russian vs. English speakers) could not be tested and should, pending future studies, be removed from the model, (b) participants' age was found to moderate the buffering effects of social support, and should therefore be included in the model, (c) the model should reflect the results of the factor analysis indicating that the U.S. involvement scale actually consists of two different factors: U.S. Values and U.S. Behavior Preferences, each of which is associated with different outcomes, and (d) Russian-Jewish involvement should be dropped, as it was not associated with any of the outcome variables.

Based on the revised model (see Figure 2), several policy recommendations for improving Russian-Jewish immigrant mental health can be made.

Recommendations

The findings suggest that cultural values play a more direct role in predicting psychological adjustment for elderly immigrants from the former Soviet Union than behavior preferences. Thus, it is recommended that intervention efforts be focused on helping the immigrants examine U.S. values in a safe, supportive environment. Discussion groups formed around U.S. movies, TV shows, or books are one example of

this type of intervention.

The findings also suggest that social support, which is associated with better psychological health, is affected by immigrant behavior preferences. Thus, cultural programs (e.g., field-trips) which expose elderly immigrants to various elements of U.S. society (e.g., music, dance, food, history) and encourage individual involvement in such activities may lead to an increase in social support and, consequently, improved psychological health.

Finally, because immigrants' involvement in the host culture is likely to increase as a result of first-hand contact with people outside their ethnic group, it may be beneficial to offer language instruction in ethnically integrated classrooms, instead of the current system in which classes are ethnically homogeneous and the instructors are fluent in the native language.

Limitations

As always, caution should be taken to not overgeneralize the findings of this study. In particular, there are two methodological factors which may limit the generalizability: sample selection and measurement validity and reliability.

Sample selection. As mentioned earlier, only 1% of elderly Russian-speaking immigrants can speak English well, so it is unlikely that this sample systematically excluded anyone based on language ability. However, it is possible that immigrants with severe physical or psychological health problems are less likely to be enrolled in ESL classes, so this sample may be more healthy than the general Russian-speaking, elderly population. In addition, although Chicago, along with New York City, and Los Angeles,

is one of the three main areas of residence for Russian-speaking immigrants, since this sample was geographically limited to Chicago, findings from this study should be generalized to individuals living elsewhere (particularly to less urban areas) with caution.

Measurement validity and reliability. The SAM has not yet been standardized and the other instruments have not been validated for immigrant samples in general and Russian-Jewish immigrants in particular. However, content and cultural validity were addressed by examining the correlations between the problem items and scale scores and dropping items that were poorly correlated (i.e., $r<.15$) with the scale. Moreover, since only the overall scales (rather than the subscales) were used for all of the measures, the potentially different distribution of items into various scales was not an issue. Nonetheless, the lack of cultural norms made it impossible to determine the relative intensity of the stress, social support, or cultural involvement, which would have been useful. Finally, it is important to note that social desirability is inherent in questionnaire research. Thus, while care was taken (e.g., confidentiality was stressed) to increase the likelihood of honest responses, it is possible that some respondents under-reported their stress and mental health problems or over-reported their amount of support.

Future Directions

The present study was an important step toward a better understanding of the acculturation process for Russian-speaking immigrants, and it raises several possibilities for subsequent study. In particular, three separate areas of research can stem from this study: (a) standardization of the SAM, (b) examination of cultural involvement in different age samples of Russian-speaking immigrants, and (c) continued study of cultural

involvement in elderly immigrants.

To begin with, it will be necessary to standardize the culture-specific measure of acculturation (Soviet-Jewish Acculturation Measure, SAM) that was developed for this study. Thus, developmentally appropriate versions of the SAM will need to be developed, along with additional questions designed to assess the SAM's psychometric properties. Then, stratified (by age and gender) samples of Russian-speaking children, adolescents, and adults will be needed to complete the questionnaires.

Once the SAM is validated and standardized, future studies should use the established norms to classify respondents into different acculturation styles (e.g., assimilation, separation) based on low vs high involvement in the two cultures and examine the psychosocial impact of different acculturation styles on individuals across the life-span. Cross-national studies, which survey age-matched samples of Russian speaking immigrants in two or more different societies (e.g., U.S. and Israel) are also needed to determine how different societies affect the process of acculturation itself, as well as immigrants' acculturation strategies. Taken together, such studies can inform both policy makers (e.g., immigration agencies) and implementers (e.g., social workers), as they seek to find the most effective use of the available resources for this immigrant group.

Finally, although this study only examined the impact of cultural involvement on social support and psychological adjustment, studies with other populations have shown that cultural involvement and acculturation styles can have other mental health consequences. For example, studies with Asian populations have found that less

acculturated (i.e., have little involvement in U.S. culture) immigrants are less likely to seek services, stay in therapy, and have positive outcomes from therapy (Zane, 1998). Given the experiences of Russian-speaking immigrants with health care in their country of origin, it would seem that they may be at particular risk for avoiding, dropping out, and not responding to either mental health services or mainstream medical care. Studies examining the relationship between cultural involvement and service utilization and efficacy are needed for this population.

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APPENDICES

APPENDIX A

Table 1

Eigenvalues and rotated factor loadings for the 32-item U.S. Involvement (IUS) scale.

Factor # and (eigenvalue)		Item (item #)	U.S. Behaviors	U.S. Values
1	(5.18)	Enjoys U.S. talk radio programs (1)	.46 *	- .04
2	(1.79)	Avoids Russian-speaking merchants (3)	.19	- .09
3	(1.52)	Involved in U.S. (non-Russian) organizations (5)	.46 *	- .07
4	(.96)	Prefers U.S. way of child rearing (7)	- .11	.44 *
5	(.81)	Lives in non-Russian/Jewish neighborhood (9)	.14	.12
6	(.72)	Must give up Russian Jewish ways to succeed(11)	.08	.22
7	(.68)	Enjoys U.S. dancing (13)	.40 *	.02
8	(.60)	Enjoys reading about U.S. history/culture (15)	.41 *	.09
9	(.54)	Enjoys speaking English (17)	.67 *	- .11
10	(.46)	Enjoys reading in English (19)	.66 *	- .04
11	(.41)	Trusts doctors and medical professionals (21)	.01	.42 *
12	(.36)	When older, will not expect children to help (23)	- .03	.48 *
13	(.24)	Relative with terminal illness should be told (25)	.13	.27
14	(.23)	Children should learn U.S. values & customs (27)	- .09	.64 *
15	(.21)	Enjoys listening to U.S. music (29)	.53 *	.32
16	(.10)	Prefers U.S. name for child (31)	.16	.25
17	(.05)	Cooks American food at home (33)	.45 *	.05
18	(.03)	Enjoys American furniture (35)	.39 *	.19
19	(.01)	In U.S., anti-Semitism is not a concern (37)	- .08	.39 *
20	(.00)	Shares feelings/thoughts with Americans (39)	.53 *	- .06

21	(- .07)	Thinks it's ok to date Americans (41)	.34	.31
22	(- .11)	Has friends that are Americans (43)	.53 *	- .07
23	(- .12)	Writes in English (45)	.45 *	- .07
24	(- .15)	Trying to become fluent in English (49)	.18	.36 *
25	(- .17)	Adult children should make own choices (51)	.08	.53 *
26	(- .19)	Avoids doctors who migrated from FSU (53)	.00	.11
27	(- .22)	Enjoys reading U.S. newspapers/magazines (57)	.62 *	- .06
28	(- .25)	Enjoys eating American food (59)	.48 *	.05
29	(- .26)	Young children should go to U.S. day care (63)	.01	.44 *
30	(- .29)	Glad if child/grandchild married an American (65)	- .05	.32
31	(- .31)	Not important to practice Jewish religion (67)	- .17	.35 *
32	(- .38)	Enjoys watching U.S. television programs (69)	.63 *	.03

Note: * indicates item loading exceeded .35 cutoff. Items 3, 9, 11, 25, 31, 41, 53, and 65 did not load on any of the factors. FSU refers to the former Soviet Union.

APPENDIX B

Table 2

Order (By Size of Loadings) in which Variables Contribute to Factors.

Factor 1: U.S. Behaviors	Factor 2: U.S. Values
Enjoys speaking English	Children should learn U.S. values/customs
Enjoys reading in English	Adult children should make own choices
Enjoys watching U.S. television programs	In old age, won't expect children to help
Enjoys reading U.S. newspapers/magazines	Prefers U.S. way of child rearing
Enjoys listening to U.S. music	Young children should go to U.S. day care
Shares feelings/thoughts with Americans	Trusts doctors and medical professionals
Has friends that are American	In U.S., anti-Semitism is not a concern
Enjoys eating American food	Trying to become fluent in English
Enjoys U.S. talk radio programs	Not important to practice Jewish religion
Involved in U.S. (non-Russian) organizations	
Writes in English	
Cooks American food at home	
Enjoys reading about U.S. history/culture	
Enjoys U.S. dancing	
Enjoys American furniture	

Note: Variables with higher loadings on the factor are nearer the top of the columns. All loadings are .32 and higher.

APPENDIX C

Table 3

Correlation of ISJ and IUS sub-scales.

Measures	Russian Involvement (ISJ)	US Behavior Preferences	US Values
Russian Involvement (ISJ)	1.00	.16	.32 *
US Behavior Preferences		1.00	.27 *
US Values			1.00

Note: N=142, * $p<.05$

APPENDIX D

Table 4

Cronbach's Alphas for the Soviet-Jewish Acculturation Measure.

Scale	# of items	N	raw alpha	standard. alpha
Total ISJ Scale [1]	30	140	.84	.85
Total IUS scale [2, 3]	29	141	.82	.83
U.S. Behavior Preferences	15	142	.84	.84
U.S. Values	9	141	.66	.67

Notes:

1. The original ISJ scale had 35 items. Three items (32, 46, and 62) were dropped due to an inadequate frequency distribution (i.e, skewness >2 or <-2; kurtosis >4 or <-4). Two additional items (52 and 56) were then dropped due to low correlations with the total scale (i.e., r <.15). However, items 52 and 56, unlike the poor frequency items, were not excluded from the factor analysis.
2. The original IUS scale also had 35 items. Three items (47, 55, and 61) were dropped because of the poor frequency distribution (i.e, skewness >2 or <-2; kurtosis >4 or <-4) and three others (3, 53, and 67) were dropped due to a low correlation (r<.15) with the total.
3. The total # of items in the subscales does not equal the # of items in the Total IUS scale, because eight items (3, 9, 11, 25, 31, 41, 53, and 65) did not load onto any of the scales.

APPENDIX E

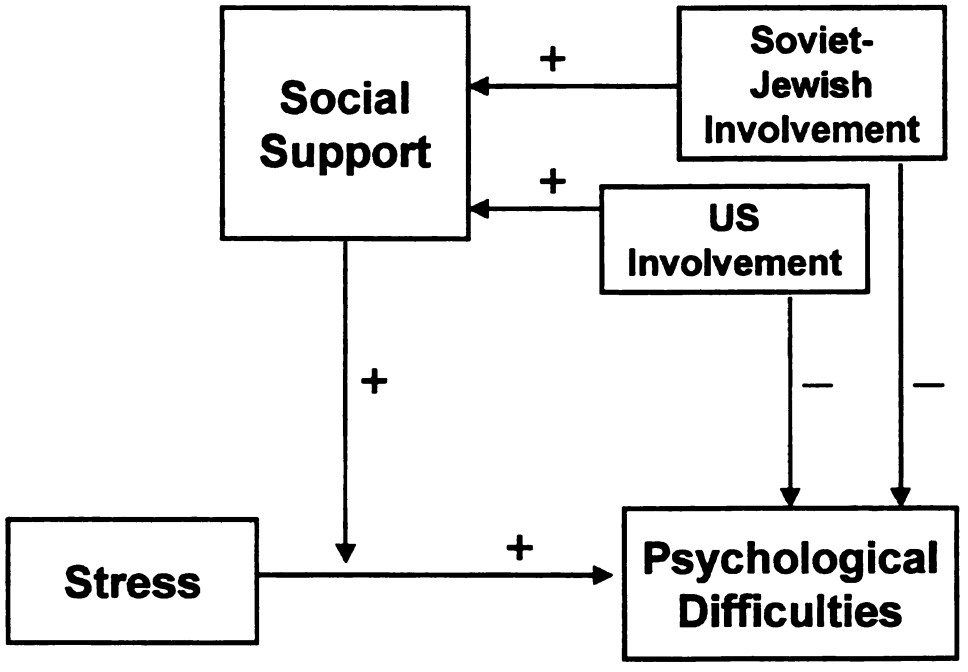
Table 5

Soviet-Jewish Acculturation Measure: Sample Items.

Culture	Item	Response / percent	
ISJ	If I were a parent of a young child, I would adopt the **Russian-Jewish** way of child rearing by encouraging obedience, respect, and a hard work ethic.	not at all true	1
		somewhat true	9
		mostly true	24
		extremely true	66
IUS	If I were a parent of a young child, I would adopt the **U.S.** way of child rearing by encouraging independence and individuality	not at all true	14
		somewhat true	23
		mostly true	22
		extremely true	41

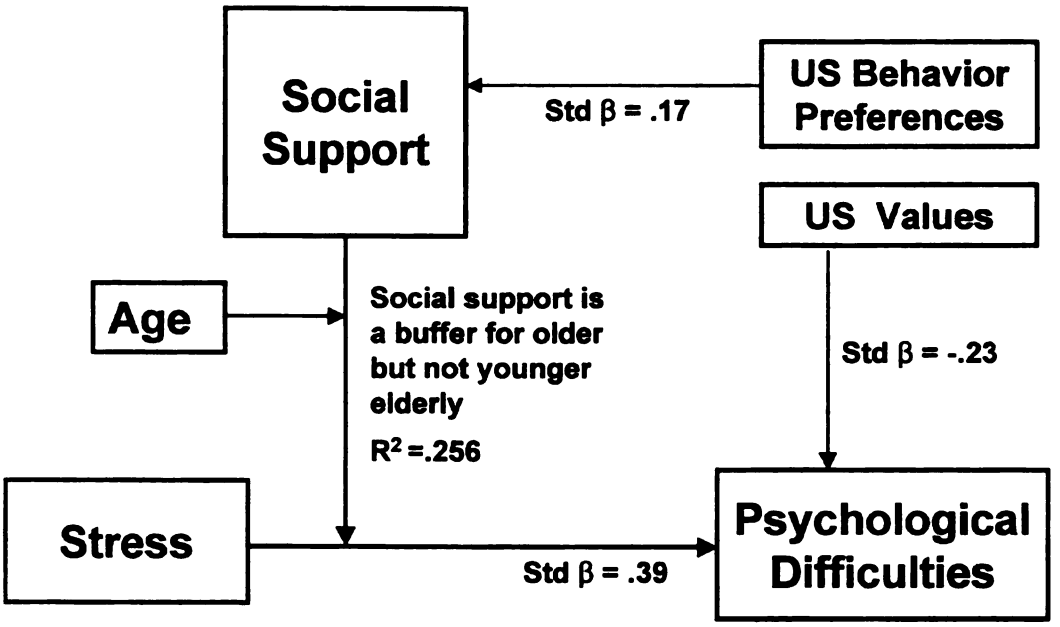
APPENDIX F

Figure 1. Model of immigrant adjustment



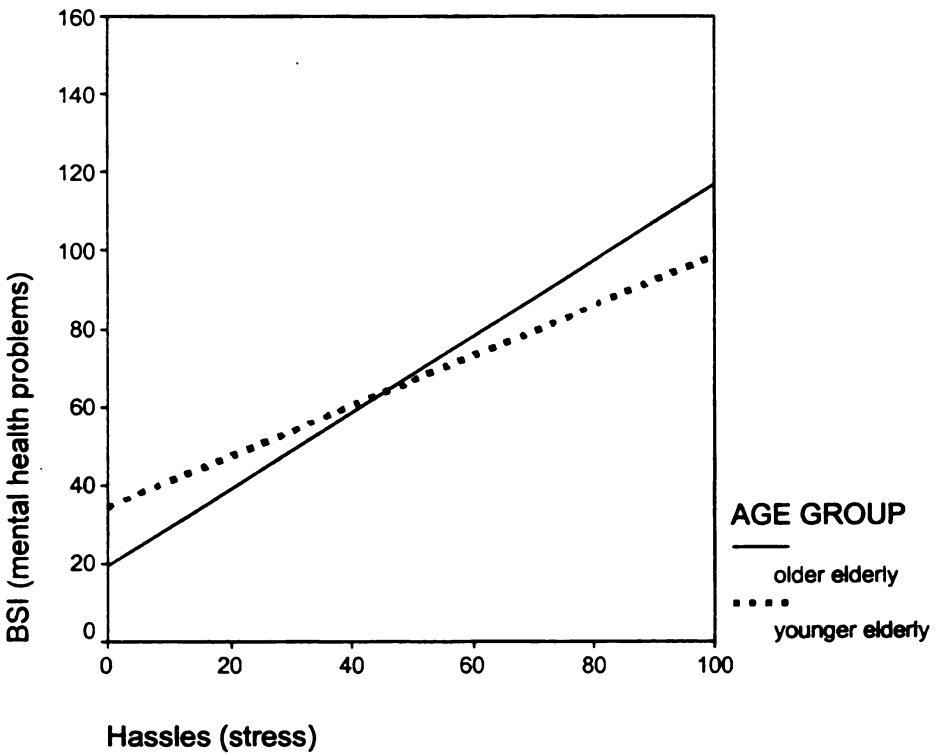
APPENDIX G

Figure 2. Revised model of immigrant adjustment



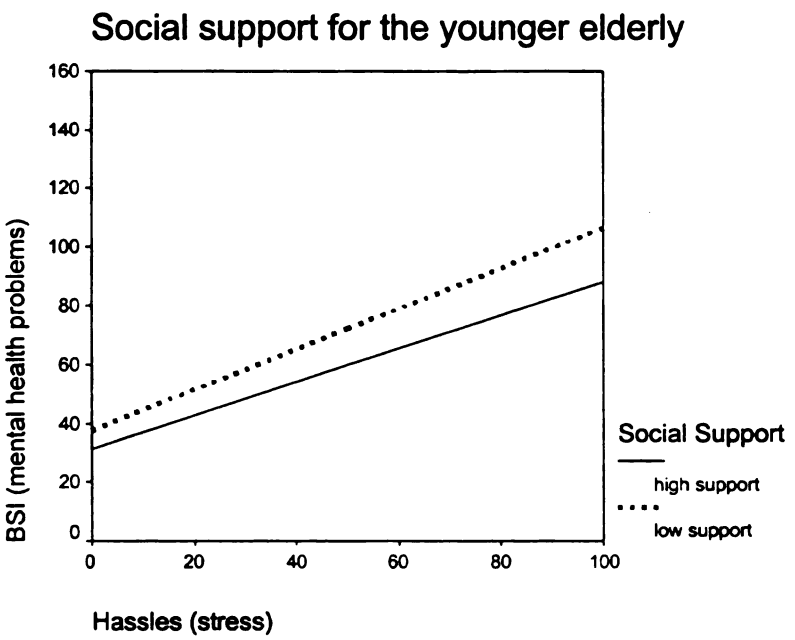
APPENDIX H

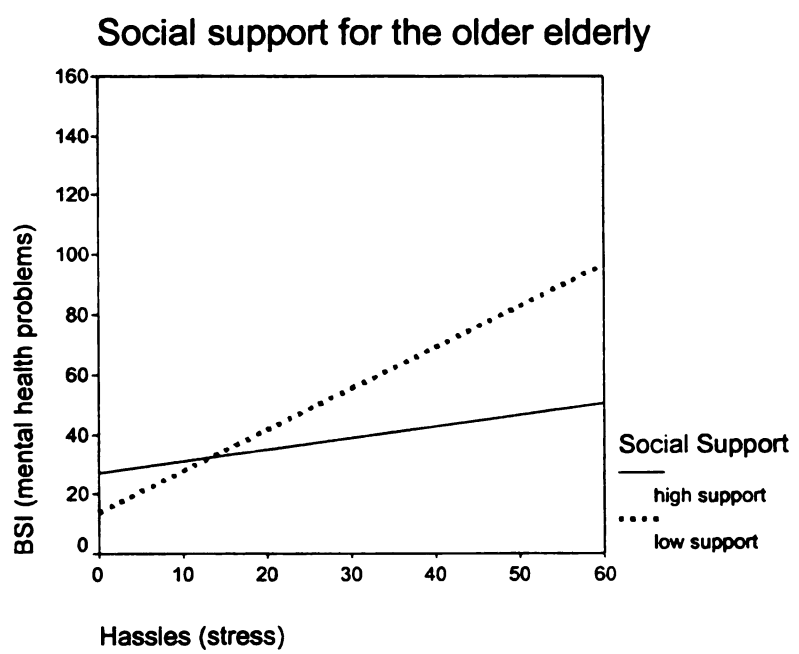
Figure 3. Graphical representation of the age X stress interaction, showing that stress is more strongly associated with mental health problems for the older elderly than the younger elderly.



APPENDIX I

Figures 4a and 4b. Graphical representations of the age X stress X social support interaction, showing that social support is a buffer for the older elderly, but not the younger elderly.





APPENDIX J

Summary of internal consistency analysis for the Acculturation Measure subscales.

Soviet-Jewish involvement (ISJ)

Item	Corrected item-total correlation
2. Enjoy reading books about Russian history/culture	.357
4. It is important to practice Jewish religion	.283
6. Enjoy reading Russian or Jewish newspapers, magazines	.436
8. Would be pleased if child wanted to marry a Russian Jew	.423
10. Enjoy eating Russian food	.462
12. Easy to relate to other Russian-Jewish immigrants	.202
14. Enjoy European furniture	.413
16. Live in predominantly Russian-Jewish neighborhood	.224
18. Enjoy using given Russian or Jewish name	.434
20. Believe it is all right to date other Russian Jews	.448
22. Adult children should listen to and do what parents say	.407
24. Must remain on guard for anti-Semitism	.289
26. If not for children would have remained in old country	.179
28. Healthy for children to be cared for by relatives/friends	.316
30. Has several friends of Russian-Jewish origin	.416
34. Involved in or support Russian-Jewish organizations	.354
36. Enjoy Russian and/or Jewish dances	.348
38. Enjoy watching Russian-Jewish TV, films, and plays	.449
40. Should retain Russian-Jewish lifestyle	.537
42. Would choose Russian or Jewish name for a child	.333

Item	Corrected item-total correlation
44. Enjoy listening to Russian or Jewish music	.539
48. Enjoy speaking Russian or Yiddish	.362
50. Would teach children mainly Russian-Jewish values	.438
54. Prefer Russian-speaking doctor	.262
58. Cook Russian food at home	.315
60. Enjoy listening to Russian radio programs	.276
64. Continues to speak Russian or Yiddish	.429
66. Prefer Russian-Jewish way of child rearing	.418
68. Prefer Russian-speaking merchants or professionals	.403
70. Children are responsible for taking care of elderly parent	.295
U.S. Behavior Preferences	
1. Enjoys U.S. talk radio programs	.386
5. Involved in U.S. (non-Russian) organizations	.379
13. Enjoys U.S. dancing	.351
15. Enjoys reading about U.S. history/culture	.389
17. Enjoys speaking English	.542
19. Enjoys reading in English	.545
29. Enjoys listening to U.S. music	.607
33. Cooks American food at home	.414
35. Enjoys American furniture	.438
39. Easy to share feelings/thoughts with Americans	.459
43. Has friends that are American	.457
45. Writes in English	.359

Item	Corrected item-total correlation
57. Enjoys reading U.S. newspapers/magazines	.505
59. Enjoys eating American food	.464
69. Enjoys watching U.S. television programs	.590
U.S. Behavior Preferences	
7. Prefers U.S. way of child rearing	.292
21. Trusts doctors and medical professionals	.327
23. When older, won't expect children to help	.312
27. Children should learn U.S. values/customs	.447
37. In U.S., anti-Semitism is not a concern	.291
49. Trying to become fluent in English	.328
51. Adult children should make own decisions	.463
63. Young children should go to U.S. day care	.358
67. Not important to practice Jewish religion	.259

Note: For the Russian Involvement Scale (ISJ), items 32, 46, and 62 were dropped because they did not meet the criteria for a normal distribution and items 52 and 56 were dropped due to a low correlation (<.15) with the total score. For the U.S. scales, items 47, 55, and 61 were dropped because they did not meet the normal distribution criteria, and items 3, 53, and 67 were dropped because of low correlations with the total score.

Summary of internal consistency analysis for Hassles scale.

Item	Corrected item-total correlation
1. Your children	.451
3. Other relatives	.230
4. Your spouse	.270
5. Time spent with family	.422
6. Health or well-being of family member	.405
8. Intimacy	.297
9. Family related obligations	.444
10. Your friends	.477
18. Enough money for necessities	.542
19. Enough money for education	.338
20. Enough money for emergencies	.408
21. Enough money for extras	.447
22. Financial care for someone	.504
25. Your drinking	.177
26. Mood-altering drugs	.402
27. Your physical appearance	.415
29. Exercise	.433
30. Your medical care	.537
31. Your health	.375
32. Your physical abilities	.455
33. The weather	.436
34. News events	.348
35. Your environment	.551

Item	Corrected item-total correlation
36. Political or social issues	.357
37. Your neighborhood	.561
38. Conserving (gas, electricity, water, etc.)	.459
39. Pets	.365
40. Cooking	.591
41. Housework	.568
43. Yardwork	.333
44. Car maintenance	.232
45. Taking care of paperwork	.366
46. Home entertainment	.595
47. Amount of free time	.624
48. Recreation outside the home	.532
49. Eating (at home)	.524
50. Church or community organizations	.402
51. Legal matters	.266
52. Being organized	.513
53. Social commitments	.557

Note: Items 11-17 were dropped because they were related to employment and, therefore, not applicable to a retired sample. In addition, items 2, 7, 23, 24, 28, and 42 were dropped due to a low correlation (<.15) with the total score or because of a lack of variance.

Summary of internal consistency analysis for the Social Support scale.

Item	Corrected item-total correlation
2. Someone to help you if confined to bed	.605
3. Someone you can count on to listen to you	.648
4. Someone to give you good advice about a crisis	.655
5. Someone to take you to the doctor if you needed it	.526
6. Someone who shows you love and affection	.743
7. Someone to have a good time with	.732
8. Someone to give you information	.741
9. Someone to confide in or talk to about self	.769
10. Someone who hugs you	.738
11. Someone to get together with for relaxation	.704
12. Someone to prepare your meals if you were unable to	.734
13. Someone whose advice you really want	.787
14. Someone to do things with to help get mind off things	.791
15. Someone to help with daily chores if you were sick	.786
16. Someone to share your most private worries with	.753
17. Someone to turn to for suggestions about a problem	.760
18. Someone to do something enjoyable with	.791
19. Someone who understands your problems	.786
20. Someone to love and make you feel wanted	.700

Note: Item 1 is an open-ended question regarding the number of friends and relatives. It is not used in the computation of the total social support score.

Summary of internal consistency analysis for the Brief Symptom Inventory.

Item	Corrected item-total correlation
1. Nervousness	.571
2. Faintness or dizziness	.481
3. Idea that someone can control your thoughts	.479
4. Feeling others are to blame for most of your troubles	.451
5. Trouble remembering things	.441
6. Feeling easily annoyed or irritated	.595
7. Pains in heart or chest	.322
8. Feeling afraid in open spaces or on the streets	.517
9. Thoughts of ending your life	.618
10. Feeling that most people cannot be trusted	.423
11. Poor appetite	.319
12. Suddenly frightened for no reason	.745
13. Temper outbursts that you could not control	.590
14. Feeling lonely even when you are with people	.724
15. Feeling blocked in getting things done	.745
16. Feeling lonely	.671
17. Feeling sad	.683
18. Feeling no interest in things	.611
19. Feeling fearful	.723
20. Your feelings being easily hurt	.609
21. Feeling that people are unfriendly or dislike you	.638
22. Feeling inferior to other people	.521
23. Nausea or upset stomach	.490

Item	Corrected item-total correlation
24. Feeling that you are watched or talked about	.516
25. Trouble falling asleep	.562
26. Having to check and double-check what you do	.601
27. Difficulty making decisions	.642
28. Feeling afraid to travel on public transportation	.544
29. Trouble getting your breath	.429
30. Hot or cold spells	.582
31. Having to avoid certain places because of fear	.670
32. Your mind going blank	.565
33. Numbness or tingling in parts of your body	.648
34. The idea that you have sinned and deserve punishment	.476
35. Feeling hopeless about the future	.649
36. Trouble concentrating	.767
37. Feeling weak in parts of your body	.712
38. Feeling tense of keyed up	.735
39. Thoughts of death or dying	.592
41. Having urges to break or smash things	.510
42. Feeling very self-conscious with other people	.581
43. Feeling unease in crowds	.472
44. Never feeling close to another person	.482
45. Spells of terror or panic	.676
46. Getting into frequent arguments	.452
47. Feeling nervous when you are left alone	.640
48. Others not giving you proper credit for achievements	.362
49. Feeling so restless you couldn't sit still	.647

Item	Corrected item-total correlation
50. Feelings of worthlessness	.626
51. Feeling that people will take advantage of you	.548
52. Feelings of guilt	.389

Note: Items 40 and 53 were dropped because of a lack of variance in responses.