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Life Narratives of Iranians in the San Francisco Bay Area

By

Jaleh Niazi

B.S. (University of California) 1983

THESIS

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MASTER OF SCIENCE

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in the

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of the

UNIVERSITY OF CALIFORNIA at BERKELEY

Approved: *[Signature]* 5/17/90
.....
Chair *Eleanor H. Rosen* Date
.....
Julienne Y. Lipson
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Life Narratives of Iranians in the San Francisco Bay Area

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Table of Contents

Chapter I: Introduction:	1
I. Nature and Purpose of Study	
II. Informants and Procedure	
III. Expectations	
Chapter II: A Selective Background	4
I. Self-narrative as a Study of Social Identity	
II. Background Information on Iranian Health issues and Health Care	
A. How Was the Health System Before Emigration?	
B. What Did the Modern Medical Set-Up Try to Replace? The Hot/Cold Food Concept	
C. Some Obstacles in the Path of Emigration	
D. Cultural Traits	
Chapter III: Method	18
I. Subject Pool	
II. Style of the Interviews	
III. After the Interviews	
IV. Author's Own History	
Chapter IV: Results and Discussions	22
I. Informants' Background	
II. Family as a Recurrent Theme	
A. What Is a Family?	
B. Family Obligations Pertinent to this Sample	
C. The Decision to Emigrate Tied to Family Obligations and Relationships	
D. Individual Attitudes not necessarily Parallel with Family Decisions	
E. Family Obligations in Receiving Immigrating Relatives	
III. Spiritual Virtues (Maanaviat) in Society and in the Family: Society versus the Individual	
A. Hassas (Sensitive) vs. Zerang (Clever)	

B. Automated Life in the U.S.; Lack of Time	
IV. Financial Themes	
A. Drive to Work	
B. Social Status Related to Financial Status	
V. Non-Judgmental Theme	
VI. Future Expectations	
VII. Health	
A. Definition of General Health	
B. Physical Health (Salamati-i-Jesmi)	
C. Mental Health (Salamati-i-Fekri)	
D. Addiction	
E. Health Seeking Behavior in the Old Days	
F. Health Care; Attitudes toward the ill	
G. Health Care Practices of this Cohort Before Emigration	
H. Health Care After Emigration	
I. Preventive Medicine	
J. Mental Health Care Before Emigration	
K. Psychiatric Care After Emigration	
VIII. Concerns	
A. Concerns Tied to the Family	
B. Financial Concerns Affecting the Family	
IX. Style of Interaction with Informants	
X. Conclusion	
Chapter V: Recommendations	70
I. Suggestions for this Population	
II. Recommendations for Further Studies	
Appendix A: Sample Questions	83
Appendix B: Informational Letter/Consent Form	86
Appendix C: Informants' Background	89
Appendix D: List of Herbal Medications	91
Appendix E: Data	92
Bibliography	175

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*I dedicate this work to my family
whose love and support have been never-ending*

CHAPTER I

INTRODUCTION

I. NATURE AND PURPOSE OF STUDY

Within the last decade the San Francisco Bay Area has accommodated a large number of Iranian immigrants (an estimate of 50 thousand people¹), yet relatively little is known about how this population is coping with emigration to the United States. As a medical student and an Iranian I am primarily interested in understanding how Iranian immigrants make accommodations for their health² care needs. Due to the broad nature of this topic two major foci were determined for this study:

- 1) health care practices and attitudes before and after immigration.
- 2) experience of immigration as perceived by the immigrant.

The purpose of this project is to delineate the health care systems accessible to Iranian immigrants in the U.S. and Iran. The perception of accessibility is based partly on an individual's attitudes, expectations, and interpretations.

The self-narrative method was mainly chosen so that the subjective meanings of actions and events could be studied more effectively.

¹ Figure obtained from a prominent figure in the community

² WHO Definition of Health: A state of complete physical, mental, and social well-being.

II. INFORMANTS AND PROCEDURE

Early in the planning, it became evident that the age of the immigrant influenced this experience markedly. Subsequently, the decision was made to divide the informant pool into two age groups: 20-30 and 40-65 year old. This arbitrary division was made with the intention of contrasting the experience of the immigrants who were "just beginning to build their lives" with those "who had to start over again;" the precise cutoff points are not significant. In addition, each age group was divided equally between the sexes. Five individuals were interviewed from each age/sex group with the exception of one group. Unfortunately, due to time limitations the male/40-65 group had to be confined to only four members. A few other criteria for informant selection existed, relating to date of emigration, and familial relations (see Chapter III for a more detailed description).

All nineteen participants had been invited to join in this study by a letter of invitation/consent form (Appendix B) which was distributed to members of the Iranian community via some of the researcher's acquaintances in the Iranian immigrant population. The anonymity of the participants had been guaranteed in that letter.

A list of questions relevant to these topics guided each interview (Appendix A). However, interviews were not limited to those questions and depending on the nature of the interview other topics of interest would be discussed.

Each interview was transcribed, and the subsequent transcription was corrected and approved by the appropriate informant. These steps were taken to allow for a more consistent narrative. Also, in a population that is very careful with

regard to revealing personal information, this method possibly invited more participation by transferring some control to the participants. The language used was Persian, English, or a combination of both, whichever was more comfortable for the interviewee. All questions were asked in Persian.

III. EXPECTATIONS

The interview transcripts were scanned for themes, recurrent both individually and collectively. Even though certain expectations did exist in advance for this study, due to the nature of the study unanticipated trends were anticipated as well. Length of stay, age, and previous medical care experience were expected to be positively correlated with American medical care use at times of perceived need. In addition, factors which help with adjustment were also expected to affect this behavior positively. Met expectations, extensive social support, prior familiarity with the West, mastery of English, and financial security were thought to make the adjustment easier and use of health care facilities in times of perceived need more extensive. However, this study was not meant to prove or refute any hypotheses. Rather, it attempted to recreate social realities, e.g. immigration, health care seeking, based on a variety of perspectives from pertinent informants (Gergen, 82; Rosenwald, 88).

Chapter II

A Selective Background

I. Self-narrative as a Study of Social Identity

Narrative as defined by the Webster Dictionary is "something that is recited or told; a story." In psychology the life-narrative has been defined to be the individual's account of the relationship among self-relevant events across time (Gergen & Gergen, 1983); a storied autobiographical account told in the person's own words (McAdams, 1988). Even though such a process can be recognized as a common human activity or habit, as a scientific tool of inquiry it has had a controversial history. The major point of discontent has been the narrative's inability to properly reflect "reality." The rationale for this can be manifold. First, a person brings with him-/herself a plethora of experiences, emotions, and interpretations as well as innate abilities, the combination of which can serve as a means of distorting incoming information (Mink, 1978). Second, in retelling narratives, one has the advantage of hindsight which one did not have at the time of the occurrence (White, 1972). Third, related to the latter point, is that events and experiences can be presented in various intensities and from various perspectives, depending on the purpose of narration (Mink, 1978 & White, 1981); hence, the information can be disproportionately portrayed in order to further the "plot." Fourth, there is an inherent fault in the construction of narratives, which unlike life have beginnings, middles, and ends, again the form of a plot. However,

all these points can be challenged by considering reality to be what the individual, based on his or her past experiences and future expectations, presently perceives the experience to have been.

David Carr in his "Narrative and the real world: An argument for continuity" argues for a direct relation or "continuity" between narrative and reality. His major premise is that reality as perceived by individuals, both personally and collectively, is as valid a reality as any objective or "physical reality" which others argue for. This reality of the self-narrative is very closely linked to the concept of the self. As one encounters new information both from the external environment and internal insight one is constantly reevaluating the data in light of what was accepted and occurred in the past and what one's expectations are for the future. Life is not an unstructured sequence of events. Present actions serve as a door to the past experiences and to future intentions and expectations.

"More than cognitive or aesthetic--ethical or moral, narration is constitutive of the self which acts and experiences. I am the subject of a life story which is constantly being told and retold in the process of being lived. I am also the principal teller of this tale, and belong as well to the audience to which it is told. The ethical-practical problem of self-identity and self-coherence may be seen as the problem of unifying these three roles (Carr, 1986)."

Without this unification the self is in danger of fragmentation and destruction.

The narrative method is an excellent method for understanding the decision-makings and attitudes involved in health care practices and immigration, the two foci of this study.

"Detailed studies of individual life histories are far more useful than experimental or correlational studies for tasks such as delineating the particulars of persons and their circumstances; conveying what individuals said, thought, felt and did; representing the subjective meanings of actions and events; and developing context-specific or

idiographic interpretations and explanations of individual behavior (Runyan, 1982)."

The individual is given an opportunity to express one's key thoughts on a subject in a way that one has most recently evaluated and categorized in one's search for a self-identity. In addition, during the course of the interview as his or her inconsistent or deleted points are probed more deeply, the narratives become more consistent with the concept of the self¹. The chance for corrections aids in a similar fashion. More importantly, the amount of individual information collected by this method is plentiful, allowing both the researcher and informant to draw relations between a variety of different aspects of the informant's life. Such detailed information does not readily present itself in statistical or correlational studies. It is not difficult to see how a broad topic, such as health, can benefit from this method.

In the social realm Carr sees the collective narrative as playing a similar self-sustaining role for a community as the narrative does for an individual. Namely, that by participating in shared experiences and acts, individuals can attribute their experiences to a larger subject or agent, i.e., a collective subject. The existence of this collective subject, or "community," depends on the unification of the three roles of audience, character, and narrator, all of whom can be found within a community.

"A community exists where a narrative account exists of a we (collective subject) which persists through its experiences and actions. Such an account exists when it gets articulated or formulated perhaps by only one or a few of

¹ Rosenwald, 1988. "It (interviewing) seeks to make readers into participants and thus to help them clarify their lives."

the group's members--by reference to the we and is accepted or subscribed by others (Carr, 1986)."

Gergen & Gergen (1983) also believe in a social nature of narrative. An individual is bound by the requirements for adequate social functioning, or at least sees the utility of acting according to such norms. "A mature individual," in their viewpoint, has not necessarily developed a firm sense of personal or social identity. Rather he or she develops the capacity for understanding him or herself as a social being and for communicating creditably that such a state is possessed. They further say that a social narrative does not inherently direct behavior, instead "it may be viewed as a construction undergoing continuous alteration as interaction progresses."

This is of interest to us for two reasons. First if consistency in narratives is sought, macronarratives, narratives which span a long period of time, become much more important than micronarratives, narratives of short duration. "One's account of an evening with a friend," as Gergen & Gergen suggest, "would not seem to dictate one's account of one's life history; however, one's life history does constitute grounds for understanding the trajectory of the evening (Gergen & Gergen, 1983)." They extrapolate to suggest that a person with an older culture or a historical perspective may be more consistent in his or her narratives. Or, on the other hand, a person with less of a history, may feel less constrained to act in certain ways. It should be noted that Iranian culture is very ancient, which accordingly would be more constraining for individuals who have a deeper understanding of this culture.

The second point is that each participant's interview has a social component to it. In other words, both the interviewer and the interviewee as members of the Iranian community are subject to social constraints, which may affect the quality of the interview. However, by the voluntary nature of the study, as well as an understanding of the purpose of the interview from the very beginning, it is intended that ta'arof² is minimized in this study. In addition, the detailed in-depth nature of this study of these interviews is hoped to elicit narratives closer to the "self" as judged by their consistency. The researcher is not implying that the attempt was made to disregard the social aspects of the individual, rather that the social etiquette which may have played a role in distorting the "true" interview was minimized. Meacham (1984) also suggests that in addition to social background, the interviewer should keep in mind her own personal sociocultural history, in order to be able to analyze more fully the subject's sociocultural history and "identity" within its proper context (see chapter III).

A multiple-case method can help to discern an additional reality. As Gergen (1982) writes persons are members of society and each member constructs knowledge about society from a slightly --but not completely--different perspective. Such as a collective case method can aid in (a) discerning each participant's individual life situation and (b) shedding light, through synthesizing various viewpoints, on the nature of the socially constructed reality.

Subscribing to Gergen's vision, Rosenwald advocates abandoning the search for universal and replicable "facts" about human behavior and focusing instead on

² Persian social etiquette

current social dilemmas and problems "so that others (the readers) may more easily recognize them in their own experience (Rosenwald, 1988)." He uses the different responses that two individuals may get from a public institution as an example. The first individual, having corresponded cordially with the institution, receives a very positive response. A few days later when talking to his friend, he hears about a very different quality of service. Comparing their strategies they realize a social reality of that institution. The friend uses the same method of correspondence and receives his commodities promptly. This simple example is used to show how two different perspectives can shed light on a social reality.

"The interpretive construction of a social object is not judged by how often it is reiterated by other interpreters but by how well it fits the exemplary images and the needs of the subsequent interpreter. It can be revised as new images are added to it or when an ingenious interpretation of a given set of images overturns the previous synthesis (Rosenwald, 1988)."

Rosenwald himself is quick to point out that the major strength in this methodology is not to show how things are, instead, how things can be. If the participants' actions and attitudes have resulted in a "positive" result, others after them can learn from it. If not it could sway a person toward the "right" direction. The other strength of narrative method, according to Rosenwald, which is partially realized in this study, is that it can serve as an educational tool when the participant himself or herself is requested to respond to criticisms of his or her ideologies, understandings, and attitudes. This investigator returned their transcripts to each of the individuals who did not waive this right (one person did) for proof and corrections. This step allowed them to once again analyze their own concepts.

Lipson and Meleis (1989) have recommended specific guidelines for

interviewing the Middle Eastern population. One of their recommendations, revision and approval of transcripts, has already been discussed at length. In addition, oral consent was favored over written, since the former was judged to be binding in Iranian culture. To ask for a written consent would be judged inappropriate and possibly damage the mood of the interview. The dress codes and cultural etiquette were noted. However they were not felt to be pertinent to this set of interviews, since to many of the participants the interviewer was already known.

In conclusion, the self-narrative method was chosen for the study of lives in order to be able to study individual attitudes, expectations, and beliefs as influenced by social realities.

II: Background Information on Iranian Health Issues and Health Care

A. How was the health system before emigration?

The Iranian health system has experienced major changes during the past fifteen years. During the latter part of the pre-revolutionary Pahlavi regime the health care system, fueled by the economic affluence and growth which had arisen from the success of OPEC in substantially increasing oil prices in 1973, had rapidly "modernized." New hospitals were built, new medical education programs were implemented, and the level of medical technology was advanced in Iran. In 1974 a new ministry was formed, the Ministry of Social Welfare, for the purpose of implementing a universal social security plan. This ministry was subsequently

merged with the Ministry of Health. The new ministry's mission included a comprehensive medical insurance, with coverage of the total population to be completed by the year 1983. It was financed by a 30% payroll tax: 7% borne by the employee, 20% by the employer, and 3% contributed from the government budget. The count of total insured at the end of 1978 was 13 million persons (out of a population of 36 million)(Andreano, 1984). Therefore, it is easy to see that for the upper class and/or government employees of our subject pool, there was a general feeling of prosperity and economic growth; the maldistribution of resources which was felt the most by the lower class, probably did not affect this subject pool as noticeably.

From the limited amount of data that is available with regards to the recent revolutionary health system, it seems that the Islamic Republic has used basically the same health managerial system, but has tried to make it more centrally controlled and more unified; it has also shifted its focus from urban to rural areas (WHO, Global review). Most hospitals are now state-owned, even though the number of hospital beds has not increased (Fosse et al, 1987). After the Islamic revolution, a high percentage of physicians left the country. Shortly thereafter, with the beginning of the Iran-Iraq war and an increased demand for medical personnel, this gap was felt even more. The Islamic government tried to compensate by creating alternative educational pathways in training health care workers and also by requiring newly graduating physicians to work an obligatory period in the rural areas (Fosse et al, 1987). I am not aware of more recent governmental policies which address this issue. The success of their strategy is yet to be determined.

B. What did the modern medical set-up try to replace?

The popular or traditional system of health care in Iranian culture is based upon a system which was developed from the Greek, Arabic, Latin, and Indian philosophies of medicine, i.e. the Galenic-Islamic tradition. The classical theory of humoral medicine was based on a stable state between the four humors; hot, cold, wet, and dry. I should add that each individual, according to the classical doctrine, has a different temperament based on a distinctive balance of the four humors. This physical constitution is affected by age, sex, race, and climate. Based on this unique temperament, the same external (environmental, climate) and internal (foods, distress) can affect two people differently.

Balance seems to be the essential component of the classical conceptions of health. An imbalance in the humors which could be caused by food, stress, environment, or climate can result in illness. For example, rheumatism is thought to be due to the coldness of the joints; therefore, the person afflicted with this condition should avoid damp and cold places. In addition, an imbalance in the mind and emotional faculties does not necessarily have to manifest itself in the emotional realm, instead, it can induce physical sickness. "In fact, traditional Galenic-Islamic medical theory postulates the interrelationship between the mind and the body (Pliskin, 1987)."

However, the classical theory of humoral medicine as described above no longer exists in its entirety in the popular health system. As an example, the

qualities of hot, cold, moist and dry in maintenance of health are no longer explained in terms of the humors, but in terms of food and climate as they affect individual temperament.

The hot/cold food concept

In Iran all foodstuffs are classified as hot, cold, or neutral; such categorization, however, involves a range of "temperatures." For example, nabat or walnuts are very hot, whereas bread may be mildly so. As some of the participants will discuss later hot foods may be associated with high carbohydrate and fat foods and cold foods with vegetables and fruits. However, it is not that clearcut, as sugar is considered to be cold and melon hot. The terms hot and cold refer to qualities, the essence or character of things. As was mentioned earlier, in order to maintain health it is very important to keep the balance between these opposite food categories. If too much of one kind of food substance is consumed, the opposite kind is taken to alleviate the symptoms.

Sardi (coldness) can manifest itself in various symptoms, mainly nausea and vomiting. Garmi (hotness) can create headaches, rashes, pimples, sore throat, and sore mouth although not necessarily simultaneously.

Specific foods from the correct category can be associated with each symptom: headaches, citrus fruits and lemon juice; pimples, lemon juice; sore mouth, thickened pomegranate juice; sore throat, lemon juice, sweet lemons (a fruit native to Iran), hot milk.

The reason for onset of an illness is not always attributed to food categories; once manipulating the diet does not relieve symptoms, food is ruled out as the etiology. Yet, the herbal medications which can be used subsequently also correspond to the correct hot/cold category. At times, there are discrepancies between the symptom and the appropriate hot/cold food type. The symptom itself takes precedence over the hot/cold etiology. "In other words, for the symptom of a cough, which may or may not be due to a common cold, some foods must be avoided as bad for coughs and colds, such as pickles which are cold and sweets which are hot, whereas other cold foods such as turnips, are considered beneficial for coughs, but they are cold (Pliskin, 1987)."

C. Some obstacles in the path of emigration

This information is based on the nineteen interviews and the interviewer's understanding of the situation.

Before the Islamic revolution, in general, Iranians were welcomed in various parts of the world, partially due to their general affluence. During the first few months after the revolution, the success of the revolutionary movement in obtaining a "newly found freedom" had produced a general feeling of prosperity and openness. And the general traffic back and forth did not seem to have been affected noticeably. Shortly thereafter, the borders began to be watched more closely "in order to prevent the escape of the "corrupters of the earth," e.g. responsible agents from the previous regime." In addition, issuance of visas by other countries did not

seem to change at this time period. But in late 1979 the U.S. embassy was shut down, during the well-known U.S. embassy hostage event. U.S.-Iranian relations suffered for it. From then on any Iranian who wanted to obtain a U.S. visa had to do so in a third country, which had a U.S. consulate, and was not issued a visa as easily. Turkey and other European countries were the countries of choice for submission of applications. In the latter part of 1980 at the onset of the Iran-Iraq War, restrictions were placed on the younger (eighteen to thirty year old) men leaving the country. A young man who wanted to study abroad had to register with a Student Abroad agency and take a test so that his competence in the appropriate language could be tested. His registration also enlisted him into the military services. In case of a failed exam, the person would be sent off to the war front. As the war effort escalated it became more and more difficult to leave the country, especially for the young men whose threshold age for not being allowed to leave the country was continuously being lowered. Other countries became much stricter in issuing visas to Iranians. In 1983, the Iranian newspaper Keihan began printing on a weekly basis names of people who could reapply for passports, from a backlog of unprocessed applications. Hence, the ways were opened. However, at this point other countries had become very hesitant to accept Iranians, even as tourists. Currently, it pretty much stands at this same level. Even though this information is merely based on nineteen interviews and the author's interpretation, it will allow the reader to appreciate some of the difficulties that the immigrants faced in leaving the country.

D. Cultural traits

The self in the Iranian culture consists of an inner, true core and an outer, public shell (Good, Good & Moradi, 1985). The inner self is protected from the uncertain and dominating world by the public shell. "Appearance and reality invariably differ when cultures have highly developed communication codes protecting the social transactions of the individual in individuated, hierarchical societies, (i.e. Iranian society) (Pliskin, 1987)." A person can climb up the social hierarchy by taking advantage of opportunities (and perhaps other persons) without appearing to be socially threatening; the trait which is needed to achieve this objective is *zerangi* (cleverness, manipulating). Iranians tend to use this trait in certain situations of competition and/or protection, such as bureaucratic settings when people vie against others within a defined hierarchy, and economic transactions when buyers and sellers pursue profits. The flip side of this trait is to become distrustful of everyone, due to the possible conflict between reality and appearance. On the one hand, the possibility of attaining some sort of power via personal *zerangi* is positive because of the network of personal relations and consequent possibilities of influence one acquires. On the other hand, power is highly distrusted, and those who attain it are therefore suspect.

The counterpart to the active, manipulative *zerang* person is the characteristic of sensitivity (*hassasiyat*). Sensitivity is deemed an inherent trait of people, a characteristic which must be concealed in social interactions to protect the sensitive individuals from the actions of others who might take advantage of them.

Sensitivity, unlike *zerangi*, is believed to be possessed by almost everyone; it is the internal essence of an individual. Together, sensitivity and *zerangi* are two facets of personhood in Iranian culture, positively valued in some contexts, negatively in others. This double-sided view of the person shows not only that there are different concepts of the person cross-culturally, but that different and contradictory concepts of the person can exist together in one person, in one culture (Pliskin, 1987).

In this traditional world of the *zerangs*, the inner self and the related emotions cannot be expressed freely due to the risk of being abused. Instead, emotions are expressed in culturally appropriate forms, e.g. during mourning processions (*rozeh*), or through somatic transformations, which attract major sympathy and care (Pliskin, 1987).

Chapter III.

Method

I. Subject Pool

Copies of the invitational letter and consent form (Appendix B) were distributed among members of the Iranian community who were acquainted with the researcher. Thirteen out of nineteen of the interviewees belonged to this group of acquaintances; the other six had heard about this project from members in the Iranian community other than the author. However, only one participant was a complete stranger to the researcher at the time of the interview; other participants had been previously acquainted with the interviewer to varying degrees. Not everyone who expressed an interest in participating in this study was interviewed. Reasons for excluding individuals included exceeding the target number (five interviewees per age/sex category) or not satisfying the criteria, i.e. age range (younger 20-30, older 40-65), emigration date (after February 11, '79; however, one older man had left Iran prior but close to that date and was judged to be congruous enough in experience to be used in this study), and familial relations (no two respondents belong to the same nuclear family post-marriage, e.g. siblings who had their own nuclear families were interviewed, but no spouses nor single siblings of subjects were interviewed). In addition, the attempt was made to interview individuals with differing backgrounds in order to document a wide range of perspectives. However, limitations existed due to the voluntary nature of the study.

II. The Style of the Interviews

The interview itself was performed at the Health and Medical Sciences departmental office at the University of California, Berkeley, the researcher's home or the interviewee's home according to the informant's preference. All interviews were tape-recorded (Appendix B). All of the questions were asked in Persian, with the exception of one interview, where the interviewee spoke only in English. The respondents were allowed to speak in English, Persian, or a combination thereof. After one and a half hours of interview, the subject would be reminded of the time limitation per session. Usually, the participants whose interviews exceeded this time limit felt that they did not need a break. Two informants did; one continued with his interview on another day, while the second interviewee resumed the discussion later that day. Interview time ranged from an hour to four hours with an approximate average of an hour and a half.

Each interview was guided by a list of questions (Appendix A), which were asked in a variety of orders depending on the flow of the interview. Even though some responses were followed through, never during the interviews were the respondents pressured into answering. Overall, the interviews were perceived by the researcher to be a relaxed and comfortable way of exchanging information.

III. After the Interviews

Subsequently, each interview was transcribed and translated by the researcher and returned to the subjects for correction and approval; all identifying information was deleted in this process. Four of the subjects preferred their copies to be in

Persian and were given a Persian copy of their transcripts. A fifth subject received an English transcript even though he had preferred Persian; the reason for this was two fold: 1) a major portion of his tape was erased for the Persian transcription 2) he is well-versed in English. Consequently, each transcription was summarized and organized under general categories (Appendix E).

In analysis of these data, both original interviews and outlined forms were used and an attempt was made to recreate social realities which each informant had seen from a slightly different perspective. This was attempted by scanning the obtained data for recurrent themes and looking for a model which would be consistent with the different points of view.

IV. Author's Own History

Before discussing the pertinent findings, the researcher will offer a brief history of herself to provide the context as was suggested in Chapter II.

I immigrated to the U.S. in 1979, approximately 8 months after the revolution; our stay was meant to be a temporary one. I had lived in the United States as a child and had some fond memories of it; however, I soon found the new environment to be very different than what I had imagined. My family was under financial pressure, but the children were not expected to help financially and we did not.

At the time my main concern was to maintain my academic standing. I saw that not only as a goal for myself, but also an obligation to my family. Even though English was initially a problem, I eventually managed to access my former skills and

function in this newly encountered society. At that time, I did not allow the new environment nor my grief over Iran to distract me from reaching these goals. Indeed, I did not analyze deeply enough what this emigration had meant to me. Currently, I realize that I have adopted many of the cultural values of the West, but have remained true to many of the Iranian values, as well. I hoped to use this research opportunity not only to understand my own experience better, but to present the Iranian immigrant experience as it was lived by a selected, not necessarily representative, number of immigrants.

Chapter IV

Results and Discussions

I. Informants' Background

The majority¹ of the informants had belonged to the upper middle class in Iran. Approximately half of the interviewees had lived in Tehran and the other half had been residents of other major cities² in Iran. There was only one person who identified herself as belonging to an ethnic group, even though many stated that one of their parents' belonged to such groups. All of the interviewees had been born Shiite Moslems. All of the ten younger participants had been students or were currently university students; this is not surprising, given the educational obligation which is placed on the younger generation (see page 30). The older group came from various educational backgrounds. For more information please see Appendix C.

II. Family as a recurrent theme

1

At times qualitative words will be used to describe the number of informants. It has been arbitrarily chosen for specific words to represent a specific number of informants. When discussing the whole sample: a few=3-4, some=5-6, many=7-9, majority=10-12, most=13-15, bulk=16-18, and all=19. When discussing one age range: one=1, two=2, many=3-4, majority=5-6, most=7-9, and all=10. When discussing one age/sex category: one=1, two=2, majority=3, most=4, and all=5.

² major city = population over one million

A central theme throughout the majority of the interviews was the importance of the family in the Iranian culture. This theme surfaced at various times and under different themes.

A. What is a Family?

Family was in general believed to be the extended family. However, a few of the subjects had not had much contact with their extended family in Iran or in childhood. For a few, friends had become more important than some family members; those friends were considered to be part of or equivalent to the family.

B. Family obligations pertinent to this sample

Before addressing this subject, I should say that in discussing conflicts regarding family obligations, I am in no way underestimating the emotional attachments which can exist between these members. Instead, I am trying to underline some of the factors which might affect adjustment.

Within the family unit, the parents are expected to provide for their children both financially (madi) and spiritually (maanavi) and in return the children have the obligation to respect their parents and in old age provide for them both financially (madi) and spiritually (maanavi). The parents' obligation was reflected in their predominant reason for emigration to the U.S.; i.e., to provide for the "future of their children" (see page 25). Also it presents itself in some of the concerns of the older subjects: one concern is that they have lost their traditional role as guidance providers and the children are indifferent to their direction and advice. Related to

this, in one case, is the fear of being institutionalized in old age due to this breakdown of family relations.

Four from the older group specifically mentioned being concerned about the reciprocal obligations toward parents. The man of this subset stated: " My mother ... and my siblings, especially, when a person has been successful either financially or educationally, are depending on that person to a great extent." The three women belonged to Group 1a of individual attitudes (see p. 26). One of these women lives close to all of her family members in the U.S. The family members of the other two live in Iran. For the women it was not the question of financial support as the man had hinted towards, but emotional support.

A conflict had existed for a younger man between the obligation to support his family after its move to the U.S. and the obligation to continue with his education both for his family and for himself. He had not realized this conflict for many years and had felt miserable in trying to accomplish both partially. The obligation to pursue one's education, at least in this population, was strongly felt and it will be discussed (on page 25).

The father is traditionally the economic provider in comparison to the mother who provides for the emotional, medical, and dietary needs of the family. Even though none of the subjects acknowledged having had marital problems due to the change in these roles, a couple of the older women spoke disapprovingly of marriages which had broken down because of the women not tending to the house and the man not being able to provide financially for the family.

C. The decision to emigrate tied to family obligations and relationships

The bulk of the decisions to emigrate were made at the family level, even for the individuals who came alone. Even though the majority of the decisions were made at the parental level, all decisions were reported to have been unanimous, i.e. children supported parents' decision and parents supported children's decision (the latter applying to only a few cases).

Even though the majority of decisions were based on a combination of antecedents, by far the major theme for emigration was to guarantee a "future for the children." The parents' role was to provide guidance and support so the children could choose the "right path." Education was seen as the number one indicator of having chosen the "right path:"

--"Hope for the children to select the right path, to continue with their education."

--"I mainly came for my children. I saw that my children could not obtain a proper education in Iran."

--"What I wanted was for the children not to be in that environment, to be able to continue their education, to be abroad. And before the revolution, I would see that if they could afford it they would send their child abroad."

For some families the danger of military service played a more immediate impetus for emigration, namely, for three of the younger men and four of the older group who were concerned about their children. However, the drive for education for even these families would be reestablished once that obstacle was overcome. One of the young men had to urgently leave the country shortly before receiving his high school diploma in order to evade military service. He began to work soon after

and attended school as well. His zeal to continue with his education has made him endure a heavy load of full time school work in addition to a 50 to 60 hours/week work schedule.

D. Individual attitudes not necessarily parallel with family decision

Even in this small group of subjects the families could be divided into five groups based on more specific individual attitudes toward emigration:

1) The older group:

a) Forsaking one's own comfort for children/spouse Six of the adults from the older group stated that the only reason they came was for their children's future and education, or due to their spouse's endangerment, even though they themselves would have preferred to live in Iran. One man from this group came before the revolution for the children's sake, but then his return path was impeded due to the revolution. Another man came because he had been specifically requested by the government to leave the country, due to his wife's nationality. They had sold everything and come to the U.S. Two of the older women had "torn down" the result of many years of hardship and had endured many hardships in order to get the family unit out of the country. One woman had come alone to bring her third child and join her two other children in order to tend to their needs and to look after them (balay-i-sareshoon basham; lit. trans. to be over their heads). Her husband had stayed to support the family financially. The fourth woman came for her children despite having very strong attachments to her place of residence. She still has a very difficult time accepting this place, but she has become used to it.

b) Individual reasons One of the older women and one of the older men left the country because they could not cope with the new environment. They were both U.S. educated and intolerant to a suffocating environment. Even though a major reason for their move was personal, they both place great importance on their children's education. One older man came because he did not have any family responsibilities, i.e. had never been married, and saw the revolutionary instability as a possible time to further his education, elsewhere.

2: The younger group:

a) No personal decision involved This group basically came along with their family unit. One of the younger women and two of the younger men came along with their families at a very young age. Two of these individuals began to work shortly after entering the U.S. They felt they could be of help by at least supporting themselves. Both these individuals came in the very early days following the revolution. One of them had left the country due to a sibling's need for proper education, and the other because of a long- term family decision to come to the U.S. The third person came in the days following outbreak of the war and part of the family's decision to leave was based on his eventually becoming eligible for military service. All three of these individuals are still continuing or planning to continue with their education.

b) Initially came alone but were complying with parents' wishes Four younger women belonged to this group. Their parents' decision was based on wanting to give an equal opportunity, as far as education went, to their daughters as they had been given to their sons. All of these women had older brothers living in this country and initially went to stay with them. Two of these women began to work almost full-

time while continuing with their education, because they wanted to cut down on the financial load on their family in Iran. One of the other two also worked for money, but did not have to work quite as extensively. The latter two were reunited with one parent after a short while. All of these women have managed to continue with their education despite it all.

c) Personal decision Three of the younger men left Iran based on their own decision, with family approval. One of the young men left solely in order to escape military service; he later wrote to his family asking them not to send any money. Another in addition to service evasion had a difficult time adjusting to the new system. (He is the young man referred to on page 29) And the third left because he could not adjust to the system in Iran, even though he was trying very hard to cope. They all pursued higher education in this country. None of these men were supported financially by their families, basically because of these men's own decision not to accept it.

E. Family obligations in receiving immigrating relatives

Sixteen out of the nineteen respondents came to cities in the U.S. where their relatives lived. The length of stay with relatives varied from one month to nine months. In addition to housing them and providing food for them, these relatives were able to provide emotional support and guidance to help them adjust as quickly as possible. There was one case where the relative only helped to obtain a visa, and then left them on their own; family relations suffered because of it. The other three had lived in the U.S. before and had returned to familiar places; for them there was

not much of an adjustment necessary.

The positive aspect of this obligation is readily apparent. The complications which can arise may be as apparent, but were rarely made explicit, e.g. financial pressure on the receiving family. One of the interviewees spoke of a "divergent evolution" which occurs because of divergent paths which family members take once they become separated physically, i.e. each personality develops under the influence of the new environmental circumstances. When these relatives are once again thrown back together tensions might arise. She likened this to the case of newly weds who try to get along but through their efforts only make the situation worse.

III. Spiritual virtues (maanaviat) in society and in the family: Society versus the individual

The majority of the individuals spoke of strong spiritual commitments and societal reverence towards higher ideals in the Iranian culture. A few of the interviewees were shocked to see the degree of "materialism" which existed in the West upon their arrival, where commitments and obligations appeared to have been sacrificed for the sake of materialistic ideals. On the other extreme of the spectrum, four of the individuals spoke of Iranians being very individualistic and selfish; they were disappointed in seeing the Iranian community so ignorant of and indifferent to the problems that existed for many Iranians in the U.S. and other parts of the world.

A. Hassas (sensitive) vs. zerang (clever)

Family and societal obligations fall under these spiritual ideals. The standard expression of the zerangi-hassas dichotomy seems to be challenged in the U.S. Traditionally in Iran, it is valued for a person, especially a woman, to be hassass (sensitive) and selfless, as it fits into the traditional nurturing role. The three interviewees who mentioned hassassiat as part of their perception of themselves were women, two from the older age group and one from the younger age group. The two older women qualified their comments by letting me know that their answer was not meant to be a boast. Therefore, concern for others was highly regarded by them or they felt that it would be highly regarded by me. I should also mention that these two women were the least adjusted members to the U.S. society in this sample. One was very disapproving of the U.S. society and its "looseness and irresponsibility." She specifically stated that, "if my children were not here, I would return to Iran immediately." The other was having a very difficult time accepting the change from the close network of friends and associates which existed in Iran to no one else in the U.S. They both belonged to the attitudinal Group 1a (see page 31). Traditionally in Iran, as a woman one is less required to use one's zerangi (cleverness) skills and climb up the social ladder. These two older women have been raised to believe in that model and are feeling threatened by the outwardly more individualistic attitude which exists in the U.S. Their care for others may play a role in not wanting to adjust to this "individualistic society."

The younger woman of the three however mentioned that she saw this as a negative trait, in that she was not able to be aggressive in this aggressive society. One of the younger men also expressed a problem in not being aggressive enough

for this society. These two participants who are required to build their lives in this new society feel somewhat hindered by these cultural values. Two other younger women seemed comfortable describing themselves as assertive; one characterized herself as a go-getter and the other as independent and determined. Another younger woman described herself as self-made, responsible, but at times unknowingly insensitive. Two of the male participants, one in the older and one in the younger sample, also felt pleased to have stood on their feet despite life's pressures. However, none of these self-made participants belittled the strong social ties which exist in the Iranian culture. All of them were very approving of such values.

B. Automated life in the U.S.: lack of time:

Life in the U.S. was perceived by most of the participants to be automated and routine, where little attention is given to spiritual aspirations. From their perspective it is a society which requires individuals to produce hour after hour without considering the human sacrifice involved. "In this society there is plenty of work for everyone." But the trick is not to get caught up in it. One reason why one might get entangled in this web, according to one participant, is due to lack of job security (ultimately financial security) which results from the expectation to produce.

"Lack of time," which can result from such expectations was perceived by the majority of the participants to play a detrimental effect on familial and societal obligations/interactions. This intrusion into the familial and societal structure and relations was specifically mentioned as a major concern by one participant. Many

others voiced their concerns when discussing the change in health care practices. As will be described later, many of these interactions have a direct bearing on health, i.e. increased stress, no time to tend to the ill, no time for preventive measures.

-- "The only concern I have is lack of time: I don't have time to enjoy life, spend time with my family, with my friends."

--"I don't think that they (family members) care less, it is just that they don't have time."

IV. Financial themes

One factor which probably affected these participants' attitudes was the change in their financial, hence social status. None of the participants improved financially as a result of their relocation. There was only one subject who thought that due to his education he might have a better life than his parents eventually.

A. Drive to work

The bulk of the immigrants began to work for a salary shortly after their arrival independent of their previous work history. The majority of the immigrants perceived the need to work inexhaustibly (more than full-time or considerable number of hours in addition to attending school). Others were either supported by family members in Iran, or were working but not as extensively. Two themes contribute to this drive to work:

1) Financial survival This was felt more in the U.S. due to a more expensive standard of living in the States and very few resources. Lack of job security in the U.S. was seen as another motivator to work.

- "The life that we had in Iran is not comparable to what we have here."

--"It was much easier to live comfortably in Iran; one did not have to work as hard."

--"This environment is one of working; one can work forever."

2) As a means of distraction A few of the immigrants mentioned that keeping busy and occupying one's time was treatment for afsordegi (depression) (see page 44).

B. Social status related to financial status

Fowler describes the Iranian society as "based on relationships of hierarchy that are mediated by prescribed form of communication in social situations in which persons of different statuses interact." In Iranian culture social status, similar to many other cultures, is largely determined by one's financial situation. Of the two participants who are having the most difficult time adjusting to the U.S. one has experienced a major change in her financial status, hence a self-perceived change in her social status. In her advice to me, she suggested that when I became a physician I should treat everyone the same way, even if they did not have any money. She also mentioned that she had learned from this relocation that some of her previous spending had been unjustified. It seemed to me that throughout this interview, she was attempting to rationalize the tremendous loss in social status that she had experienced. A younger man also declared that Iranians are very proud people; they do not work under any condition.

However, many other narratives spoke of Iranians disregarding the social expectations and working under very difficult circumstances for long hours, in order to be able to support themselves. Among the family of the nineteen informants ten had worked in positions lower than their previous "social positions"--many of them much lower. With regards to this resiliency of the Iranian immigrants one person said:

"Due to the economic mobility of the country they can work in some position. For example, I know people who were at the level of the ministry, who were able to work at a menial level to support their families. And because this availability exists even though culturally it may be very stressful, but at least it does not face them with an impenetrable economic wall. I think in this respect despite the resentment that people have felt, some have done jobs which they would never have considered doing in their home country, in order to provide food and housing for their families. And, very rarely, do I hear about Iranians who have become freeloaders of the American System."

In other words, the Iranian obligation to one's family and oneself had overcome the societal taboos, which should also be less felt in the U.S.

What seemed to hold true in this small sample was that post-emigration financial status was not a major indicator of adjustment. As a matter of fact, those who out of necessity had to work very hard were either denying the emotional clues or based on their accomplishments they felt relatively comfortable living in the U.S.

However, there might be a latent adjustment period which is awaiting them at the time of more secure financial stability. Also note that the second "less well-adjusted" woman had also started to work very hard upon arrival. Perhaps, I should say that in these interviews financial situation did not seem to be a determining adjustment factor, as had been anticipated.

V. Non-judgmental theme

Ten of the participants stated specifically that they tried not to be judgmental. They used terms such as non-judgmental, open-minded, and relaxed to describe this trait. Eight of the ten belonged to the younger group. All ten of these informants had been exposed to the American culture at a very young age and had all been educated in American universities. However, there were others in the general sample with the same qualifications who did not describe themselves as such. It seemed that the younger group had recognized the need to accept other points of view in order to start building their lives in the new environment.

The older generation, as most of the participants suggested, were less open to ideas and a new culture. One younger person said: "You and I are flexible right now. We can state our opinion, and listen to the criticisms. After a while, we become less flexible, because we have discarded a number of our ideas based on that. And eventually, we say, this is how I think, based on years of experience, and this is how I stand on issues. Who cares if you don't agree with me!" Later when discussing the perceived problems and concerns within this population, this attitude will be discussed as a hinderance in the adjustment process.

VI. Future expectations

Twelve of this group expected to live in the U.S. in the future, even though they did not necessarily rule out the possibility of living in Iran. Two of the women in the younger group could not see themselves living under the policies for women which the current government has instituted in Iran. All of the older women expected to live in the U.S. Four of these women commented that they wanted to stay wherever their children were, and it seemed to them that their children would stay in the U.S. The fifth older woman could not live under the government's policies towards women. Two of the older men were expecting to stay in the U.S., one for medical treatment and one for his family. Three of the younger men were expecting to live in the U.S., even though they all expressed an interest in returning to a different Iran.

A few are ambiguous about their conditions. One of the older men (visit had been seen as temporary; more than ten years in the U.S.) has not entered the system completely, in the hope of being able to return to Iran and fulfilling his obligation both to his family and to his country. Two of the younger men described their futures as uncertain. One preferred to possess a global perspective; he had made his own decision to come for a long stay. He has lived in the U.S. for more than ten years. Another wanted to go back and try to live in Iran, even though he was afraid of what he might find. He came with family at a young age more than ten years ago. A younger woman had similar thoughts. She had come mainly because of family's suggestion less than ten years ago. Another younger woman thought that she would either live in Iran or in the U.S., wherever her family could gather. She had come mainly because of family's decision less than ten years ago. And a third

younger woman did not know; her major concern for the future was to continue with her education. She had come mainly because of family's decision less than ten years ago.

There was only one person who sounded relatively certain about living in Iran. He had come on his own decision more than ten years ago. He felt that he would like to retire in Iran and work on the soil.

Despite this major trend of expecting to stay in the U.S., everyone spoke of visiting Iran. The ideal situation for some of the older participants was to live in Iran, and to be able to visit their children freely. Some of the members of the younger generation envisioned an ideal situation in living in the U.S., and being able to visit their parents in Iran. It seemed that the majority of the participants were not satisfied in being confined to one country, but instead wished to have the freedom to live in both.

VII. HEALTH

A. Definition of general health

The definitions of health were very diverse even in this small group of respondents. The majority of them felt hesitant to define health because of what they perceived to be its personal nature, which is consistent with the individual temperament of the traditional (Iranian) ways. A few emphasized this point in their definitions. One younger man labelled a person to be healthy, if that person does not have a disease to which he has recently been exposed, either through personal

experience, or a disease which is 'popular' in the media. A younger woman thought that a person can be considered healthy if that person has adjusted to a physical abnormality and is functioning according to one's own standard. Some gave biomedical definitions, i.e. absence of physical and mental illness. A few of them subsequently qualified their statements by describing major and minor illnesses, i.e. conditions which really did not affect health and conditions which were serious to be considered as such. There were intermediate grounds for some depending on the patient's own attitude.

They all agreed that health is divided into two, interrelated categories, mental (fekri) and physical health (jesman). The point of departure for each subject was his or her definition of each category.

A. Physical health (salamati-i-jesmi):

Ideally, physical health (salamati-i-jesmi) was defined to be perfect organ or body function. Moving away from these ideal states, individuals began to define health at a more practical level. Life-threatening illnesses such as cancer were considered by everyone to be true illnesses affecting the general health of a person. Cancer was considered to be a one hundred per cent physical illness according to one definition (she had divided illnesses on average to have a %30 psychological component and %70 physical). Chronic illnesses for many fell into the same category, but for those who were suffering from chronic illness, it played a minor part in their general health, since they had been able to cope effectively with it. Therefore, the attitude of an ill person towards one's illness played a crucial role in

this definition. Temporary illnesses did not seem to play a major role in the collective definition of health. One person categorized an ulcer as being an emotional illness, and another categorized mental retardation as being a physical illness.

B. Mental health (salamati-i-roohi, or salamati-i-ravani or salamati-i-Fekri):

The answers again were very diverse. One group of persons was hesitant to label anyone as having a mental illness. The stated reasons for this hesitance were several fold:

- 1) The ubiquity of mental illnesses (two men, one belonging to the younger group and one to the older). The older man felt that everyone at some stage of the game can be considered crazy or mentally ill (synonymous for this person). "Each individual in one's own way causes mental torments for oneself." The younger person gave examples of individuals who were suffering from mental illness, including most of the people he knew in addition to himself.
- 2) Related to (1), based on social norms (one woman and one man from the younger group). The disoriented and confused on Telegraph Avenue were seen as people who "think too deeply," or "think beyond our times; they do not concern themselves with life's commonalities."
- 3) Mental illness other than schizophrenia (with an organic basis) were not considered to be illnesses (an older man and a younger woman). This younger woman also thought that it was rude to label anyone crazy. Incidentally, she was joined by another woman from her age group. It was interesting that these two were

also the only ones who thought "mental illnesses" were principally due to lack of affection. One of these young women thought that even though some of the local Telegraph Avenue homeless did not act appropriately at times, their condition could be reversed by provision of love and affection. However, the other woman did believe in mental illnesses as an illness. I should say that everyone in the general sample did agree that a person having homicidal thoughts with no foundation is mentally ill.

Several terms came up during our discussions of mental health. *Salamati-i-Fekri* (health of the mind) seemed to be the most general category pertaining to this group of illnesses. *Narahati-i-roohi* was either interpreted as an illness of the *fekr* (*narahati-i-fekri*), hence, a broad term for mental illness, or it was interpreted as a polite and/or mild form of mental disturbance. The second definition of *narahati-i-roohi* seemed to correlate roughly with affective disturbances (not necessarily a disorder) in the Western model. They were believed to affect the *roohieh*, which can be approximately translated as affect (in psychiatry the general emotional state of a person), emotional drive, and state of mind. It is used in sentences such as his *roohieh* is constricted, or he had lost his *roohieh*. Therefore, *narahati-i-roohi* can be considered to be an emotional problem. Depression (*afsordegi* or *gham-o-ghosseh*) and anxiety states (*assabiat*; lit. trans. disturbance of the nerves) belong to this category. These disorders in general were not considered to be true illnesses, but instead to be natural responses to the environment. The majority of the participants accepted progressed cases of this category, which result in loss of function, to be an illness.

The etiology for this category of disorders had to be external stress, e.g. loss of a close relation, change in living arrangement, change in job status, difficulty at work, societal pressures, lack of love. It was generally accepted that these conditions could not occur without such an etiology, and that once that situation was corrected the condition would resolve itself. A few respondents specifically considered emotional disturbances as having their roots in childhood and the family situation, making them very difficult to resolve, hence, the importance of family care in prevention of mental illness. Therefore, the majority of the group did not think that this group of discomforts could be treated with counseling or psychopharmaceutical therapy, because either there was an external reason for them or it had become innate to one's personality. For example, one of the older women described herself as a Fekri (thinking) person. She described this trait of hers as being constantly worried about events, whether in the past, present, or in the future. She felt that this had developed in her due to family interactions and now had become an innate part of her character. In her opinion, psychiatric help was far from necessary.

Narahati-i-ravani was another label which could have various meanings. Once again it could be used as a broad mental illness category. Or it was considered to be a category one level higher in severity than narahati-i-roohi. Etiologies for this category included organic problems of the nervous system, or unsurmountable external pressures. To a few individuals it was synonymous with being crazy. The symptoms associated with this level of narahati-i-fekri had progressed to more behavioral symptoms; e.g. being oblivious to the major social

rules, inappropriate shouting, twitching. Or as one person put it, symptoms which begin to affect others (e.g., affects maintaining a relationship with others). In general, this category was thought to be at the level where it would require therapy and/or medications. As one can see the mode of therapy defines the extent of illness in this population.

Deevaneghi (craziness) was generally thought to be the most severe and advanced kind of mental illness. There were several symptoms which were pathognomonic. By far the most popular symptom was "the state of being out of control." There was a breakdown within this category into one group who when out of control are harmless to others and one group who are not necessarily so. The main problem in interacting with even the harmless group is that their next move was unpredictable, and hence a personal risk or danger. Another symptom is the "state of being out of it;" hence a flaw in reality testing. A popular example was for a person to walk with a coat on in summer time and barefoot in the midst of snow. Another example of this flaw in reality testing, offered by one participant, is being unaware of the social implications of one's actions, i.e. being unaware of the social reality. At this stage of the game a psychiatrist was definitely deemed to be necessary, and for the harmful, some kind of psychiatric institution. Apparently, in the olden days in Iran this included being confined by ball and chain.

C. Addiction (Aityad)

In Western medicine addiction is considered to be a psychiatric illness. For the bulk of this sample it was not considered to be a mental illness; there were only

three subjects who believed the converse. All of the respondents took addiction to mean being dependent on something; the majority of this group emphasized the craving aspect of it, while a few were concerned more with the amount of use. The addictive substances were defined based on two categories. the proponents of the first category believed in a select number of chemicals causing addiction while the second group believed that anything could cause addiction; chocolate and children were used as two examples.

The informants' attitudes were based on two different emphases as well. The majority placed more of an emphasis on the hazardous nature of it, and a few on its dependency-forming nature. Heroin, hashish, and crack were frowned upon for both reasons, and were by the bulk of the participants considered the ultimate taboo. Nicotine and caffeine addiction were generally not defined as such, or if accepted to be addictive did not constitute the same social taboo, most likely because of the perceived relative harmlessness. Only one younger man expressed a stronger dislike towards cigarette smoking compared to heroin use. For him the question of control seemed to be more of a factor than the danger to a person; he thought that a cigarette smoker could control his or her addiction more easily than a heroin addict.

Opium was perceived as a substance of abuse which was used as a pain-reliever in the old days. Some of the older groups' elders had been opium addicts. This created in some more of a hatred towards this specific substance and in some more of an acceptance of this practice. In effect, there existed a hands-on understanding of this practice. The younger generation had heard of people using

such substances but had never met an opium addict.

All of the participants mentioned that if a close friend or family member were perceived to be addicted (with the exception of tea) that they would be concerned. They would try to resolve the problem by discussing the situation with the person. Four of the participants were completely non-judgmental about drug abuse. All of these members had known people who used marijuana, opium, or hashish; one was open about personal marijuana use. For this group, as long as their mutual relationships were not affected by the substance abuse, it was of no consequence. Many others, even though aware of such activities discriminated between the type of substance used; one person spoke about the previous history of the substance abuser affecting her attitude, i.e. she would be more understanding towards a person who has suffered in the past.

The majority of the older generation vehemently opposed hard-core substance abuse, and would not associate with such people (outside of the family). Cigarette and alcohol were more socially acceptable to this group, even though they were still frowned upon.

D. Health seeking behavior in the old days (or currently but not very relevant to this sample)

The level of health care in Iran has changed noticeably over the life-span of the older sample. The picture which is delineated by the various points of view is a health care system with a handful of physicians at the top of the referral hierarchy and a plethora of various herbal and traditional practitioners at the primary level.

There were no primary physicians per se in those days. Only chronic and serious illnesses would reach physicians. There were traditional general practitioners who were well-versed in all aspects of disease and would provide some sort of treatment for all illnesses. There were also different specialists who were consulted for specific treatments, such as bone setting, or kachali (baldness due to fungal infection) treatment. The traditional treatments which were mentioned in the interviews were herbal medications, administered orally and topically both on the skin or in the form of enemas, foot soaking (for high fever), blood letting (badkesh), bone setting (performed by shekastehbands), inoculations with dried up small pox blisters, written prayers, and oral prayers which could be accompanied with a ritualistic act of encircling the disease with a clergy's saliva. A list of herbal medications can be found in Appendix D.

The hot/cold variation on diet as a mode of treatment cannot be separated nicely from herbal medications, because some mechanisms of herbal medications are based on their hot/cold properties. Herbal medications were in general used to treat acute illnesses, such as a fever, stomach ache, diarrhea and prophylactically to prevent heat stroke (khaksheer), nervous attacks (gholgavzaboon), and a chahar gol to improve the mezaj (general strength). They were also used for chronic illnesses such as headaches and knee pain (hot medications), but usually the diet was the first factor to be manipulated for these. Some people used opium to relieve chronic pain. Hot/cold variations on the diet were used mainly for chronic conditions or emotional illnesses, such as arthritis, headaches, and depression. Opium was usually used after the regular dietary changes or change in geographic locations, e.g. moving

from a wet to a dry place, had not been effective. They could also be used for acute illnesses, such as diarrhea.

What should be emphasized is that through an elaborate system of networking families with an illness would eventually be referred to the "right" practitioners. If a health care giver was known to be *khoshdast* (good handed), one's practice would prosper. Referrals, therefore, were a major component of the health care seeking behavior. Physicians would be consulted, depending on the nature of the disease and the economic status. The better social status one had, the higher up the ladder one was able to reach. One of the nineteen subjects used a primarily herbal method of treatment as had been passed down to her by her mother. In this educational process she had been taught to categorize illnesses based on "physician required" and "not physician required" categories. For example, measles was categorized as a "nonphysician required disease;" it has a ten day course and it does have a dietary prescription, and cold food should be given. Another person mentioned that:

"A typical Iranian who went to a physician expected a pill, a syrup, an injection, and a food order. If any of these were missing the physician's credibility would be questioned."

As it will be discussed in later sections, family was the primary health advocate and support. Physicians were consulted very rarely. Only very serious and chronic conditions would reach the physicians. The small number of physicians available, the high social class they held in the Persian culture (historically they had been priests) and the family based health care system shaped the physician-patient

relationship. The physicians as ministers were expected to know the diagnosis, hence, be able to diagnose it in a very short period of time, and prescribe for it, to prove their knowledge in this very short impersonal session. Since the bulk of the health care was performed at the family level, what the patient's family expected from the physician, additionally influenced by the physician's short time and patience, was to deal with a very limited aspect of the health care picture.

Several old sayings were quoted when referring to the traditional expectations from physicians. With regards to quick diagnosis: "If you take a pot that has a hole in it to a messgar (tinker) he quickly fills the hole." Otherwise, the physician would be judged incompetent. With regards to trust in physician and expectation of a diagnosis and treatment: "An ill person leaves one's sickness outside of a physician's office." Expectation for prescription: "Prescribe chalk if you have to." There were many tales of Iranians leaving very unhappily from a physician's office because of lack of a prescription.

E. Health care/attitudes toward the ill with respect to the family

The family is one's major health resource in Iranian culture. Illnesses are taken care of first at the family level. Even though usually the sick role attracts attention from all members of society, certain unsocial illnesses which cannot be made public, are very silently and inconspicuously handled at the family level. A few of the medical conditions which can carry a stigma are venereal diseases, psychological illnesses, and out-of-wedlock pregnancies.

Tying in with social obligations is the obligation to pamper the ill, to nurse an ill person back to health. As one woman expressed it: "an ill person needs emotional nourishment (roohan) much more than physical nourishment." All of the interviewees were aware of this close level of care in Iranian culture, some experiencing it more so than others in their own families. An older man who was raised in the rural region put it this way. "If I did not feel comfortable sleeping alone in my house, all I had to do was to call my neighbor, and say: "I am afraid to sleep alone." Ten people would immediately come over."

Only at the extreme levels of "mental illness" would family members be handed over to the authorities. "Up through the mild forms of *narahati-i-ravani*" an effort was made to care for the illness at the family level." Of course, as most of the informants' suggested, even though there was a cultural obligation to care for the ill, the extent of that varied from one family to the next.

F. Health care practices of this cohort before emigration

All of the members of this study had combined traditional medicine with modern medicine; however, the extent of each varied from family to family. Only one person used the herbal medication as the primary mode of treatment. She had avoided physicians in Iran, yet was very well acquainted with treatments of medicine. She emphasized that if it had been deemed necessary to see a physician, she would not have hesitated to do so. Insurance also did not affect her decision, since she carried military insurance. At the other extreme, an older man who dismissed the traditional ways as "friendly treatments." His diagnosis of having a chronic disease

had been made in the U.S., and he had received excellent care here. On the other hand, in Iran he had been misdiagnosed, and did not find the system comparable to what exists in the U.S. Also, an older woman, who is married to a U.S. trained physician, stated frankly that she does not believe in such medications at all. The rest of the informants fell somewhere in between.

Eighteen of the interviewees used Western medicine as their primary health care system. The general practice was to visit physicians only for prolonged illnesses, or high fevers, or trauma, such as broken bones or extensive bleeding. This was also true among the Western educated interviewees. Some of the children had received regular check-ups at young ages. And the adults who had received regular check-ups in Iran were suffering from chronic conditions which required regular care.

Neither having a physician in the family nor age seemed to correlate with health care preferences. For example, there was a younger man who basically used a pluralistic³ health system. He would use traditional ways for specific illnesses, such as general fatigue or chronic headaches, but would see a physician for an infection, such as high fever. Two other older women and one older man also followed this pluralistic model, i.e. believing in the wisdom of their forefathers as well as giving modern medicine a chance. Others were not sure about herbal medications, and basically would take them as a curiosity and as a supplement. But never would they forsake modern medicine for the traditional ways. An additional factor impeding this process is the relative incompetence in this traditional mode of treatment. A

³ A medical system composed of different, not necessarily ideologically identical, medical sub-systems.

few who expressed an interest in trying these medications could not use them due to lack of information. The bulk of the respondents felt that from each generation to the next much of the traditional methods had been lost, referring specifically to the last three generations.

The majority of the sample had physicians among their colleagues, friends, or relatives. Therefore, they felt a very strong relationship with them, which made health care much more accessible and acceptable to them. For two or three persons who did not have friends among this group, the referral system played a crucial role in selecting a trusted physician. As was explained by many of the respondents trust in the physician was the most important part of the health care, since their expectations would then correlate with the physicians interactions, diagnosis and treatment.

Most of the group specifically spelled out their expectations. Not surprisingly, correct diagnosis and treatment was the most popular expectation. But with regards to the time elapsed before a diagnosis, even though most everyone preferred it to be as short as possible, they did understand that some conditions required a longer time to be properly diagnosed. Other popular expectations were for a physician to do a complete initial history and physical and to listen and speak to the patient. There was only one person who adamantly opposed this for herself; she belonged to the younger group and had travelled around the country with her father, a physician, to tend to the needs of the poor. She mentioned that in Iran, due to shortage of physicians, the psychological aspects of health care were luxuries. She herself when she had been treated in the hospital here, was disturbed by the fact

that her whole body was examined. It seemed to her that they were not certain of their diagnosis and were searching for some sign which would lead them in some direction. She had wanted them to get to the point.

The majority of the subjects did not want to be needlessly medicated. One of them quoted the opening sentence of a pharmacology book: "All drugs are more or less poison." Some were less negative about drugs, but did not seek them needlessly. There was only one older woman who expected a physician to provide prescriptions. She was in general very troubled by the care given by the internists in the U.S. even though her own care had been good; but, she praised the surgeons highly.

Access to medical care in general, with the exception of the traditionally trained woman, was much easier in Iran. There was easy access to physicians in this group because 1) there were physicians among their families, friends, or colleagues 2) they belonged to a well-to-do sector of society 3) they had government insurance (including military).

The modern medicine in Iran of which I speak is a modern version of the indigenous philosophies. After all Persian medicine was influenced greatly by the Greeks, as in turn it influenced Greek medicine. Therefore, the roots of modern medicine can be found in the Persian traditional medicine. The interviews delineated a picture of physicians who worked within the traditional framework in recent Iran. As was mentioned earlier, physicians would give dietary prescriptions for illnesses. Also, some of the interviewees who had a physician in their family spoke of their relatives using herbal medications, even the physicians, themselves;

reportedly, one physician mainly did so to test its efficacy. Therefore, the "modern medicine" that the interviewees made use of was culturally aware. Three of the interviewees in this sample, two older women and one younger woman, were vexed that the physicians here were not familiar with hot/cold modes of therapy or that they did not give food prescriptions.

G. Health care after emigration

A couple of the informants had obtained insurance through their employment upon arrival. And, also, they were required to undertake regular physicals. Therefore, these individuals were able to maintain a connection with receiving regular health care. The students in the group received student health insurance, whatever scanty a coverage it provides. However, those who were not forced into this situation did not voluntarily enroll in a coverage due to the more important adjustments they had to make. There was one student whose family still does not have health insurance.

This relocation in general has affected the health care seeking behavior of these immigrants in several ways:

- 1) Change in financial status A recurrent theme was that health care expenses were felt much more by the immigrants here, both because of the loss of financial resources and the increased level of medical expenditures in this country. Many families have now become HMO (Health Maintenance Organization) members.
- 2) Expectations from physicians

a) Professional judgment: One recurrent theme concerning expectations about physicians here was that physicians here use less of their own judgment and more labs and tests. For some this carried a positive connotation. For example, the older man who was very pleased with the U.S. system saw this as the correct way of patient care. "When a patient comes in with a small complaint, they run various tests to determine the situation. In Iran the physician would listen to your heart a little, and prescribe something and send you off." For some others the increased number of tests is a possible indicator of incompetence in a physician. A daughter of a physician (please see p. 50) had mentioned that the extensive physical examination and tests suggests to her the confusion of a physician with regards to the diagnosis; she thought that only pertinent systems should be checked out. Personal judgement seemed to be an essential part of the physician's role. An older man mentioned that a computer program could be written to make a diagnosis based on the signs and symptoms; but it would be very difficult to develop a personal judgment in that program. That was seen as the essential role of the physician.

To make matters worse many people felt that the physician's judgment and interaction with the patient had been affected by materialistic aspects of health care, namely, the interference of litigations on the patient-physician relationship. Therefore, the maanavi aspect of physician care is visibly threatened by the materialistic ends.

b) Lack of referral system: Another aspect of physician expectations, namely, trusting the physician based on referrals, was changed after the immigrants relocation. They had lost the referral system which existed for them in Iran, namely, through colleagues, friends and family. There was only one person in this group who had been able to reestablish a similar system of networking in the U.S., based on her public health work and connections. Others especially those who were members of the HMO's could not trust their physicians completely. One person specifically stated that the level of skill of a physician is questioned if the physician is working for an HMO. Also, they are assigned a physician as opposed to being allowed to chose their own.

The extent of physician care was definitely influenced by their health care coverage. HMO physicians were accused of taking illnesses lightly and being less skilled. Private physicians and tertiary care facilities were accused of running too many tests, involving too many specialists and being automated. There were at least five respondents who were completely satisfied with the medical treatment which they had received here. But the majority were dissatisfied because of the loss of trust (maanavi aspect) towards a physician after their immigration.

H. Preventive medicine:

Pliskin suggests maintaining balance between the hot/cold food categories, warding away evil eye, and avoiding damp places as preventive measures (Pliskin, 1987). Our participants in response to "What do you do to maintain your health, and/or to prevent illness?" spoke of related themes.

Before entering this discussion, I would like to make note of one attitudinal aspect of the sample. Many participants, despite their age, had felt healthy and young in Iran. As healthy individuals they were not very concerned about their health. The 61 year old man spoke of being young and healthy in Iran as did the 21 year old woman. However, in the U.S. they were older and less healthy; this "age inducing" effect of immigration reportedly played a role on the preventive practices.

1. Diet:

Diet was the most popular mode of prevention. The dietary control was based on two related categories:

a) Balance Balance among different food categories, i.e. meat, rice, vegetables, fruits, bread, and/or among different hot/cold categories. The bulk of the older sample were concerned with the former type of this balance. Many mentioned that they had decreased the red meat and fat content to a certain extent, but the key was more in the balance of foods. I should mention that the older women who tended to be more traditional in some respects in comparison to the rest of the group also had changed their cooking based on the new healthy diet they had been made aware of in the U.S. One had tried to substitute white meat for red meat in her recipes and had changed from butter to mazola, the quality of which was highly belittled in Iran. One of the younger participants commented on his father being very resistant to changing his eating habits to a lower fat diet, specifically giving up on eggs. However, he eventually did so through his children's persistence. No one

in the older group would try to balance hot and cold food categories; instead, they felt that in following a general balanced diet that part would follow naturally.

In the younger age group a few of the participants also spoke of balance, but the form of balance they had experienced had been a low fat, low meat kind in Iran as well. One younger woman, even though, belonging to the next category was very careful of balancing hot/cold categories because she was very sensitive to hotness/coldness. All of the participants who belong to this group, with the exception of the aforementioned younger woman, thought that traditional Iranian cuisine was healthy.

b) Very little meat, fat, cholesterol, starch; more vegetables and fruits, i.e. healthy Western diet. The majority of the younger population subscribed to this form of thinking. Three of the younger group felt that the Iranian diet was very unhealthy. Others believed that the form of Iranian diet they had been exposed to had been a low fat one.

Four of the participants specifically spoke of an intrinsic inclination their bodies had toward certain diets; two belonged to the younger female group, one to the older male group, and one to the older female group. One believed that her body was very sensitive to changes in hotness and coldness; two others felt that their bodies did not tolerate fat very well; and the male felt that his body could not tolerate much of one thing, especially chocolates.

2. Exercise

All participants spoke of exercise as a preventive health measure. It was believed by many that exercise "opened" or was uplifting to the roohieh. A few mentioned that exercise revitalizes their roohieh. One older man recited an old Persian verse: "In a healthy body resides a healthy soul."

A few of the younger cohort spoke of having been very active in their younger years. Basketball, swimming, skiing, were mentioned as examples of exercises they used. Others had exercised but not as avidly. None of them had truly cared or had been aware of the preventive aspect of such activities at that time. Many suggested that their parents, who had been very supportive of their health effects, probably were. It was mentioned by one that exercise in the Iranian culture is for the children, not for the older people.

It was suggested by the same person that walking was the method of exercise for the older people. Also, walking perhaps for some would bring them closer to nature and fresh air, an activity which was valued in two of the definitions of health. A few spoke of having walked 2-3 hours per day in Iran. One of the younger men commented on his father walking extensively in Iran. Two of the older men mentioned that they had been very active, using field work, tennis, volleyball as example, in "their younger years" but unfortunately were not as active.

None of the participants exercise more in the U.S. than in Iran. One of the older women had just recently begun to exercise the same amount she had done in Iran, because of her physician's recommendations. Reasons which were offered for exercising less in the order of decreasing popularity were being older in both age groups, having less time, having a physical disability, and having less enthusiasm.

Another reason which was not suggested, but which might hold true is that due to the change in surroundings immigrants, especially the older population, are less comfortable to walk far away from their homes. Especially with the "societal problems" which are perceived to exist here. In effect, the major method of exercise of this age group has been taken away due to this immigration.

3. Sources of infection

Everyone in this sample was aware of the Iranian sensitivity to cleanliness, at the extreme of which one would develop a vasvas (compulsion/obsession). The bulk of the older population plus one of the younger participants were still very sensitive to this method of health maintenance. Practices which attempt to isolate a source of infection from healthy people include not kissing a sick person, sterilizing and keeping separate the utensils used by an ill person, physically isolating an ill person, washing hands frequently, and not eating anyone else's food. This, however, can develop into a vasvas (compulsion) which some of these participants denied having and one mentioned it positively.

Others did not follow this line of thought. This group could be divided into groups who had never believed in such behavior and some who had changed their habit since Iran.

1) Nonbelievers. One older man and one younger woman had never felt this practice to be necessary. They felt that if a person lived a healthy life, one would be strong and would be able to ward off these infectious agents. They were quick to add that, of course, they would not purposely subject themselves to major sources

of infectious agents.

2) Changed habits. Many of the younger group had become more careless about such habits, because a) they could not afford to be concerned about such habits b) their necessity was questioned. One of the younger men who was working very hard and also continuing with his education said laughingly, "if I want to worry about isolating spoons and such, we would have to eat with our hands" referring to the limited resources which are available to him.

4. Climactic precautions

A few of the participants mentioned temperature control as a means of preventing illness, i.e. drying hair before leaving house and wearing a sweater to compensate for changes in temperature.

5. Emotional Preventive Measures

Four of the participants mentioned keeping busy as a way of tolerating depression. On the other hand, two others mentioned working out their problems and reducing their stress levels as a way of preventing unnecessary stress. Herbal medications were also used as prophylactic measures to prevent nervous conditions by some; one popular medication was golgavzaboon. Also, there were herbal medications which were supposed to improve general health of a person, which would have a bearing on the emotional aspects of an individual.

I. Mental health care before emigration

A recurrent theme in this sample was that mental illnesses seemed much less visible in Iran. The reason for this was thought to be double-fold: 1) the visible ones were readily institutionalized and 2) there were less mental illnesses due to more societal and family support. One participant mentioned that in Iranian culture no one individual accepts responsibility, but instead it is shared among family members, hence, stress reduction. Another suggested that a pre-planned life for the children as a possible stress reducer.

As the definitions of mental illnesses suggest, psychiatrists were not consulted prophylactically or as counselors. They were only seen when a problem was felt to be out of hand, and began to affect other people.

Concerns voiced with regards to psychiatric care included being labelled as *ravani* and crazy from the society's perspective and the inappropriateness of psychiatric treatment. Labelling was perceived to affect different levels of social interactions. These included general social interactions with neighbors, friends, and family, including the marriageability of a woman, and employment or business relations. The skills of psychiatrist were also doubted by many. The relevant concerns included inability to resolve a situation when it has an external etiology (such as emotional problems) and inability to understand what a person with a different background has experienced, e.g. a person who has experienced the war.

The most recent immigrant to the U.S. spoke of a new picture which had developed in Iran. Namely, due to the social stress that exists in Iran today, seeing a psychiatrist or psychologist no longer constitutes a social stigma. The reason is that the blame of having a mental illness has now been shifted from the individual

to the society at large. As a matter of fact, the participant felt that at the time of his departure people were losing their trust in physicians since they believed that diagnosis was being overused. "Nowadays, physicians have it easy. They don't have to do much; they can diagnose anything as being a mental illness (narahati-i-roohi)." There was general concordance that psychiatric visits were handled very secretly and privately in Iran.

J. Psychiatric care after emigration:

The major supports concerning emotional illnesses are disturbed after emigration, namely the social support of friends and family. In addition, to financial concerns stresses on the family structure can be devastating (see family concerns p. 63) Therefore, the increased level of stress is accompanied by a decreased support system for the immigrant. A couple of the interviewees had seen psychiatrists and many more knew of close family members who had used their services. It was generally accepted (by at least half of the participants) that Iranian immigrants feel more comfortable in seeing psychiatrists in the U.S. Still, as one older man put it: "Since I have been raised in that kind of a social set-up, I would think twice before I see a psychologist."

VIII. Concerns

It was unanimously believed that the older age group had a much more difficult time adjusting to the new environment than the younger group. The older immigrants were likened to old trees by one participant: they don't withstand

transplantations very well. Instead, saplings (the young immigrants) could readily adjust and grow. These differences could be interpreted both in the financial realm and the nonfinancial realm.

In the financial realm, a life's labor of hard work had been largely lost due to the relocation, and the older immigrant had to start over again. Members of the younger generation are just beginning to create a life of their own. In the nonfinancial realm, relocation means a loss of social status, culture, a whole way of life. The younger group were thought to be more open towards new ideas (see non-judgmental theme page 35). The older generation was described by many as having the "wrong attitude."

--Iranians (referring to the established Iranians) are very self-righteous; they are not open to new ideas.

--The younger generation has always absorbed Western Culture; the older generation repelled that way of life.

Even though all of the members of the younger generation recognized major problems which existed for the older population, this appreciation was not reciprocated by the older group. A few of the older members did not consider the younger generation to have had any problems due to the relocation, with the possible exception of financial concerns. But in reality (as perceived by the younger adults), in addition to major financial concerns, they had to face new social roles, cultural conflicts, homesickness, loneliness, to name a few concerns. Five of the participants in the ambiguous future category (see page 36) belonged to the younger group. One person specifically stated that he considers himself to be homeless, and

that disturbs him to a great extent. In addition to personal problems, many of the members of the younger group were very disturbed by their family's newly acquired situation, both in the financial and in the nonfinancial realm.

A. Concerns tied to the family

Four major perceived threats against the family unit in the Iranian immigrant population are 1) the actual physical separation of family members due to financial stresses or political red tape, e.g. a father who needs to remain in Iran to support family members in the States, government policy not to allow both parents out at the same time (e.g. for physicians) 2) the acculturation of the children in the U.S. 3) lack of time to attend to family obligations due to financial-occupational stresses 4) change in family role due to change in women's need to work. As one can observe three of the four reasons stated here are financially dependent.

The acculturation of the children was by far the number one consideration of the older group, as it was either explicitly stated as being a personal concern or stated as a community concern by the bulk of the respondents. This truly is the ultimate irony as the parents' predominant reason for emigration, i.e. the future of the children, resulted in the children taking family obligations more lightly. In addition, the societal problems which were perceived to be rampant in the U.S., i.e. drugs and loose relationships, were strongly disliked by some of the members of the older group.

Other families who have effectively been able to cope with this conflict can serve as advisers for their friends and family, as one informant suggested. An older informant suggested that parents should grow up. She said, "People ask me how do you control your children? I say, 'I don't control them; they control themselves. I grow with them.'" A younger man felt totally despondent with regards to this issue and could not suggest a way; he noted that one generation had to pass before stress level could be reduced.

B. Financial concerns affecting the family

Financial concern was by far the most popular concern which the subjects expressed for themselves, for others in their age group, and for members in the other age group. In addition to the question of actual survival, i.e. being able to provide for food and housing, there are other social implications of change in financial status. I should say that even though one interviewee mentioned being aware of Iranians in the Bay Area who had been having difficulty in maintaining an income compatible with survival, the predominant feeling was that the Iranians in the U.S. are capable of fending for themselves at that basic level (gheleem-i-khodeshoon ro az ab meetonan beeroon bekeshand; lit trans. are capable of pulling their carpets out of the water). Three interviewees, however, spoke of Iranian immigrants in other countries, especially Turkey, Pakistan, and Germany, who were breaking into vending machines in order to survive.

The Iranians in the U.S. were felt to be the most hardworking, the most educated, or the wealthiest of the world wide Iranian immigrants. Their situation

was quite different from Iranians elsewhere. If this is true, perhaps it can be explained by the degree of difficulty Iranians face in reaching the U.S. due to lack of common borders with Iran, difficulty obtaining a visa, or perhaps some minimum financial security in order to get to the U.S. and survive.

However, financial stress has other implications as well. In Iran, being from a "good" family means coming from a financially acclaimed family and/or an educated one, which carried the same implications.

One last comment should be made with regards to the system used in dealing with financial stresses. All of the informants spoke of avoiding financial dependency as much as possible. But previously in Iran in times of need they would mainly refer to family and friends as financial resources. Banks were used very rarely. In the U.S., due to the availability of loans from banks (even at the level of credit cards), loss of the old system of family and friends, less trust among Iranians (reportedly, some Iranians have participated in embezzlement, fraud, etc. within the community), and less funds available to family and friends, the bank system is used much more in the U.S. than it had traditionally been used in Iran. I am not sure how to interpret this. This could lessen the strength of the family unit by creating fewer financial obligations within the family. It could also strengthen it for exactly the same reason, since having an obligation to pay a family member can be very stressful, especially in the "expensive U.S. system." Even though the bulk of the respondents were aware of the obligations which exist between extended family members, the interference of these members with family affairs was interpreted differently depending on the issue. All of the married individuals preferred to

resolve their marital problems privately despite being aware of the traditional cultural practices of extended family counseling. Also, many of the older individuals did not borrow from family members in Iran, primarily due to their families' lack of resources, and looked upon their friends as the primary financial resources in times of need. Therefore, lack of the extended family was not felt by some members of this group as strongly as it was felt by those who had been more dependent on their families.

IX. Style of interaction with the informants

All of the interviews were conducted in a relaxed manner. Many respondents were very interested in providing more information than had been inquired about. In general, the narratives were deemed consistent. There was only one interview whose narrative seemed otherwise, and that was attributed to the age of the interviewee. The interviews with the younger group felt more comfortable and on an equal basis. The older group, I thought, was trying to educate me about the past. However, none of them showed impatience or disregard. It also seemed to me that the main motivator for the whole group's participation in this project was to help a member of their community to further her education.

Everyone, with the exception of one participant, was given the chance to revise one's transcripts. Even though very few changes were made on the transcripts, I received some verbal feedback. The person with the inconsistent narrative was surprised at her style of speech. For a few it had awakened tucked away emotions. However, those who talked to me about it were happy that they had

participated (about half of the sample).

X. Conclusion

In conclusion, this study has once again emphasized the multi-disciplinary nature of health, as medical, psychological, socioeconomic, and cultural factors are seen to be closely intertwined. The number one determinant of American medical care use at times of perceived need seemed to be financial status, as it both affected insurance coverage and out-of-pocket expenditures. Previous health practices did not seem to affect the frequency of physician visits as much as it did the perceived satisfaction with the medical system. Extensive social support, prior familiarity with the West, and met expectations did seem to make adjustment easier for these immigrants, however, financial security did not seem to play a role. As a number of the better adjusted group had had to work very hard to support themselves, and in the process had become more accepting of the American system. However, one of the less adjusted immigrants was also very involved with her work. Therefore, financial security or change in financial status were not very conclusive determinants of over all adjustment.

The picture which is painted is of a family-oriented, yet individually self-sufficient society. The focus of the family is the children, and their education. Lipson (Lipson; unpublished work) speaks of the newer, hence, less well adjusted immigrants identifying their children as the reason for their immigration in this population. However, in this sample the amount of stay did not seem to correlate with this focus, as most of this sample, even the one participant who had immigrated

more than twelve years ago, emphasized this point. In addition, various obligations exist between different family members which may conflict with educational goals in this transition. A strong drive to work and to remain self-sufficient were seen in this sample as well as an appreciation of higher spiritual ideals.

This sample seems to exist between two different extreme societies, possibly resulting from a combination of a pre-emigration life style and a post-emigration exposure to new ideas. On the one hand, the importance of the family unit, attitudes toward drugs and sexual relationships suggest an Iranian influence. On the other hand, acceptance of mental illness as an illness, acceptance of psychiatrists, possession of a general non-judgmental attitude, expression of non-traditional physician and health expectations speak of the influence of another culture. The older generation seems to be slanted toward the traditional Iranian narratives, while the young generation is more in favor of the other perspective, as was expected by the relative ease of adjustment younger immigrants seem to possess (Lipson, unpublished manuscript). And within each age group there are varying attitudes and beliefs. However, none of the participants completely belonged to either category. The recognition of this point both in the health care system and within the community itself could help the adjustment process and can create a more "healthy" population.

In the recent past it was accepted that preventive medicine is not practiced in the Middle Eastern population (Lipson & Meleis, 1983). However, more culturally acceptable ways have become more and more recognized (Pliskin 1985; Lipson, unpublished manuscript). In this sample numerous methods of prevention were practiced, some belonging to a more traditional practice and some

to a newer culture. The older women of the sample, even though more traditional than the rest of the sample had changed their preventive techniques, e.g. proper diet, under the influence of Western medicine. This group also seems more suitable to target as a means of introducing more appropriate health practices due to the women's traditional role of health care provision. I say appropriate because due to the complex interactions and relationships between various beliefs, practices, and attitudes Western medicine should not be introduced irresponsibly in this population, as it may lead to serious repercussions. An example of an inappropriate technique would be to encourage psychiatric prophylactic treatment without emphasizing the role of the family as a counselor and as a friend. I am not suggesting that counseling should not be advocated in this population as it was widely accepted that emotional stress has increased due to the relocation. Instead, I am pointing out that there are many culturally appropriate ways of coping with such stresses which, even though may prove ineffective at times, should not be ignored.

Chapter V

Recommendations

A: Suggestions for this population

In general, the participants seemed to have accepted their relocation and were functioning very well in the this society. However, based on what the interviewees suggested (Appendix E) as well as their expressed concerns I would like to suggest a few approaches for promoting general health:

1) House of Iran, to serve as a base for Iranian immigrants in the U.S. The use of this center no doubt should be optional. In setting up such a center, the value of the family should not be forgotten. The less bureaucratic the system appears and the friendlier the atmosphere, the sooner trust can develop. The attempt should be made to involve the whole immigrant unit¹ in the activities and services of the center. This center can provide many services:

a) Settlement of recent immigrants: Each immigrant unit should have a sponsor to help it become acquainted with the new environment. As one participant suggested just being able to direct a newcomer to a place can save a lot of anxiety and time. In effect, the sponsor can play several important roles:

i) Emotional counseling:

1) inform the newcomer of how others before them have felt in regards to

¹ A family or a portion thereof who has made it to the U.S.

the new culture and the old one they left behind. Newcomers will probably experience different stages of emotional adjustment, which each individual deals with in his or her own way. Loneliness, homesickness, incompetence (both due to change in social roles and inadequate language skills) might occur for some, not necessarily for everyone. Participation in community and social activities and the passage of time can make them more bearable.

Many established immigrants have perceived the U.S. society to be fast-paced and individualistic. Lack of time has been a major concern to them. Others have taken advantage of what was available to them, and have seen it to be the land of opportunities, where anything can be accomplished through hard work. U.S. is not "heaven," "a dream", "perfect," as many of the informants later discovered. Like any other society it has its flaws and imperfections. Accepting the U.S. as different, not necessarily bad, has helped many before them adjust to the new environment. A "divergent evolution" might be affecting their relationship with their newly found past acquaintances. For example, one relative might have experienced a war and another loneliness in a different society. All have coped with these stresses in their own ways. Therefore, the more open they are to these changes the easier they would be able to interact with their relatives or new Iranians they meet.

Apparently those who have been able to adjust successfully have taken advantage of the existing opportunities without sacrificing the family unit, since the family unit seems to be the strength of this culture. Many may have

strong nationalistic feelings toward Iran. One suggestion could be for them to become engaged in community activities, which may help to address that concern (see page 78).

Granted that at the time of entry very little is taken seriously or even absorbed mentally. Many of the interviewees recognized the shock of the relocation, many years after their arrival. As a few informants hinted many may be distrustful of a social system upon arrival; they should be informed that the individuals working at the center are there to help with their adjustment purely on a voluntary basis. These should be recognized both on the part of the newly arrived immigrant and on the part of the staff.

What should be emphasized is that the center should be perceived as a resource; as a place where an immigrant has the option of visiting and using the services of for their own benefit. Anytime during their adjustment process, if problems (gereftari) should arise, which they are incapable of resolving, they should feel comfortable to contact their sponsor and House of Iran. As the bulk of the informants said, very few Iranians want to be dependent on others. Therefore, I don't anticipate creating a dependent population if this service is provided. What they need is emotional assurance that they are not alone in a society where the social and family obligations are different than their own.

ii) provide information about the relevant social institutions, such as schools, social security office, Immigration and Naturalization Service, etc. Education

and career counseling were recommended by the majority of the informants. English courses should be highly recommended by the sponsor, since the bulk of the informants agreed that English skills played an essential role in their adjustment. One informant had specifically related her self-confidence with her eloquence in speech.

iii) Helping with the initial resettlement tasks: In addition, to providing suggestions and guidance, a sponsor can help with school registration (for the children), looking for a job, language class registration, buying a car, etc.

The option of asking a sponsor to help with the above activities should be left to the immigrants. The majority of the informants came to a city where their relatives resided, hence, those relatives served as their sponsors. As a result, they were able to fit into the new society as quickly as possible. As one of the informants suggested, if an immigrant knows one U.S. resident, one can very quickly enter the social realm of the Iranian community.

b) A basic level housing and food should exist at this center for immigrants who cannot afford them. Even though none of the informants had arrived in such destitute in the U.S. one person had known of people who had. And as new waves of immigrants enter the U.S., based on "typical" immigration patterns it is anticipated that they would belong to a less affluent class.

c) Financial help. Financial aid can be provided to students in the form of scholarships or loans. Three of the younger participants had endured very difficult working conditions at the same time as attending school full time in order to be able to further their education; Education, as it was discovered, was a major theme in this sample of the Iranian community. Financial assistance can help them with this goal. This aid should not aim to completely do away with the pressures, but instead lessen the financial burden. Financial assistance in the forms of loans could also be provided as a starting capital to launch a business or get started on a career.

d) Social gatherings/get-togethers. Social gatherings are the culturally appropriate way of providing emotional support. According to most participants, they have functioned as an effective method of coping with being away from "home." Even though this form of coping seems to be well established in this community, it is not universally established yet, as a few of the participants suggested. The center could serve as a rendezvous location for the lonely, isolated immigrants.

e) Legal/career/educational counseling. Legal consultation was recommended by one participant who had not been successful in launching a business of his own due to legal disputes. He mentioned that most Iranians are unaware of the legal set-up in the U.S. and will suffer for it. A legal consultant, or at least a library of laws and regulations would benefit the business oriented immigrant in that respect.

Successful Iranian professionals, businessmen, students, etc. can provide guidance to newcomers in those fields. In addition, House of Iran could serve as a center for formulating new ventures and ideas. As many in this sample suggested, the potential exists to launch major projects and enterprises with the cooperation and innovation of the large number of Iranian professionals who live in the Bay Area.

f) Emotional counseling. Continued emotional counseling as the adjustment process continues. This counseling was suggested by many to be performed by colleagues and friends, rather than psychologists and psychiatrists, which is a more culturally appropriate way of dealing with emotional problems. Family conflicts between the older and the younger generation will undoubtedly occur do to the acculturation of the children; these issues were suggested by a younger participant to be addressed by members of the community, who, themselves, have been able to deal with those issues effectively. Professional counseling may be necessary in some occasions (see medical insurance on this page).

g) Cultural center. Literature, drama and other artistic activities can be hosted by this center. In addition, Persian classes and libraries can be organized from this center for the children of the immigrant, in order not to only familiarize the young with the heritage of their forefathers, but in addition to help them understand their parents better.

h) Center for Iranian newcomers. As was specifically mentioned by three of the participants there are many Iranian refugees in Turkey, Pakistan, and Germany, to name a few countries, who are living under very difficult conditions. Arrangements can be made to enter Iranians into the country, to provide for a sponsor, and to help them adjust to this society. An Iranian Newcomer Organization did exist which recently shut down. It is my understanding that the main reason for this was financial.

2) Medical insurance/services. This could be a subcommittee in the House of Iran.

a) A referral system could be set up to help refer Iranian immigrants to the appropriate health care provider; the SIHA project at the University of California, San Francisco provides such a service for Middle Eastern immigrants in general. As has been discussed, a referral system is a culturally appropriate way of establishing a workable patient/physician relationship.

Since references in Iran were traditionally comprised of friends and family, the establishment of trust is of utmost necessity in making this program useful, hence, being accepted into the close network of family and friends.

b) Health insurance. Emphasis should be placed on providing health insurance to Iranians who cannot afford an essential and indicated medical treatment. Currently, an Iranian Health Plan does exist, with exactly that aim. But it is very sparsely staffed and funded. Other health care plans can also be developed or recommended by this agency to address various needs and expectations.

c) Psychiatric/psychologist referral: Even though it was generally believed that the family and social unit was a very effective way of dealing with emotional and mental stresses, this system was not proven to be perfect. A few cases of mental and psychiatric conditions were cited which had required professional help. Three cases had benefited from this approach, and a few had not, just like any other treatment. A psychiatrist/psychologist who is familiar with the situation in Iran and the Iranian culture would be very appropriate for this population, since a better level of understanding and trust can be developed between the therapist and the patient. The social stigma against psychiatric care was reportedly much less in our sample than it is perceived to be in Iran. And also, according to one account, the stigma in Iran has in general decreased due to the changes in the societal stress level. However, I am hesitant to recommend professional help on a counseling or preventive basis, not because I myself am prejudiced against it, but rather because the extended family unit, including close friends and associates seems to be serving that purpose effectively. On the other hand, immigrants should be encouraged to seek help if that system is overwhelmed or nonexistent. And they should be reminded as many participants in this study suggested that it is better to treat an illness at the beginning of its course than at a more progressed stage, especially psychiatric illnesses.

d) Making available preventive/educational information in the form of brochures or seminars. As has been discussed, there are many cultural practices to prevent illnesses. Not that this correlation is necessary, but each in its own way can correspond to a Western category of disease prevention. For example, a balance in

the hot/cold system can establish a nutritional balance which is generally recommended in Western medicine, or walking as a means of "opening or uplifting the roohieh" is definitely recognized as a preventive method. Such culturally accepted preventive techniques should be encouraged in this population. Beyond that, more Western measures with a culturally sensitive explanation should be recommended in brochures, and/or seminars. For example, the more traditional older women were very open to changing their Iranian cooking based on Western recommendations. White meat had been substituted for red meat, "mazola" for animal fat, and salt was used much less. At the same time they had remained true to their culture by continuing to prepare Iranian cuisine. It seems to me that the women in the family would be the best group to approach for preventive measures as in Iran it has traditionally been their role to attend to the family's health needs.

One concern voiced by two older immigrants and most of the younger group was the inability to serve Iran with the use of their acquired skills and knowledge when living abroad. I would like to suggest to these individuals as a way of reducing their stress, to consider the Iranians abroad as a representation of that country.

Many spoke of "Iran" as the people who live in it, rather than the soil itself. Even if the land itself is of primary importance to some immigrants, surely the importance of its residents cannot be denied. Therefore, one way of addressing this concern is to help the Iranians who are living abroad. Another way to justify this approach is to hypothesize that many of these Iranians might return to Iran, and serve that country, hence, through them they are assisting their country.

I realize that all immigrants experience an increased amount of stress, and to accomplish their own adjustment is a major task. That point is well taken. This recommendation, however, is for those who in addition to experiencing personal adjustment issues, are regretting not serving Iran. I, also, understand that "helping" is not an easy task at all, as many Iranians have spoken about the "self-righteous" Iranian who is unwilling to listen to anyone else's point of view. However, that same trait exists in Iran, probably to a greater extent.

The above recommendations have been based on the opinions of twenty members of this community. Their feasibility have not been determined, and are based on what we feel the Iranian immigrants need the most.

B. Recommendations for further studies

Even though the study was of value in eliciting a number of "social realities," the small sample size was probably not representative of the population. A larger sample may be able to deal with this issue more effectively.

Influences on the degree of US acculturation could be a main theme of several studies. Possible acculturation indices, such as the degree of health care seeking behavior, financial practices, friends' ethnicity, familial cohesiveness, and language usage, may correlate with the degree of acculturation and/or adjustment or inter-correlate with other indices. Health care seeking behavior, for example, could be measured by correlational means, both in the fekri realm and the jesmi realm. Specific symptoms could serve as the main parameter, confounded with

identifying information, i.e., age, ethnicity, religion, education, sex, associated symptoms, previous history just to name a few relevant factors.

Another focus of acculturation studies could be the factors influencing the degree of acculturation, e.g. types of leave-taking (reasons, degree of difficulty), degree of acceptance of Iranian culture, social set-up in the receiving country, language skills and gender.

Gaining a better understanding of the importance of the family unit to Iranian immigrants is of essence in providing health care services for them. Close family connections seemed to be valued greatly in caring for the ill and in general, providing an emotional support system, but for many married couples in this sample it was very important to be able to work out their differences away from the family influence. Also, some sentiments were voiced with regards to having developed beliefs and standards different from their families', which could serve as a motivation towards individualism versus family cohesion. In general, what are the factors which strengthen each or conversely weaken each?

The effect of depending financially on the banking system instead of the family could be the topic of further studies. It seems that this emphasis might be another detriment to the cohesion of the family unit. Since financial problems ranked highest among this sample's concerns, this change in the support system is probably a major source of stress in this population. Alternative methods of borrowing money, such as community based loaning institutions, could be further studied as a way of addressing this concern in a more culturally appropriate way.

A study could be designed to probe the magnitude of the generational conflict between family obligations and how it could be dealt with. One possible study is to interview members of the community, who have been able to integrate both cultures, and ask about their secret to success. This group could be selected by a statistical survey or by self-description.

Health care behavior did not seem to correlate with the attitudes of the health care users in this study. What is the relationship between health care attitudes and health care behavior? Related to that issue, different methods of introduction of new health information could serve as the focus of one study. Possible parameters which could be varied are the targeted family member, the method of introducing data; i.e. pamphlets, slides, videos, and the cultural relevancy of the information.

Another point of interest is the age-inducing effect of immigration. This general feeling could be due to the combination of increased "wisdom," increased fatigue, any other factor, or a combination thereof. What does it mean to be aged? How does immigration influence it? How does it influence health care practices? Does the degree of discontinuity of the social self play a role in this perception? If so, we would expect discontinuous conditions, such as loss of family structure, starting in a new job, living in a different social set-up, would help to "age" a person more effectively.

The roots of two possible longitudinal studies could be found in our study. The focus of one could be immigration and aging, long-term health and social outcomes. Is the fear of one of our participants well founded that the elder

immigrants will end up in a senior house if acculturation occurs? Another study could follow the influence of acculturation on child-rearing and possible conflicts which might arise.

Appendix A

SAMPLE QUESTIONS

A. Identifying Data

How old are you?

Are you married, single, or widowed? Do you have any children? How old are they?

Where are you from?

Which ethnicity do you belong to?

Where did you do your schooling?

What did you do in Iran and what do you do here?

Did you have to work as a child to support your family? How was your general economic status?

B. Practice/experiences pre-emigration:

How did you define health?

Who was considered healthy? How did people act towards a medically ill person?

What did people do to maintain their health? Did people exercise? Did people have regular "check-ups"?

How did you define the mind?

Who was considered to have mental problems? How did people act towards a mentally ill person?

Who is considered crazy? How did people react towards a crazy person?

What was your economic status during the ten years before emigration? What did you do?

When did people go to the doctor? What was their expectations?

Was herbal medication used?

What was the practice when someone had a high fever?

What was the practice when someone had a skin lesion, mole, growth, cut?

What was the practice when someone had a fracture or extensive bleeding?

What was the practice when someone had chronic pain?

What was the practice when someone was comatose, or was delirious after an accident?

What was the practice when a person was ,in general, delirious or hallucinatory?

How do you define depressed? What was the practice when a person was depressed about one thing?

What was the practice when a person was generally depressed?

What was the practice when a friend was experiencing suicidal thoughts? homicidal thoughts?

Who do you consider to be an addict? What was the practice when a person was a drug addict?

What was the practice when a person was alcoholic, smoked cigarettes or a pipe?

What was the practice when a person used opiates?

What was a typical day's meal?

Was there ever a conflict between what a physician recommended and the generally acceptable diet for an illness?

How did people relieve their economic concerns (bank, family, friend.), medical concerns, family problems (abusive spouse, a non-obedient child)?

How did you feel about the United States?

Did you know English?

How familiar were you with the West?

How did you feel about Iran?

C. Transition information:

Did you have to move from a city to another or change houses in the same city?

When did you emigrate from Iran? Why? Did you participate in this decision?

How difficult was it for you to enter the U.S.?

Was the transition difficult?

D. Post emigration information:

All the questions that you asked pre-emigration.

What percentage of your friends are Iranians?

How has your experience been in general? Have there been any changes since the first few years of emigration?

Where is home? What are your expectations for the future?

How do you perceive yourself? What have you learned from this experience?

What would you consider the main problems that should be addressed in the Iranian emigrant population? If there were sufficient funding, what programs would you recommend for this population?

How would an Iranian immigrant from the other generation (either 20-30, or 45-65) respond?

Is there anything you would like to add?

Appendix B
Informational Letter/Consent Form

November 17, 1989

Dear recent Iranian immigrant:

I am a Berkeley graduate student in the UCB-UCSF Joint Medical Program, and as part of my master's work I am interested in interviewing Iranians who emigrated after Feb. 12, 1979 to better understand how adjustments have been made in health care practice, and how economic, ethnic, and educational factors influence this behavior. Also, I would like to gain an understanding of the support systems available to respond to stressors in the environment.

With the permission of participants I would like to tape-record these interviews. I will transcribe the interviews leaving out any identifying information and the tapes will be immediately destroyed. Furthermore, I will provide a copy of the individual interview to each person for their corrections and approval. The information that appear in the finished paper will not contain any identifying information. I anticipate there will be two to three interviews for a maximum of one and 1/2 hours per session.

The benefits in this study will include greater understanding of an understudied population and their adjustment to a new environment. Additionally, I know from personal experience in this community that members do feel some personal benefit in being able to tell their stories and share their experiences of how they have coped in making major adjustments in their lives.

Regarding risks, some of the information disclosed may be of a personal and private nature that subjects would not want make public. However, as already mentioned, the identities of the subjects are kept confidential, and will be only known to the interviewer, namely, myself.

If this is something you would like to do or would like more information about, please contact me so we can arrange a time to meet. You should remember that participation is entirely voluntary and if any time during the interview you would want to end the session you should feel completely free to do so. Thank you for considering this invitation.

Sincerely,

Jaleh Niazi
(415) 642-5479

LETTER OF INVITATION/CONSENT IN PERSIAN

هموطن عزیز مهاجر؛

اول دی ۱۳۶۸

این نامه را بعنوان يك دانشجوی ایرانی دوره پزشکی مینویسم تا از شما در مورد جمع آوری اطلاعات مربوط به تهیه ترم یاری طلبم. دوره تحصیلات پزشکی من مشترکاً از طرف دانشگاههای کالیفرنیا در برکلی و سانفرانسیسکو (UCB-UCSF) ارائه میگردد و بدین لحاظ مستلزم يك سال تحصیلات فوق و تهیه رساله ای برای گذراندن دوره فوق لیسانس میباشد. موضوع انتخابی این رساله عقاید و آداب بهداشتی جمعیت مهاجر ایرانی در BAY AREA قبل و بعد از مهاجرت به امریکا است و چگونگی تأثیر عوامل مالی و فرهنگی بر این مسئله. در ضمن مایل هستم که نکته دیگری را مورد بررسی قرار دهم و آن سیستم کمکی و امدادی است که ایرانیان این ناحیه در این جابجایی از آن استفاده کرده اند.

برای جمع آوری اطلاعات صحیح در این زمینه مایل هستم با هموطنانی که بعد از ۲۲ بهمن ماه ۱۳۵۷ از ایران به امریکا مهاجرت کردند مصاحبه نموده و از دانش آنها استفاده نمایم. با اجازه شرکت کنندگان این مصاحبه ها ضبط خواهند گردید اطلاعات بدست آمده بدون ذکر نام و نشان افراد بر روی کاغذ خواهد آمد و نسخه ای از متن مصاحبه جهت تأیید و تصحیح در اختیار شخص مصاحبه شده قرار خواهد گرفت و نوارهای ضبط شده بلافاصله پس از نقش اطلاعات از بین خواهند رفت. زمان لازم برای انجام مصاحبه بطور متوسط ۱ تا ۲ نشست حد اکثر يك ساعت و نیمی است.

امید است نتایج بدست آمده به آشنا نمودن مشکلات بهداشتی ایرانیان در امریکا یاری بنماید. مضافاً تجارب شخصی نشان میدهد که ذکر مشکلات و راههای ابتکاری افراد برای مواجهه با آنها در تخفیف تأثیر مشکلات کمک مینماید.

با وجودی که نگرانی از مخاطرات مربوط به استفاده عموم از این قبیل اطلاعات شخصی ممکن است بی میلی هموطنان را در بازگو نمودن تجارب خود بوجود آورد ولی چنانچه گفته شد اطلاعات مبادله شده بدون ذکر نام و نشان مورد استفاده قرار خواهد گرفت و تنها مصاحبه کننده، یعنی نویسنده این نامه از هویت اشخاص مطلع خواهد بود.

اگر مایل به شرکت در این مصاحبه یا اخذ اطلاعات بیشتر در این مورد هستید لطفاً با من تماس بگیرید. لطفاً فراموش نکنید که شرکت در این مصاحبه ها کاملاً داوطلبانه صورت میگیرد و اگر هر موقع در طول مصاحبه مایل به اتمام جلسه باشید، اختیار کامل با شما میباشد. از همکاری شما بسیار سپاسگزارم.

با احترام کامل،

ژاله نیازی

۰۵۴۷۹-۶۴۲ (۴۱۵)

Appendix C

	YW	OW	YM	OM	Total
<u>Socioeconomic class</u>					
Upper Class	2	4	0	1	7
Upper Middle Class	2	0	4	3	9
Middle Class	1	1	1	0	3
<u>Prior US Contact</u>					
Lived in US	1	2	2	3	8
Visited US	0	3	1	1	5
None	4	0	2	0	6
<u>Marital Status</u>					
Married	1	4	1	3	9
Single	4	0	4	1	9
Separated	0	1	0	0	1
<u>Highest Educational Program Enrolled in</u>					
9th Grade	0	1	0	0	1
High School	0	2	0	0	2
A.B.	0	1	0	0	1
Bachelor	4	0	2	1	7
Master	0	0	1	1	2
Doctorate	1	1	2	2	6

YW = Younger Women; OW = Older Women; YM = Younger Men; OM = Older Men.

Number of Years in U.S. Since Latest Trip

	YW	OW	YM	OM	Total
3-5 Years	1	1	1	0	3
6-8 Years	3	3	3	0	9
9-11 Years	1	1	1	3	6
12-14 Years	0	0	0	1	1

Appendix D

List of Herbal Medications

<u>Herbal Medication</u>	<u>Purpose</u>
Golgavzaboon: bugloss, borage (hot)	just a drink; ease the nerves (both prophylactically and treatment); fever; colds heart disease. foxglove according to one source.
Khaksheer: London rocket seed (cold)	good for the mezaj (general health); heat stroke constipation; fever.
Foloos: Cassia pods	good for the mezaj
Par-i-syavash: perseus	?
Sonboleteeb: valerian	good for heart and nerves; according to one source foxglove
Roghan-i-karchak (castor oil)	laxative; fever
Eucalyptus leaves	disinfectant; for upper respiratory condition
Scorpion oil: (oil which has had a scorpion die in it)	applied to open wound;
Behdooneh (quince seeds)	sore throat, bronchitis, i.e. lower respiratory condition
Chahar Gol (four flowers)	fever (to make liver and kidney function properly)
Gol khatmi: marsh mallow	fever (enema)
Badyoon: anise	get rid of bloating, gas
Carpooreh (green dried leaves)	stomach ache
Shahtareh: fumitory	fever
Haleeleh: myrobalan (very hot)	cold, arthritis, practically anything
Opium	pain reliever (usually for chronic pain)
Boiled rice bran	hair loss

Appendix E Data

Case 1:

Age: 20-30

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class¹

Had visited U.S. for short time periods for a family member's medical treatment

Very stable residency history²

Very close family (including extended family) relations

Not well versed in English

2. Decision making:

Reason: Long term decision: Father had always wanted to live in the U.S. because of the economic opportunities it offered for progress. Actual move precipitated by the revolution

Whose decision: parents

Feelings/expectations before immigration:

She had different images of the U.S.: 1) land of opportunities and rights; warmth and happiness. Derived from correspondence with relative who lived in the U.S. and T.V. series "Little House on the Prairie" 2) Oppressive country. Derived from English teacher's lectures. Overall the positive balanced out the negative image. And Iran was home.

3. Relocation:

Difficulty leaving: Relatively easy.

Difficulty entering: Relatively easy.

On arrival: Stayed in a motel for less than a month, close to relatives' place of residence; began to work shortly thereafter and continued to work through B.S. degree.

The U.S. was not at all what she had expected. Father had a very difficult time starting his business. "No one trusted us,

¹ The economic classes are loosely assigned, based on parents and/or self occupation, self-designation, servants, recreational trips.

² Referring to history of relocation

because we came from a country, which had a terrible image. When I went to school I was harassed." It created a hatred in her against the U.S. for a short time.

Parents borrowed money from relative and started a business. Even though no longer in the same business, they have managed to stabilize financially through hard work.

It took a long time before she felt comfortable with English, approximately 3 years, because high school curriculum was at a very basic level, parents did not speak English, and her friends were Iranians.

Problems and concerns:

Financial;

Language problems;

Homesick;

Cultural: her gender was mistaken several times because of lack of make-up and short hair; also, she noticed extensive drug use in American schools.

4. Currently:

"I see myself as a drop in an ocean, very insignificant." Learned from this experience: "In Iran one's thoughts are mainly occupied with really insignificant things, such as knitting, being a lady, getting married, having kids, and these things. I can pick and chose from the endless opportunities available to me."

Very well adjusted--too well.

Currently she is still working and is financially stable.

Attitudes/feelings now: U.S.: "Eventually, when I tried harder and adjusted to this society, I realized that it is true that problems exist, but problems exist in all societies. If a person can make the best of it, not it isn't that bad. I mean that it has problems but compared to other countries it is very good."

Iran: "I try not to think about it, and that is the plain truth. Because whenever I think about Iran, I have this terrible feeling that I can't do anything. And I think that I have tried to block out everything, including the events that occurred, my family, my birthplace, and where I have been raised. And now I am concentrating on my life now and my future life."

5. Future:

"Neither is Iran right for me, nor am I right for it." Women's rights are important

to her. Most likely the U.S., because her family is here.

B. Adjustment to Health Care Practices:

1. Definitions:

Health:

In Iran: due to sibling's congenital illness, appreciated health to a great extent. "... left an everlasting impression on me: because I saw that an infant, who was clear of all sins, was ill this way."

"Mentally, a person is healthy who can live comfortably without any addiction, without any outside control. Physically, a person is healthy who has no illness. But in my opinion, even those who are ill can be very healthy people, because of the way they take care of themselves and the way they undermine their illness, in contrast with those who are supposedly physically well, but constantly complain of insignificant (psychological) headaches."

Mareez-i-ravani: "... needs something to continue living; this could either be by choice or not, but in a lot of cases the decisions we make are based on our previous experiences. For example, one of my relatives drinks alcohol to a great extent, you can even call her alcoholic, and yes you can say that she is doing something wrong. But when you look at her family background and personal hardships, I am not saying that I accept what she is doing, but I can understand why."

Depression: "Lack of interest; very disturbed about something. corner seeking; just wants to solve his or her problems on his or her own."

Crazy: In Iran: A form of mental illness in which the opinions of others are irrelevant to the person and the person's behavior. But personally she does not like to label people as crazy. "I try not to just look at the final outcome and base my decision on that, because one should look at a person's background and ask what has happened to result in this. Was there a reason or was the person raised in the best of families and turned out this way? I place a major difference between these two situations."

Addiction: "A person who has to do something every week (regularly) to become happy or to get one's life going is addicted."

2. Before Relocation:

Medical care:

No regular check-ups; regular visits;

Father and grandmother did not like to see physicians; only when they were severely ill.

Extensive emotional support: "Grandmother, other family and friends would

come take care of us.... They tried to support my mother, because when a child has such a problem it can really affect a young woman, and they helped us a lot."

Preventive medicine:

Due to young age did not participate in decision.

Alternative methods:

Once every 2 to 3 years khaksheer was used to reduce fever and nabat for stomach ache. In general, her family is more modern than to use such practices. Grandmother did use herbal medications usually after physician visit. She is aware of some hot/cold food categories and follows them to a small extent.

3. Currently:

Medical care:

No regular check-ups; parents receive regular check-ups; mother makes the appointments.

The subject somewhat has grandmother's feelings that if a person is supposed to get sick, the person will, which translated into: "I have a relax attitude towards it."

Physician care available for medical conditions. She believes in first allowing the body to fight the condition, the body develops a defense.

Attitudes toward illness: same feelings exist; however the support system may have decreased to a small extent--mainly due to lack of time and societal structure.

Expectations from physician:

Preventive medicine:

BALANCE: balanced food intake and food content; not much exercise, but tries to walk to destination and has been recently doing sit-ups daily; tries to avoid harmful activities, e.g. smoking, alcohol (only occasional), drugs, sexual activities (to avoid VD's or AIDS); tires to make up for lost sleep; works out her feelings and thoughts. She doesn't pay much attention to sources of infection, because she "believes that if a person is healthy and strong, the person can resist such organisms. Of course, if one house is completely sick I might not visit them for a week, but in general I am not afraid of contracting disease in this way."

Alternative methods:

Very infrequent; hot/cold awareness; some adherence to these guidelines. Not very familiar with mechanisms of herbal medications. Also please see

"before relocation."

4. Health in Iran:

Physical illness was supported to a great extent.

"In Iran I knew one person who really did not have a mental illness, but unfortunately in Iran individuals are labelled early in childhood on some basis, for example they have not been outstanding, or are from not so good a family. And it stays with them. Of course, this behavior is also seen in the U.S. but more so in Iran.... He was a very intelligent person, but was slower in performing other tasks. He was called mentally retarded."

Health care was very dependent on social class.

Attitude toward depressed: "Would not be left alone; but my parents allowed 2 to 3 days of this sadness, so I could resolve my feelings."

A close family member saw a psychiatrist and in general they kept a lid on it. Those who found out would say: "her chances of getting married have been greatly compromised." ..." Because unfortunately they looked at girls as assets which eventually needed to be liquidated."

5. Health in the Iranian community in the U.S.:

She was involved in the care of suicidal friend; the friend had had a few attempted suicides. In her opinion, "in reality, whenever she needed attention, she would use this device, because she knew that friends and family would immediately gather around her." She underwent psychotherapy and is now doing fine.

Deal with stress of immigration: talking about it, getting into fights in social gatherings. It could be that friends get into fights just to vent their frustrations, drugs, cigarettes, politics.

"Iranians don't really support each other very much; .. The Iranians here with their education and financial wealth have not done anything positive in the past ten years."

6. Health in the U.S.

Attitudes toward mentally ill seems to be the same. "A good example are the homeless in Berkeley, at least fifty percent of whom are mentally ill.

Society's attitudes toward drugs and cigarettes have changed during the time period which she has been in the States.

C. Concerns among the population (for immigrants who have been here as long as the subject):

- a) 20-30 year old. Financial.
- b) 45-65 year old. Financial survival; homesickness for family members and friends more than Iran itself (this does not necessarily have to be fixed).

D. Recommended Programs for Iranian Groups:

- b) 45-65 year old. Educational exercise programs (not necessarily high speed exercise)

Case 2:

Age: 25-30

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status=upper class;
 Father is a physician
 Close family relations; family problems were mainly repressed.
 Very obedient children; she was very proud and believed she could do anything.
 Very stable environment
 Had never been to Europe before last journey, but parents had visited often;
 siblings in the States
 Not very well versed in English

2. Decision making:

Reason: subject's education; to have the same opportunity as siblings.
 Whose decision: father's (no disagreements); decision was carried out subtly; but she was aware and did not mind or care.
 Feelings/expectations before immigration:
 indifferent about the journey (family and friends and financial security vs. education and financial insecurity); thought the U.S. to be heaven, because of good smelling souvenirs she received and due to her pride she thought she could overcome any financial strain.

3. Relocation:

Difficulty leaving: Easy departure;

Difficulty entering: Two to three months in third countries.
 Entered with temporary visa.

On arrival:

Stayed with sibling;
Thought the Americans to be materialistic and money oriented (probably did not sense such concerns due to family situation in Iran); hostile feelings toward the States; "this is not my place."
Had to work 20 hours/week to pay rent, but nonresident tuition was paid by parents; switched to laboratory work after marriage.

Problems and concerns:

absence of parents,
new environment
unfamiliarity with English;
loss of self confidence, because
1) not being able to speak fluently, 2) not being known
as doctor iiiii's daughter

4. Currently:

No longer self-righteous; thinks her experience to be very limited; not judgemental. Has become very responsible; learned that she should get her self-confidence based on her own accomplishments and merits, not on anything else; she is a sensitive person, and not aggressive (weak point); need to be aggressive here. Also, like to think about issues a lot.

Financially stable. Now she has become used to the situation.

Attitudes/feelings now: Misses her parents and friends, but does not have any nationalistic feelings towards Iran. Home will always be Iran: "Maybe not Iran, but limited to where I lived, limited to my memories. Those are very important to me. Perhaps nothing will replace them."

Problems and concerns:

Studying in a graduate program has lessened considerably from her concerns for her educational future. And being married has done away with being lonely. "Being able to speak has helped me a lot, but it is still very difficult for me here; I am not saying that it is simple."

5. Future:

Would like to live close to her family, wherever it may be. Would like to have children, spend some time working, some time with my family. I would also like to work with small children and teach them.

B. Adjustment to Health Care Practices:

1. Definitions (developed here):

Health: "A person whose organs work well. In addition, be an athletic kind of person; no aib's (defects or flaws) or any narahati's, both physically and mentally.... If a person is under pressure mentally his or her physical conditions may be affected."

Mental disorder: (narahati-i-ravani): "There are different forms. Those who are under a lot of stress, those who are very anxious, have a lot of work, those who have had situations in their lives which has depressed them. I have encountered only a small percentage." Also, organic causes. "Don't behave normally, you aren't as happy as you have always been, maybe, you don't have the same energy level."

Depression: "not happy; doesn't have much hope in life; has no specific goal; because of preoccupation very tired--uses up all of his or her energy; is a very sensitive person."

Crazy: "has no control over his or her behavior; not necessarily harmful." "A serious form of mental illness."

Addiction: "if it is taken away from you, you become irritated, be it physical or mental."

2. Before Relocation:

Medical care:

Father physician; also had a personal physician;

No regular check-ups but frequent visits;

Father did not prescribe medication readily;

Access and use of physician care very regular;

Family support illnesses, physical or mental; ladies usually didn't work and had more free time to tend to the sick.

Preventive medicine:

Eat food regularly; lots of fruits and vegetables; not much meat or fatty foods; exercise helps mentally. Family practiced isolation of infected person, utensils, such. Did not have regular check-ups, but if something arose would immediately be seen for it.

Family members were familiar with hot/cold categories.

Alternative methods:

Herbal medications used as a secondary method, somewhat familiar with hot and cold mechanisms of treatment. Relatives used them for chronic illness and father tested acupuncture; methods were not deemed useful.

Insurance: was not necessary.

3. Currently:

Medical care:

Has become more aware of health issues; has regular check-ups performed by an internist.

Sees a specialist for a problem.

Expectation from physician: based on limited experience. Patient needs to be heard, should not be rushed. Physician should suggest various treatments (as her experience was in Iran); quick diagnosis and prescriptions are not expected, in general. Remembers, however, seeing a physician for a two year old condition and really expecting medication.

Less time and resources to take care of family or friends; even though the same feelings exist.

Preventive medicine:

Similar to before emigration; now more aware perhaps because of increase in age. However, she is not as careful about contacting sick people, because she says half seriously that after a major assault a few years ago, her body apparently accumulated a lot of antibodies.

Hot/cold: she would like to find a biomedical basis for this theory; accepts some of the beliefs based on Western concepts.

Alternative methods:

Uses only eucalyptus for the smell, not because of medicinal value.

Addiction: Not judgemental towards addicts, because not everyone is raised under the same conditions.

Insurance:

For first 2 & 1/2 years no insurance; careful about health

4. Health in Iran:

Attitudes toward physically ill people: A lot of support.

Attitudes toward mentally ill person: support, if they are aware of the situation. Mainly, in the patients' own hands. From outside, he or she is told what to do or what not to do, but the rest is up to him/her.

Attitudes toward a crazy person: Most people stay away, because person is not predictable.

Culturally, prescriptions were expected. She remembers her father saying, "a shot may become necessary to calm him/her down."

Cultural practice to differentiate between different forms of addiction; cigarette smoking is not that important, but heroin, cocaine, etc. In Iran people used opium, here it is mainly crack.

5. Health in the Iranian community in the U.S.:

Lots of mental stress and narahati. Most people she is acquainted with have experienced a major change in social status.

"Our generation does not take herbal medication and old folk ways very seriously, but the generation before us were raised with these concepts."

She thinks father would have borrowed from banks in Iran, too, rather than family and friends, if the need arose; less funds available to people she feels close enough to.

C. Concerns among the population (for recently arrived immigrants)

- a) 20-30 year old. language; lack of social network.
- b) 45-65 year old. much more serious problems; major change in financial status; language; loneliness; health care.

D. Recommended Programs for Iranian Groups:

- a) 20-30 year old. Language courses; opportunities to meet people; career or educational counseling.
- b) 45-65 year old. social groups; health insurance.

Case 3:

Age: 20-25

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: upper class; Father a physician

Both parents educated abroad.

Had lived in the U.S. for a few years in childhood

Attended international schools; considered to be too American; had frequent trips to Europe and the States.

Everything available; skiing; water skiing; own pool;

Very close family relations

Very well versed in English

2. Decision making:

Reason: Thought she should have the same quality of education as her brother did; accelerated an existing decision.

Whose decision: mother's (no disagreements)

Feelings/expectations before immigration:

No feelings; didn't think it would happen, but

"I didn't leave wanting to leave." Aware of many problems, but it was O.K. for her and her family; did not want to leave family and friends.

Thought the U.S. to be how she had left in childhood; many Americans she had come in contact with were from the Midwest and the East Coast, where family values are still much stronger.

3. Relocation:

Difficulty leaving: Uncomplicated; two weeks for the processing of exit documents.

Difficulty entering: Very easy entry; green card from childhood

On arrival: Stayed alone with sibling for a year;
Didn't know at the time what major stress she was living through; U.S. did not fulfill expectations.

Parents would come and go for the next two to three years

Family has been split off and on;

Problems and concerns:

Education;

Loneliness; Homesickness;

4. Currently:

Not a typical immigrant.

Independent; determined; "feminist." High goals for the future. Has learned about poverty and class dependent health services; has learned to appreciate much more a lot of things which are taken for granted on a daily basis; what is important is "your love, your family, and helping each other;" bicultural (has accepted the best of both worlds); considered by some too Iranian and by some too American.

Parents still apart at times; coming and going.

Attitudes/feelings now: In U.S. different resources are available to all social classes, even though not as equally as one would like to think. "I expect more

of this country."

5. Future:

Expects to live in the U.S.; no possible way to live in Iran with her feministic views. High goals in mind.

B. Adjustment to Health Care Practices:

1. Definitions:

Health:

In Iran: She was younger and did not think about her own health status at all. "Not being ill (mareez); based on closed family members' health status." Aware of a major health problem (lack of medical care) in Iran, especially rural Iran due to father's work.

In Iran (now): That you can walk.

In the U.S.: stronger definition due to available resources.

"In the U.S. much more than Iran you have to be mentally healthy... In the U.S. a lot of people are physically healthy, and yet are not mentally healthy." "A person who is healthy, is a person who has had a check-up every six months, they know that everything is right about him; and is a person who has no mental problems, namely, is not a person who has been abused, or does not have major daily stressors, for example, is not lonely."

Mental illness: (mareez-i-ravani): Some confusion about this. Genetic or organic mental condition.

Narahati-i-ravani: "does not have to be disabled. ..., most importantly, has not seen enough love." Can include mareezi-i-ravani. Danger to others shows maximum severity.

Depression: "There is no hope for the next day. Has no reason to get out of bed, who feel he/she has no energy, can't find anything positive in anything."

Crazy: it is an insult and should not be used; instead, mentally ill."

Addiction: "When you can't spend a day without something." Both physical and psychological. Can become addicted to anything.

2. Before Relocation:

Medical care:

Father is a physician;

Had regular check-ups with pediatrician;

Access and use of physician care very regular;

Family support for illnesses;

Preventive medicine:

Similar to current practices, except much more exercise, and no kissing.

Alternative methods:

Herbal medication used "on the side" in household, especially grandmother.
Not for a mareezi (sickness).

3. Currently:

Medical care:

Avoided seeking health care; much more expensive than what the Iranian villager had to face (lots of referrals and tests).

After costly medical expenditure, now has regular dental check-ups.

Tried to use her father's advice to diagnose herself;

Father's diagnosis in a very short period of time outdid what physicians here diagnosed after many visits and meticulous tests

More over the counter medications available.

She would rather let the body take care of itself.

Expectations from physician: to get to the point and see what is wrong; don't unnecessarily check other things; does not expect prescriptions.

Has the same support system, personally.

Interaction is cut off with friends who are using heroine, cocaine; less than that try to talk to them about it.

Preventive medicine:

Eating good foods, i.e. low red meat and fat content; by their nature Iranian snacks are healthier; exercise; does kiss sick people, but boil utensils;

Alternative methods:

Used very infrequently; "tempted to use them, but if for example I am burning with a fever of 45 degree I am not about to pass up on regular medication." However, for a chronic pain in the family traditional methods (acupuncture; badkesh) were used to no avail.

Psychological disorders: she doesn't act differently towards an acquaintance who had a psychological disorder; no labelling

insurance: student insurance; no comprehensive coverage; she does not think that it is worth it; more constrained financially.

4. Health in Iran:

Her father would talk about progressed cases of illnesses. When asked why they didn't seek care sooner, he would say, "They don't understand it; they are afraid; and they do not have access."

Physicians in Iran, because of the tremendous patient load, were more skilled in different fields; specialist would see nonrelated cases.

Due to the lack of physicians, a lot of Iranians "don't care if the person will speak nicely to you, or harshly, or how your personalities match. What is important is that the correct diagnosis is made, and you are made well again."

Father unwilling to readily write prescriptions.

Iran has a much stronger support system.

The support system has changed for some Iranians, but "a lot of mental illness (in this population) is mainly because they were somebody (in Iran) and are nobody."

Attitudes towards a physically ill person: very supportive;
Psychological disorders are covered up and treated secretively; don't want to ruin marriage potentials for a girl.

Class based medical system; Upper class regular check-ups; lower class very limited access.

Attitudes toward delirious persons: family members try to take care of it; avoidance on part of others.

Opium was a drug of choice in Iran.

"So the support system in Iran as far as trying to prevent problems is better and even though there is a lot of injustice, but the discipline involved for the youngsters ends up having a more positive effect."

5. Health in the Iranian community in the U.S.:

If immigrants have insurance have check-ups and regular physician visits--other wise, like Iran.

Support system has broken down for a lot of people.

Much more depression in community here. And there is much less societal understanding (compared to Iran).

Less trust as far as money goes; not that much money readily available

(maybe stored away in C.D.s); Financially, bank plays a much more important role in the U.S. Most importantly, it depends on the family.

"Here I think that due to a variety of stress factors and such a lot more drug abuse goes on."

She has heard of families going to cops over child problems; unheard of in Iran.

6. Health in the U.S.

Physicians here frequently do too much of a thorough examination, because perhaps due to their training or fear from law suits. The many referrals make her wonder if physicians know what they are doing.

Mental health is a bigger problem, because 1) you expect more; 2) stress is higher 3) societal problems (lots of broken families, lonelier people, abused people are more conspicuous);

Attitudes toward delirious persons: "nobody does anything;" She has heard from a health worker that failure cases are dumped in Berkeley straight out of Martinez."

(In California) "stress, mental illness, drugs, loss of the family unit." (in Iran some of it may be behind closed doors).

U.S. medical system is not efficient; best technologies, inefficient and inequitable distribution; elderly major concern.

U.S. should look at Europe and learn, e.g. Sweden and child care.

C. Concerns among the population (for immigrants who have been here as long as the subject):

a) 20-30 year old. education

b) 45-65 year old. very difficult; need to start all over again; work, language; loneliness; how to raise children in a foreign culture. "They have to not only adapt to a whole new life style, but to a whole new system of thinking."

D. Recommended Programs for Iranian Groups:

a) 20-30 year old. Support groups, people who can give you information, e.g. universities, programs. Getting to know the right people to help them get good advice, granted there are different types of immigrants. Not for the immigrants who come here for drugs, alcohol, and stuff.

b) 45-65 year old. "How can you tell them to adjust to something they think is wrong." Groups to vent feelings and obtain solutions, e.g. hear from parents who

have been able to raise their children in this environment.

Case 4:

Age: 25-30

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: middle class; never perceived a financial need.

Military family.

Had lived in Europe for a few years in childhood; in general, changed living arrangements several times.

Very close family relations

Not well versed in English

2. Decision making:

Reason: education

Whose decision: mother's (no disagreements)

Feelings/expectations before immigration:

No big deal; forced decision, in a way.

"Didn't really want to leave, because very attached to family and friends." She did want to get an education: stability versus education.

Thought the U.S. to be somewhat like Europe, but didn't think about it much.

3. Relocation:

Difficulty leaving: Very complicated and difficult.

Difficulty entering: 3-4 months in a third country; entered

with temporary visa, but had confidence that relatives in U.S. could help her with immigration status.

On arrival: Stayed alone in a number of different states, initially with sibling close by; only studied at that time. After a year, moved near relatives, asked parents to stop sending money and started to work close to 30-40 hours/week while studying. She was so busy she found very little time to think about sociocultural adjustment.

Problems and concerns:

Financial;

Missed parents;

Not so much cultural, because of financial concerns; does remember lack of respect for teacher as a culture shock

4. Currently:

Self made; responsible; hard worker; has accomplished a lot; tried to finish

a task; "for every year here learned equivalent to three years in Iran." In the social sense our eyes have been opened. Some pressures may be unnecessary (not necessarily good). She has gotten used to things, can't say that is better or worse. Non judgemental. She feels she is more comfortable in expressing herself, perhaps due to age or society. More self-confidence.

"I feel sometimes I am insensitive. And that is because I don't see it, not that I do it on purpose." But a kind person.

Currently has a full time job.

Attitudes/feelings now: Iran is home; she would like to visit parents in that setting, not any place else; she feels bad that there are a lot of Iranians in the U.S. not being given the opportunity to advance the situation. Because she doesn't have any commitments in the U.S., she still feels like a traveller. "I can't settle down." This might change with time and commitments.

5. Future:

She does not considers the distant future; would like to be given the opportunity to try to live in Iran. She wants to experience it on her own.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "absence of physical pain, and mental distress." Mental and physical health related: "If mental stress is not aggravated by a physical condition, it may be forgotten." Ulcer considered mental illness.

Mareez-i-ravani: different than narahati-i-ravani or perhaps a subset. Not defined specifically.

Narahati-i-ravani: "a change in a person's behavior." Might get wrong first impression the first time around but very careful not to diagnose anyone, unless very abnormal, such as being wild and untamable.

Depression: "You feel constricted." lack of interest; compounded with stress you back fire and you say I won't do anything; very sad; crying; don't want to see anyone." Can be due to metabolic activity, such as in adolescence.

Crazy: only physically aggressive abnormal behavior is attributed to craziness. Mentally disturbed harmless people are not defined in such a way. The Berkeley type on Telegraph, not the poor and the misfortunates, know too much.

Addiction: "Addiction means habit.... This could be good or bad. When they say

addiction we immediately think of alcohol and drugs; that it is a bad thing. But its dictionary meaning is habit."

2. Before Relocation:

Medical care:

Facilities available due to father's work;

No regular check-ups; regular visits;

Physicians diagnosed: when we went to a hospital, they would give an injection, a tablet, and the period would be halved.

Major family support for illnesses to the extent of pampering;

Massages were given after exercise by family member; no muscle cramps

Preventive medicine:

Didn't do much, because parents took care of it; did an extensive amount of exercise, recreationally. Diet: parents aware of fat content, but Iranian diet is not as healthy as it should be, because it contains a lot of rice, meat, heavy food. Very careful about sources of infection.

Alternative methods:

Herbal medication used extensively, along with Western medicine. She is fairly familiar with the hot/cold categories and indications for treatment.

Insurance: military insurance and facilities.

3. Currently:

Medical care:

Responsible for own health care; much more careful. Not the same level of use; there have been occasions when I have been sick and I didn't go; self-treatment.

Lack of time plays the major limiting factor in access to health care.

Has the same attitude towards sick people; pampering.

Expectations from physician: to make a diagnosis, and treat; to cut the number of sick days; prophylactic medication, e.g. medication for a cold or at least prescription in case a cold gets worse; not necessarily, does not expect prescriptions.

Family support system exists with relatives living in the area; she feels she can call up her sibling and tell him/her anything. She participates in family decisions, and feels privileged to be asked. She does miss parental support.

Preventive medicine:

Diet: light food, vegetables, fruit juices; also, maintained hot/cold balance

because very sensitive to garmi/sardi; exercises much less, due to lack of time, but very aware of its effect on one's roohieh (mood); does kiss sick people, and washes infected utensils with noninfected ones, but do not share.

Alternative methods:

Used very infrequently perhaps due to limited access; has told physicians about hot/cold categories; they don't relate.

Psychological disorders: she doesn't act differently towards an acquaintance who had a psychological disorder; no labelling

"Here, I feel being away from my family puts a lot of pressure on me. Of course, I try not to show it, not even to myself."

Friends and family would try to get her out of it, but usually she tries not to sadden them as well. She has felt depressed; cries it out; and tries to snap out of it.

insurance: mostly has been insured by non comprehensive plans

4. Health in Iran:

Attitudes toward ill: sympathy; "He/she is sick, don't bother him/her." Or "listen to what he/she says." Pampering.

Attitudes toward mentally ill: very private matter; close family and friends hear the person out; "Ask why?"; psychologist was used as the only solution; no labelling within that group.

Attitude toward harmless "crazy" in neighborhood: personally, friendly; some were afraid, but most played with him. Behaved with him as if he were normal.

Physicians diagnosed, and treated accordingly. "In Iran when I saw a physician I felt that I would be cured."

"In Iran even though every one worked and life was difficult, but assabs (nerves) were much more relaxed. Maybe it is because I was a child then."

5. Health in the Iranian community in the U.S.:

"Lots of Iranians have seen psychologists."

Personally has not used addictive substances; and cannot relate to people who crave for substances. But has been to events where others have used substances, recreationally, and has laughed about it. If a person is close will try to make the person realize his/her condition.

6. Health in the U.S.

Physicians are more careful, maybe to save their own behinds, or maybe they don't think that aggressive behavior is necessary. They give an option of ten ailments. And the prescription that they write for you is at a very basic level.

C. Concerns among the population (for immigrants who have been here as long as the subject):

- a) 20-30 year old. Financial. Culture shock, homesickness, if he or she can afford it.
- b) 45-65 year old. very difficult; as one grows old, one's beliefs solidify; less flexible. language, children, jobs in a foreign culture.

D. Recommended Programs for Iranian Groups:

- a) 20-30 year old. no specific recommendations.
- b) 45-65 year old. Basically, they need a new attitude. With regards to children in a foreign culture parents "have to relax themselves, give them a little bit more freedom, and clarify some of the issues with their children, so their children can make the correct decisions." Language courses, perhaps.

Case 5:

Age: 20-25

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class.

Had been to Europe; parents visited the U.S. and Europe frequently; one sibling educated here.

Very close family relations

Had moved once as far as she could remember

Not adequately versed in English

2. Decision making:

Reason: education.

Whose decision: parents' (no disagreements)

Feelings/expectations before immigration:

Didn't like the idea of coming; I couldn't feel the pressure.

Mother and grandmother had a more difficult time, because they something had been taken away from them; she had never had it. Didn't think it would happen; afterwards, accepted it as a task, which had to be done.

Had images of the U.S. because of family's familiarity;

3. Relocation:

Difficulty leaving: Actual departure uncomplicated; had to be on a waiting list for a year or two.

Difficulty entering: 1 & 1/2 months in third country; indifferent when decision was being made for temp. visa.

On arrival: Stayed alone with sibling and relative for a while, because parents' documentations weren't processed in time.
attended English courses in college; some difficulty with immigration; resolved.

Family has been split off and on;

Problems and concerns

Language;

Education;

Culture shock: relationships were to open; change in dress code (pants, red, pink); make-up and at younger age; relaxed social interactions, e.g. between employer and employee; people watched their health (cholesterol, elderly bicycling); forgetting a birthday is like forgetting the person;

"Evolution:" Difficult to communicate with relatives due to diverging paths. They tried to understand, but could not.

4. Currently:

A go-getter; Since does not have mental disability can get whatever they want with hard work. Learned from this transition to be patient, persevere; hard work can accomplish anything.

Parents still apart at times; coming and going.

Attitudes/feelings now: Has a pure concept to Iran: would like her achievements to be associated with the country, not so with mistakes. Feels very committed to Iran.

Feelings towards U.S. not specifically stated, but mentioned that she would miss the area if she has to leave the area, because she is used to it now.

5. Future:

Waiting to see what happens by the time she finishes her education, i.e. family commitments, etc.? in order to decide on place of residence. Education is the most important aspect of her immediate future.

B. Adjustment to Health Care Practices:**1. Definitions:**

Health: Was not sure: "Absence of pain and complaints, but a lot of people are healthy and still complain. "70 percent physical and 30 percent mental contributions

to general health....A person who is suffering from cancer is suffering from a one hundred percent physical condition."

Mental illness: (mareez-i-ravani or roohi): True mental illness has a chemical basis to it. Simple mental illness is mainly due to lack of love and needing attention, such as the kind the street people in Berkeley have or the heart distress the elder Iranians complain of. The simple kind can be reversed by affection.

Depression: "Depression means that being upset for a long time after a traumatic experience; ...guilt, sadness;" It has to be due to something very important, such as loss of a loved one.

Crazy: it is an insult and should not be used; instead, mentally ill."

Addiction: "It is a habit which we can live without and be happy without, but for the habit you have to spend a lot of money and time to basically ruin your health."

2. Before Relocation:

Medical care:

No true check-ups; visited physicians for complaints;
Access and use of physician care very regular;
Parents' cholesterol level had been checked
Family support for illness; very close;

Preventive medicine:

Very conscious of the infectious causes of disease; received vaccinations. Others should consider that Iran a third world country does not have as much money to spend on preventive medicine and research. Only their family had reduced fat because of a family member's high cholesterol level; did keep in mind the hot/cold etiologies of disease.

Alternative methods:

Herbal medication used "on the side" in household, especially by the elderly. It did not replace any true treatment. Explains mechanism using biomedical model.

3. Currently:

Medical care:

Has few check-ups; feels guilty for not having complaints when calling for an appointment for a check-up. Usually does give up going to school because of an illness

Has had an emergency situation, which was handled very unskillfully by the HMO clerk.

Expectations from physician: caring and compassionate physician; correct

diagnosis and treatment with thorough evaluation; would like to have it explained; would like a possible diagnosis after 30 to 45 minutes.

Has the same support system, personally.

Preventive medicine:

Same as Iran; just recently began to exercise and realize how much she had regressed.

Alternative medication: used very infrequently.

insurance: HMO; and student health.

4. Health in Iran:

A lot of unfounded complaints among elderly, e.g. "my heart aches, or I have cancer." "Most cultures take pride in being healthy,..... sometimes, I think it is for the attention the people say that they are ill."

Attitudes toward an ill person: "close family was much more closely bound, took much better care of ill." Also in Iran people had pity towards a person.

Attitude toward mentally ill: "Forget it."

"In Iran they tried to cover up illness. Here a person comes with his medical wrist band. In Iran people didn't want to say that they were sick; it would lessen from them."

"Mental illness was covered up more (carefully)." Probably the mentally ill were more physically abused, because of lack of control. People are readily labelled in Iran as being crazy.

In Iran the middle class thought (because it is a third world country), that the more meat and fat there is the better. Or the rosier the cheeks the better.

Taste of food was much better in Iran, and lots more fruits and vegetables.

Family members preferred physicians to spend time with them and felt tests indicated how much attention the physician was giving them.

But also, "When you go to a doctor you leave your mareezi (illness) outside."

With respect to prescriptions: "one should write a prescription even if it is chalk."

"Physician in Iran quickly diagnoses the condition and quickly prescribes for

it."

"I don't think there is any herbal medication which would alleviate bone pain. Even I think the uneducated class knows that."

Psychological disorders are covered up and treated secretly; don't want to ruin marriage potentials for a girl.

Attitude toward addictive substances is based on substance.

5. Health in the Iranian community in the U.S.:

"A lot more depression among Iranian families." Or perhaps more conspicuous due to lower base level in the population.

Much more depression in community here. And there is much less societal understanding (compared to Iran).

She is not aware of anyone using addictive substances, but is sure that it exists.

With regards to cigarettes prefer them not to smoke and would drop hints. Otherwise, tries not to meddle around with other people's affair.

Financially, no family or friends available; in her case, her sibling is around if the need arose.

6. Health in the U.S.

People here are more open minded with regards to illness. "For example lets say Mr. or Mrs. X has cancer. Well, if they want to get married they do get married."

Psychological support here exists if they have insurance.

"Physicians here have access to a lot of facilities and they run a lot more tests.....Because suing and testing are so popular here, physicians always have to have proper documentation to support themselves."

C. Concerns among the population (for newly arrived immigrants):

- a) 20-30 year old. FINANCIAL; language. In Pakistan and Turkey people are so low on funds that they have to break vending machines in order to survive.
- b) 45-65 year old. Financial even though it seems that they are better off than the

younger ones. Unfamiliarity with the environment, job market; "diverging evolution."

D. Recommended Programs for Iranian Groups:

Iranian immigrants forget the hardships that new immigrants go through; they can help with simple tasks instead of attending concerts: Helping them settle down, serve as a translator, help with locating key institutions, etc. Increase awareness of problems they face, in the population. Family sponsors. Financial Aid.

"And probably people who have stayed here for ten years forget that they are Iranian. To accept that is belittling to them....but, hey, you were brought up there."

Case 6:

Age: 25-30

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status was good; upper middle class
Very close family relations
Very stable environment
One trip to Europe before immigration
Not very well versed in English

2. Decision making:

Reason: For a sibling's education
Whose decision: parents (no disagreements)
Feelings/expectations before immigration:
Before revolution: ignorant
During revolution: loved Iran; hated the U.S.

3. Relocation:

Difficulty leaving: Uncertainty on possibility of leaving;
Easy departure;
left Iran without saying good-bye;

Difficulty entering: No prolonged stay in a third country;
U.S. temp. visa obtained w/difficulty
Uncertain about plans
Two years after entry family decides to stay

On arrival: Stayed with relatives for about a month;
Most children worked;
Family was split at various times

Problems and concerns:
Financial stress on family;

Uncertain about roles;
Education;
Living arrangement;

4. Currently:

Open-minded; enjoys learning; open to criticism; privileged to have lived through the revolution and relocation, because it has caused growth; emotional person: likes to have family and friends around him; truly attends to the needs of those important to him.

Financially stable. Parents are starting to stabilize; still travel between two countries.

Attitudes/feelings now: Mixed feelings towards Iran, consisting of the same affection plus fear and resentment of not knowing how it is; Does not hate the U.S. anymore, just dislikes the automated system; i.e. lack of time to enjoy life

Problems and concerns: No major problems or stresses;

5. Future:

Uncertain about place of residence; hopes to live in Iran; Not sure because does not know how Iran is going to be plus family responsibilities; i.e. wife's future and children. He would like to enjoy life with friends and family.

B. Adjustment to Health Care Practices:

1. Definitions (developed here):

Health: "Absence of any physical or psychological disorders. You might have a deficiency from birth, but that becomes a normal part of the body." Temporary illnesses are not considered in this definition.

Mental disorder: (narahati-i-ravani): e.g. depression, schizophrenia, etc. Mentally retarded was categorized under physical illness.

Depression: "down, a person who is unable to perform his/her function because from a mental sense, he/she is very constricted (gerefteh), he/she is very sad, very hopeless."

Crazy: "out of this world; needs to be restrained, so he won't be hazardous to others."

Alcoholism: To drink alcohol on a regular schedule and drink it quite often.

2. Before Relocation:

Medical care:

- Had a physician among family or friends;
- Had check-ups with family/friend physician;
- Saw physician as a patient advocate and a friend;
- Access and use of physician care very regular;
- Family support for all illnesses, physical or mental;

Preventive medicine:

Initially the subject did not accept preventive medicine to exist. With further discussion he began to accept a preventive practice which has become part of the Iranian culture, i.e. hot/cold balance, exercise, isolating infectious agents. But also quoted father, "If we are going to die we will. Let us enjoy this life. These are not important, etc."

Alternative methods:

Herbal medication/ (acupuncture, badkesh) used as a supplement by grandmother, and less frequently by mother

Insurance:

Had insurance but did not need to use.

3. Currently:

Medical care:

- Belong to an HMO; insurance plays a much more important role
- Has seen only two to three physicians in the U.S.
- Have not felt a special closeness towards the physicians
- More over the counter medication available.
- Does not expect prescriptions, but would like to have them psychologically.
- Complaints: Much more automated and impersonal.
 - Care dispersed among a number of care givers
 - Less time to take care of family or friends

Preventive medicine:

He sees exercise, the Western nutritious diet as a preventive method.

Alternative methods:

Herbal medications and alternative treatments used by family member for a chronic illness and deemed effective.

He hasn't used any herbal medications here, not because he denies their usefulness, but because they are less available and over the counter medications more available.

4. Health in Iran:

In Iran, the function of hospitals and the medical establishment was more limited, especially in our family, because there was frequently a physician in the family, either close or far away, who you could always call, "My child is this way, I am this way, what should I do?" Secondly problems in Iran were mainly alleviated by herbal medicines and folk healing practices. Problems which went to hospitals were of a much more serious nature."

Cultural expectation to receive prescriptions, medications for lack of trust, because physicians are not visited frequently.

Psychological care was sought in Iran when situations became noticeable, the symptoms were experienced regularly.

No counseling.

An understanding: There was more support in Iran to prevent mental illness, i.e. stronger family unit, and less automated life. Fewer options for treatment because more resistant to diagnose someone as mentally ill. A depressed person did not have a place in Iranian health treatment, not recognized as such.

Also, towards mentally ill people "there was a sympathy. Not the sympathy to go take care of him/her, but the kind which one has for another from a distance."

"The most significant observable difference between U.S. and Iran is that if a person were mentally retarded in Iran, he or she would be isolated from society, whereas here they can be part of the active sector of society."

5. Health in the Iranian community in the U.S.:

More stress on the Iranian community; more families separated.
More women's liberation placing stress on family role expectations. Less of the customary support group, i.e. family, friends.

Financially, bank plays a much more important role in the U.S.; less funds available to family and friends.

Some families are struggling to survive in the U.S. And for others they see some who are living quite comfortably and try to reach that level.

6. Health in the U.S.

more addictive substances available for different economic classes and age groups.

More accepting of mentally disabled people.

C. Concerns among the population (for immigrants who have been here as long as the subject):

- a) 20-30 year old. Time pressure
- b) 45-65 year old. children, place of death, health concerns, financial

D. Recommended Programs for Iranian Groups:

House of Iran: would include, housing facilities for the people who cannot afford housing; various offices, including, for example, foundation of Iranian Newcomers, or Foundation of Iranian Physicians, etc.; library, which could hold Persian classes for children, music classes, and art classes.

Preferable to be affiliated with the Red Cross or UN to be able to pull away Iranian immigrants from destitute and homelessness.

Case 7:

Age: 20-30

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status: middle class; surplus money would be saved for childrens' education.

Siblings in the U.S.

Had not visited the U.S. nor Europe before the various trips. He came three times to the U.S., and returned twice, until he decided to stay in the U.S.

Very close family relations

Lived in only one house, since the age of three

Familiar with English

2. Decision making:

Reason: 1) education; returned partly because level of education did not meet his standards. 2) education, obtained green card with family members; 3) education (universities were shut down in Iran) and political atmosphere
Whose decision: mainly his, but relatives took part as well (no disagreements from relatives)

Feelings/expectations before immigration:

His goal was to obtain good education. Last time his mind had been set for a long term residence outside of the country.

3. Relocation:

Difficulty leaving: First two times without much difficulty. Third time had to register for the armed forces, and if he had failed the student abroad interview, he would have been sent directly to the warfront.

Difficulty entering: A few months in a third country; reapplied for expired greencard.

On arrival: During all visits stayed with relatives. He currently has mixed feelings in that regard: feeling of security and attachment versus strengths which one develops from living independently--at the time a special and positive affinity.

He started to work within a few months after arrival along with studying. After a few years transferred to another university and hated it.

Family arrived around this time.

Problems and concerns

At the time of the transfer very unhappy, but did not know why. He has just recently discovered that there was a duality facing him: obligation and responsibilities to support newly arrived family versus education. After obtaining his degree, he had the opportunity to look back and realize this.

4. Currently:

He is still in the process of self-discovery. Very nonjudgemental; hesitant to label anything; his definitions do not necessarily need to align with society's definitions. A perfectionist; thinks deeply and analyzes in detail; very disturbed by injustice. Likes learning not for the sake of degree.

Homeless: he is not happy with either society. Iran and its memories will always be part of him, but thinks that if he returned to Iran, he would probably recall his memories from the U.S. with fondness. He thinks globally and believes even if Iran's situation should improve he would still not be completely happy, because of misery existing in other places. However, Iran and its memories will always be part of him.

5. Future:

Uncertain about the future.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: Divided into physical and mental. Physical defined based on what he has had or popular health topic, e.g. in Iran a healthy person did not have cancer, here a healthy person does not have AIDS.

Mental illness: (mareez-i-ravani): Very hesitant to label anything as mental illness 1) because of negative connotation 2) because those who are nonconformists, e.g. ahead of times, such as Hedayat (contemporary Persian writer who committed suicide) or behind times, such as mentally retarded, should not be labeled mentally ill. Kholvaazi not ill, perhaps they think too deep. A person who is bothered by symptoms and complaints and needs to be medically treated; just like a medical illness. By-product of society.

Crazy: in Iran meant mentally retarded which was synonymous with mentally ill. Also, could include those who are dangerous to others. More a congenital abnormality.

Addiction: To need to use something after use.

2. Before Relocation:

Medical care:

No check-ups other than for a long term illness;
Access and use of physician care very regular;
Family support for illness;

Preventive medicine:

Dry hair before leaving house to prevent sinusitis and cold. He is very careful to drink clean water; diet: mother made excellent low fat meals; exercise: very active.

Alternative methods:

Some traditional ways which had proven to be useful to family were used, but physician care was of primary importance.

insurance: government insurance

3. Currently:

Medical care:

Family sees physicians less readily due to financial considerations; but necessary care is not neglected. Personally, and more recently due to insurance coverage and chronic illness receives regular physician care.

Preventive medicine:

Similar as Iran; except less exercise, perhaps due to increase in age or less energy.

Alternative medication: used very infrequently.

insurance: initially very patchy; more recently HMO.

4. Health in Iran:

No general comments.

5. Health in the Iranian community in the U.S.:

No general comments.

6. Health in the U.S.:

No general comments.

C. Concerns among the population (for newly arrived immigrants):

- a) 20-30 year old. financial; career choices
- b) 45-65 year old. isolation and alienation; language; more financial than 20-30 year old immigrants, single less capable of working.

D. Recommended Programs for Iranian Groups:

a) 20-30 year old. A committee for the protection of Iranian refugees, or immigrants, or such. Should include, counseling: somewhere between Iran and the U.S.. Ask them: "What do you want to do?" "This is the way it is going to be. Be sure of the country you want to go to;" it should help establish a minimum standard of living, e.g. dormitories.

b) 45-65 year old. social groups; financial (less capable of working).

Case 8:

Age: 20-30

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class.

Personally, he had travelled through Europe and the U.S. once before relocation.

Very close family relations

Fully occupied with studying;

Very well versed in English: private tutor, private and public English courses.

2. Decision making:

Reason: avoid military service;

Whose decision: his own decision (parents agreed)

Feelings/expectations before immigration:

Did not think about it; "First of all before the trip to the States to come and study, you are so excited that you don't think much, or you don't have time to think much. I came here, and started to think."

3. Relocation:

Difficulty leaving: relatively easy.

Difficulty entering: 6 months in third country with friends and relatives, waiting for student visa to U.S.

On arrival: Stayed with relatives for a while, then moved out. Parents were supporting him for the first five to six months, but then he called them up and asked them to stop sending money. Since then he has worked forty to seventy five hours/week as well as studying in different colleges.

Problems and concerns:

Financial, "but you will always have financial concerns, regardless of where you live."

In general, no real problems. "All are part of living here. Living here is a problem, and all these are part of it. But they have never been really a problem.... They have never been the kind of problem which are impossible to deal with."

4. Currently:

"Because I have come this far, I give myself an A+. But was I successful in each of these tasks (education and work)? No, because I have to perform them together. Therefore, a compromise had to have existed. And this was the only way to have a compromise. I was successful in this compromise." He thinks that he has much more potential than what his grades reflect. Also, compared to Iranians in L.A. he perceives the students in Berkeley, to be more intellectually mature, himself included.

He has recently realized that it is "insane" to be under so much pressure; he has made major changes in his schedule for the next semester. "I know what I am doing now is not called living. It is called free labor for the regents of the university."

Attitudes/feelings now: "I would like to visit Iran. I don't have those feelings

to want to live there. Nationalistic feelings? When you are in Iran you know how it is. The first couple of years after you emigrate that issue is very hot, and you carry Iran's torch around with you. Afterwards, my life became such that I did not have time to think about Iran. I think much less about Iran. And when I do think about it, I become happy with the thought of visiting Iran, not living there.... I would really like to go to Iran, to apply what I have learned. But if I can't, I won't."

5. Future:

"Successful. I am not sure in what, but in something. But with regards to what plans I have, I have no idea."

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "A person who participates in a balanced combination of activities in the person's daily life. And the person's body is capable of dealing with such activities. A person who doesn't frequently become ill in the dietary sense eats good food, and the person's activities are proportional to what the person eats,, and has money, has a car, owns a house (jokingly)."

Mental illness (ravani): "There is no boundary among the sane and the insane.... A person who really loves money in my opinion is mentally ill, a person who really enjoys eating all the time in my opinion is mentally ill, a person who wants to close the door and read all day is mentally ill, a person who wants to interview people all day is mentally ill. I am mentally ill." Not equivalent to crazy. "I don't consider a person who has different values than I mentally ill.... I deal with them on a regular basis, therefore I have this image that a person who is mentally ill does not necessarily have to be isolated from society."

Depression: "No interest towards creativity" Personally, instead of dealing with each problem individually, he piles them all on top of one another, sit down, and stares at them. He doesn't do anything. If he does something, it is because he has to do it. "When I was in Iran, because I was not in touch with real issues, this (depression) did not exist for me. Afterwards, when I came here and faced life's real stressors, it created a maturity in me to accept depression as part of one's life, as a natural response to stressors. And perhaps sometimes, it is an escape method, or a treatment method. Namely, it might happen to anyone."

Crazy: "If I cannot deal with a person, that person is crazy. Namely, if I try all methods and still not manage to get along with that person the person is crazy... not be able to get a response."

Addiction: "Extensive use of anything." Defining addiction is different than talking

about the culturally inappropriate substances.

2. Before Relocation:

Medical care:

"Check-ups" did exist, but not very regular;

Good access to physician and medical care;

Parents had regular check-ups (one parent had a chronic illness): aware of blood cholesterol levels, EKG readings, etc.

Family support for illnesses;

Preventive medicine:

Parents took care of his diet; exercised regularly; parents careful about sources of infection.

Alternative methods:

Mother tried to balance traditional methods with modern medicine. "She believes that our culture possesses a lot of methods of healing, which we are not aware of." Both modes of treatment were considered at the time of an illness with more emphasis on modern medicine. Also, the use of each modality was dependent on the type of illness.

3. Currently:

Medical care:

Personal health habits on the decline, e.g. does not check temperature when he has fever (also, see preventive); an illness has to recur and be of grave concern for him to visit a physician.

Lack of time plays a major role in limiting his access to health care.

Expectations from physician: look at his case, individually; explain to him what his condition is about and different treatment options. He does not necessarily expect a prescription, even though he is aware of their use for psychological relief in both cultures.

No family support system.

Preventive medicine:

"The most I possibly do is drink a glass of orange juice every day, or I try to eat vegetables, and I do fool myself, I say I will put lettuce, but put a lot of meat instead, I do try to a certain extent. With all the pressures of the media to eat vegetables, and balance one's diet, I try." He does eat a lot of fruits. No exercise due to time pressure. Not concerned about infectious sources.

Alternative methods:

Aware of hot/cold categories. He eats watermelon when he considers his blood to be dirty, i.e. muscle cramps and manipulates diet to relieve head ache. Herbal medications have only been used when he has craved for them. Chinese medicine sent to grandmother in Iran, and has used acupuncture and chinese medicine here.

He has only had to deal with a cigarette addict. Attitude towards addict: "See someone might want to look at the situation rationally, and my approach is to try to help both the same way. But , at the bottom of my heart, perhaps, perhaps I would do this for both, but my attitude toward the person who uses cigarettes is better than a person who uses opiates."

"I have learned that it is O.K. for a person to become angry. It is not bad to yell and empty oneself."

Psychological disorders: no labelling.

insurance: student insurance

4. Health in Iran:

"My impression of Iranians in general is that no, Iranians are not used to going to physicians."he says." Pampering.

"I think in Iran because of the closeness of the family bonds, when a person did not cooperate with the general goal and harmony, when the person did not stay on the same path, friction was more."

"I think that we, perhaps Iranians and/or perhaps Americans, I don't know, we deal with even a family counselor only out of desperation.... Because in our culture, we have never had anything like this. When there was a problem you would go to your mother, father, grandparent, etc. They were the cultural psychologists."

No diagnosis of mental illness made: "A simple example of a mental problem is a problem between a husband and a wife. This problem is not presented as if they were crazy or mentally ill. It was presented as a problem between a couple, and to solve it the family elders would sit down and talk with them."

5. Health in the Iranian community in the U.S.:

With regards to care received in case of illness: for those living alone: " In Iran, because their fathers, mothers, sisters, brothers were around them perhaps they would have received much better care. Perhaps it is less here."

"Based on my impression on my impression of the Iranians L.A. I think that family problems have significantly increased here."

"I think to the same extent that living here is stressful, tension in Iran has escalated. But there are different ways of coping with them. In Iran addiction has increased, here children have struck the last cord, have become restless, and irresponsible. These are just examples. What I mean to say is that people in Iran and here have different ways of dealing with similar stressors."

"I think that here relationships have become weaker and more flexible. I am not sure if that is being more American. For example in American families a lot of times you see discordance between the members' points of view. The son might say don't bother me, or the father might say don't bother me, and this resolves the problem. This has perhaps affected the relationships between Iranian students and their families, who are living together. I think friction is somewhat less here, because some of these differences are blamed on the foreign culture. When I say blame, I don't mean to imply that it is necessarily something wrong. I am just trying to explain the situation. We have more room to play here, and parents whether they like it or not, may be forced to allow more."

6. Health in the U.S.

Please see health in the Iranian community in the U.S.

C. Concerns among the population (for immigrants who have been here as long as the subject):

- a) 20-30 year old. financial, family problems, cultural incongruence.
- b) 45-65 year old. Not sure, because of lack of contact. Children.

D. Recommended Programs for Iranian Groups:

"Nothing. I think one generation has to pass. You cannot have a compromise between these two generations. Why should it be corrected? This is a transition. A transition does not need to be corrected."

"I think culturally we are very self-righteous. The more self-righteous we are, the bigger egos we have, the more difficult it is to touch those egos. If you want to create a program, it would be much easier to talk to a group of Americans. They do not have any hang ups as we seem to have. Some of them are meaningless, some are very good. I just find it very difficult. Perhaps because I haven't studied the subject."

Case 9:**Age:** 20-30**Sex:** Male**A: Adjustment to culture:****1. Before relocation:**

Economic status was good; upper middle class.

Familiar with English; however had to take English course in third country.

Very stable environment;

Had not lived in the U.S. before emigration;

Very close family relations

2. Decision making:

Reason: Long term decision: green card had been approved 15 years before emigration, but had not been picked up; felt rushed to get to an American embassy and reactivate file. Also, he was reaching the draftable age.

Whose decision: parents' (no disagreements)

Feelings/expectations before immigration:

Since childhood had a gut feeling that he would like to live abroad, especially in the U.S. Also, the environment in Iran was disturbing to him.

3. Relocation:

Difficulty leaving: very difficult;

Difficulty entering: stayed six to eight months in a fourth country.

On arrival: Stayed with relatives; he immediately enrolled in difficult courses. Took two years to get used to the culture here. No financial responsibility on him.

Problems and concerns

Language;

Education;

Culture issues: drugs and sexual freedom;

4. Currently:

"I don't like to do anything wrong based on my own standards. It really upsets me, even at a very minor level. I try to be conservative.... I have learned about a new culture (due to this relocation)."

All family is here.

Attitudes/feelings now: "I am very content with my life, but it is much less glorified than before, Much worse social environment than I knew about." Misses Iran.

5. Future:

"I don't think that I would want to live in Iran ... perhaps if the situation should change, I would very much like to return to Iran. Future expectations: would like to reach his career goal and to live comfortably.

B. Adjustment to Health Care Practices:

1. Definitions:

Most health issues are not absolute; difficult to come up with definitions.

Health: In Iran: it was a family issue.

In U.S.:

Definition of ill: change in health status or normal conditions, his or her way of thinking, awareness. Something that would hinder daily activity or habit, a long term effect,

Mental illness: (mareez-i-ravani): The person is not able to tell that he or she has it: equivalent to crazy.

Narahati-i-roohi: depends on personal standard and society; it is one category of the mental (fekri) illnesses. Emotional/feeling conditions: sadness and depression come to mind. Narahati-i-roohi can progress to an illness, but not usually.

Depression: Not necessarily an illness; "a person whose problems take over all other thoughts. Namely, that the person is disinterested in anything else, and nothing can make that person happy."

Crazy: "A person whose behavior is very abnormal; if it is very obvious that a person cannot think well, speak well, or function in a daily routine, perhaps that person can be considered crazy.... but I don't have any standard of comparison." Not necessarily harmful.

Addiction: Dependent on substances in order to continue life without becoming truly disturbed. "I feel more compassionate toward a heroin user compared to a cigarette smoker, because I think that cigarettes are easier to quit."

2. Before Relocation:

Medical care:

Family members were physicians;

Father worked in the health field;

Easy access to physician care (only for illnesses).

Preventive medicine:

Basically did not participate in this decision much, because he was a child.

But in general, detested cigarette smoking.

Alternative methods:

Very rarely; remembers his father using gholgavzaboon. Nabat was also used.

3. Currently:

In general believes in prevention more than cure.

Medical care:

No check-ups; parents receive regular check-ups.
family support.

No change in
Usually does give up going to school

because of an illness

Has had an emergency situation, which was handled very unskillfully by the HMO clerk.

Expectations from physician: more than coming up with a treatment plan, to provide kindness and affection, especially because most of the time he has dealt with family members; closeness does not exist between physicians and patients. Prescriptions are not necessary, because he trusts his physicians.

Has the same support system, personally.

Preventive medicine:

"Iranian diet is not healthy in general. Perhaps in the States, because they use less oil, it is healthy. But not with regards to meat. An Iranian dish is not considered a dish without meat." Diet: tries to have a low cholesterol, low fat, high fiber diet as much as possible, but parents do not take this seriously since they were raised in Iran; also tries to prevent illnesses by balancing hot/cold categories; exercise; very much against cigarette smoking (with the help of sister persuaded mother to quit)

Alternative medication: Herbal medication use is nonexistent, perhaps because it isn't as available. Some hot/cold categories seem to hold true (from experience) such as excess of cold food such as cucumbers, melons, etc. could cause nausea.

insurance: HMO; and student health.

4. Health in Iran:

"In general, in the Iranian culture the parents are more concerned and the narahati (disturbance) due to the child's illness is shown much more than it is among Americans."

"In Iran in the old days it was very odd for a person to have spoken with a

psychiatrist ... People may have thought more about craziness or something like that."

5. Health in the Iranian community in the U.S.:

"Psychiatrists would be considered for depression ... more acceptable in this population."

"Iranian pride: they are unwilling to work in just any field"

"The automated life that everyone talks about: work, work, work and try to make money. The maanavi (spiritual) component of life has decreased."

6. Health in the U.S.

He thinks that there is more awareness with regards to mental problems. In the American culture it (psychiatric care) is a resource for people. No one gets the labels that are given in Iran.

"It seems that patient care is taken very casually, especially among physicians of HMO's. Even if there isn't a serious problem, it still seems that the physician is just doing a routine and avoiding really figuring out the cause."

"In the States a physician uses more tests to come up with a diagnosis. I don't know if it is because of malpractice or because they don't want to miss out any important findings."

C. Concerns among the population (for newly arrived immigrants):

a) 20-30 year old. EDUCATION should be emphasized; a lot of people are working instead. Cultural (sexual relations and drugs)

b) 45-65 year old. Much more serious than group a, because personalities and lives have been formed to a much greater extent. "I see my own parents still have not developed a fondness for this country. And life is only a day to day task; financial.

D. Recommended Programs for Iranian Groups:

Case 10:

Age: 20-30

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class.

Had lived in the U.S. for an appreciable period of time.

Attended international schools until revolution;

Fluent in English;

2. Decision making:

Reason: Long term decision: Mainly a cultural reason; he had some difficulty accepting preset ways of thinking; tried to adjust but could not.

Whose decision: his own (no disagreements from parents)

Feelings/expectations before immigration:

He was familiar with the States. And he had tried very hard to feel comfortable in his own country, but he could not.

3. Relocation:

Difficulty leaving: Not difficult; difficulty was more related to entering the States;

Difficulty entering: Difficult and prolonged; several attempts for visa.

On arrival: He lived in a different State and began to see similarities between Iran and there. Supported himself through work and scholarships. Obtained B.S. and moved to Bay Area

Problems and Concerns:
Loneliness;

4. Currently:

"Most of the personality that I have today was formed by this relocation. I saw the other side of the coin. Had the opportunity to look back. He perceives himself as open-minded and easy going. I try not to take things seriously." He is very sensitive to closed minds.

Attitudes/feelings now: He rediscovered the States ; in childhood he had been taught that the States was founded on principles of equality and freedom; the Iranian revolution was based on the same principles. People were very close minded in the first place of residence (in the U.S.). Having been given the opportunity to look back he rediscovered what being Iranian for him meant: a lot of nationalistic dogma was questioned as well as positive aspects rediscovered. He is now comfortable with the idea of being Iranian.

5. Future:

"I would have liked to have been able to use my skills and abilities for the people who really need it, namely Iran." Not sensible to return to Iran, because the reasons for his move still exist. Future expectations: finish school, obtain job, and do recreational activity on the side.

B. Adjustment to Health Care Practices:**1. Definitions:**

Health: There are different levels of health: perfect health is for all organ systems to function properly, like a jetfighter's. At a different level and more practical one: "Physical health: person should be able to eat food without any constraints, sleep well,... absence of any specific illness such as diabetes, heart disease.

Mental health: absence of mental pressure, to be able to sleep comfortably at night, not suffer from stress related headaches, have no bodily tremors, speak slowly." Mental stress can affect physical health.

Mental illness: (mareez-i-ravani): crazy; chained; enters the psychology of the person.

Narahati-i-roohi: pertaining to the roohieh (mood); it can become serious and affect physical health.

Depression: due to being upset about one or more issues; constantly troubles the person, and does not allow the person to function at a basic level. In addition, no sense of humor, not warm with friends, physically weak.

Crazy: ravani; in chains.

Addiction: A feeling of needing some substance regularly.

2. Before Relocation:

Medical care:

Yearly visits for illnesses;

Main constraint was to find a good physician, because they had all left.

Preventive medicine:

Similar to current.

Alternative methods:

Familiar with hot/cold food categories; some knowledge of symptoms associated with hotness/coldness. Nabat was the only form of herbal medication used.

Insurance: They did have insurance, but many physicians would not accept them. That did not play a role in their health care seeking behavior.

3. Currently:

Medical care:

Yearly visits for illnesses.

Expectations from physician: to diagnose the condition; if cannot show a path which would end with a diagnosis. In addition, be friendly, soothing; time and prescriptions are not much of a factor. "No as a matter of fact, if a

physician should write needless prescriptions it would decrease from the physician's credibility."

Preventive medicine:

Diet: balanced meal, fresh food; makes up for lost sleep; Avoids placing himself under mental stress; exercise.

Alternative medication: His perspective on traditional ways and hot/cold categories is that they may contain some truth. They have been used for many years now, and many years from now modern medicine might be looked upon as herbal medication is today.

insurance: student health.

4. Health in Iran:

He is quick to point out that he has been exposed to only a limited U.S. and Iran.

"Culturally, it is customary to attend to the ill, not only family members but neighbors as well and be referred to physicians.... most things are spread by word of mouth."

"It is very difficult for an average Iranian to find a good physician and to be able to afford it."

"I think that when I was there that resistance (in seeing a psychiatrist) did not exist anymore." Perhaps, now one does not have to accept personal flaw, but societal flaw. They say: "Here is another person who has been under a lot of pressure, like me."

"Life in Iran is much more difficult than life here." Much more stress; relieved partially by constantly talking about them.

At the time of his departure, "every illness was considered to be an assabi (nervous) condition. People say physicians have it easy now, and do not need to diagnose anymore."

5. Health in the Iranian community in the U.S.:

Within the Iranian families he is acquainted with the same support system exists.

6. Health in the U.S.

"The society here is more individualistic; they don't tend to each other's needs

as much as they did in Iran."

C. Concerns among the population:

a) 20-30 year old. financial; loneliness; faced with family members who have not experienced the same ideas and cannot understand why they want to stay in the States.

b) 45-65 year old. much more serious; familiar with another life style (good or bad). They repel this culture, as opposed to the young generation which absorbs it.

D. Recommended Programs for Iranian Groups:

a) 20-30 year old. support systems and cultural programs. He does not think psychotherapy can work, because psychiatrists cannot understand what the person's experience has been.

b) 45-65 year old. Perhaps, cultural activities.

Case 11:

Age: 45-65

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class.

Familiar with relocation from a very early age;

He had visited the U.S. four or five times before relocation;

A few close relatives in the U.S.

Very close family relations

Knew practically no English;

2. Decision making:

Reason: education.

Whose decision: his own decision

Feelings/expectations before immigration:

He came with the expectation to study; During previous visits even though the option had existed of buying a house, he had not considered it; he felt Iran to be his home. Since he did not have a family to support, he thought that he could further his education during the revolutionary chaos.

3. Relocation:

Difficulty leaving: relatively easy.

Difficulty entering: relatively easy.

On arrival: Stayed with relatives and attended classes. This situation changed shortly thereafter, after the hostage taking and the

subsequent termination of financial support from parents. Under financial pressure began to work at relative's business 15 hours/day. His work was mainly in the labor sector, which he could not have imagined doing back in Iran.

Problems and concerns:

Financial;
Language;

4. Currently:

"Not a bad person; I haven't bothered anyone and I have tried as much as possible to help others. He has learned to become independent from this relocation. He has had to do everything on his own. Feels more productive. Content: "Praise the Lord, I almost have everything that I need for living."

Attitudes/feelings now:

U.S.: "You need to work very hard, but it is an environment in which one could easily live, without any harassment." Almost feels like home: know the streets, lots of Iranian friends and family.

Iran: It will always be home. More constraints in all respects."

5. Future:

Very confused. He thinks he would like to work as much as possible here, retire, and then return to Iran and work on the land. He wouldn't mind living here either.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "A person who doesn't have any narahatis (complaints) and possesses a healthy physical strength. And not have a long term illness." Temporary illnesses do not affect general health. "Having a healthy body is healthy." Health is divided into physical (jesmi) and roohi (mental), which though separate are related.

Mental illness (ravani): Could be due to pressures of life. Symptoms disturbed sensorium, lost volition, or does things that disturbs others. Its severe form is craziness. This form of mental illness requires psychiatric care and/or medical treatment. One explanatory model was related to the person's strength in dealing with problems of life. A person with a ravani problem has not been able to cope with these problems.

Narahati-i-roohi: Usually not a true mental illness. It is caused by the pressures of

life, and can be reversed by changing the environment or in general, the etiology. It does not require psychiatric care nor medications. Depression is a subcategory. If it is prolonged for six months (citing a physician) then it can be considered an illness (the mode of treatment was not discussed).

Depression: a roohi condition: Feeling constricted and low. Can be reversed with reversing the etiology.

Crazy: "A person who does not have control over the person's actions; unable to deal with life's pressures."

Addiction: "development of symptoms and craving for the substance with abstinence." In general, he does not have any close relationships with addicted people. Cigarette smoking and coffee and tea do not carry this stigma with them.

2. Before Relocation:

Medical care:

Excellent support system, both social and insurance wise.

Good access to physician and medical care;

Regular check-ups because of predisposing conditions of illness. etc.

Preventive medicine:

Similar to current.

Alternative methods:

Alternative methods were the main method of health care in childhood; gradually shifted to Western medicine. Please see current.

3. Currently:

Medical care:

He lives alone. Even though friends and family are around due to lack of time for everyone, he needs to attend to his own needs. Both because of financial concerns and limited time more self treatment than Iran; more use of over-the-counter medications. Definitely, would seek physician care if it is deemed necessary.

Expectations from physician: Correct diagnosis based on whatever is at their disposal (including various lab tests); In general would only go to physicians that he knows and trusts. Even though quick diagnosis is preferred, it is not necessary. Prescriptions are not necessary, either.

Preventive medicine:

Diet: not eating too much or too much sweets; also protects his body from variations in temperature. Regular check-ups because of predisposing

condition. He believes to a certain extent in hot/cold mechanisms of disease and tries to avoid unhealthy dietary practices. His belief is based on his own experience.

Alternative methods:

In general believes in traditional medicine; has seen them work. However, he has not used them because they have not been as available.

insurance: does have a coverage with a one thousand dollar deductible.

4. Health in Iran:

"Strong support system for physically ill and mental conditions up through mild ravani illnesses."

"In Iran there was more time for family and friends."

"If you were alone, for example, you would call your neighbor and say, 'I am afraid to sleep alone.' Tens of people would come and stay with you."

Remembers in the dahat (villages) a patient becoming upset because of lack of prescription.

Remembers opium being used for chronic pain. He draws a parallel with codeine use here as a pain killer.

Gender differences exist with regards to sexual relationships: more socially unacceptable for women.

Money was not that readily available from banks. Borrowed from friends and family.

Family levels were resolved at the family level."

5. Health in the Iranian community in the U.S.:

The children who have been raised here tend to "not care." Children who came when older still know about family responsibility and obligations.

Cultures are very different, but it doesn't bother him.

He uses banks here for loans because it is very easy to borrow from banks in the U.S.

Here it is much more customary to take family problems to the legal system.

Iranians who make it to the U.S. are very strong willed and motivated.

6. Health in the U.S.

"In the States, people are totally occupied with their own lives."

C. Concerns among the population (recent immigrants):

Much better now than when he came.

a) 20-30 year old. less complex than elder problems. They want to start with nothing and build themselves. Problems they may face are related to their inexperience, i.e. drugs, sexual relations.

b) 45-65 year old. Finding a job; living on a minimum wage job (loss of job status); in general, not many problems, of course those with a family have a much more difficult time.

D. Recommended Programs for Iranian Groups:

a) 20-30 year old. set up classes, which they should attend upon arrival, familiarizing them with the problems they will be facing, i.e. drugs, sexual relations. In Turkey and Pakistan a lot of young girls have to sell themselves, and young boys need to sell drugs in order to support themselves financially.

b) 45-65 year old. He is contents with existing programs.

Case 12:

Age: 45-65

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status: upper class.

Studied in the U.S.;

Children attended international school;

Work required extensive travelling and living abroad on several occasions;

Very familiar with English;

2. Decision making:

Reason: children's education (children were more comfortable with English)

Whose decision: family's

Feelings/expectations before immigration:

He looked at it as a temporary stay, during which time the revolution occurred and they were advised from within the country not to return.

3. Relocation:

Difficulty leaving: relatively easy.

Difficulty entering: relatively easy (at that time green cards were very easily granted to Iranians)

On arrival: They tried to adapt; started a business, which failed. They were on the way back when they heard about the revolution. He lost everything because of the revolution based on a misconception. Subsequent businesses also failed due to inadequate knowledge of existing rules and regulations. Soon afterward, he was diagnosed with a chronic illness, and stopped working. His wife soon began to work, both to occupy her time and be of financial help.

Problems and concerns:

Financial;
Homesickness;
Unfamiliarity with rules and regulations;

4. Currently:

He has always been a social person and enjoys social interactions. He makes every day life enjoyable for himself; content person. Also, his descriptions and definitions were mostly given from a historical perspective.

Attitudes/feelings now:

U.S.: "Of course, university years are very different than the period of money making... the line of work was unfamiliar." He is very impressed by some aspects of American culture, e.g. medical system, and the respect they show one another.

Iran: home country. "We saw its low points and also its high points. We were raised there, we worked in that country, we had a comfortable life in that country. Forgetting that is impossible. Iran for us is everything."

5. Future:

Expects to live in the U.S. because of medical condition, but doesn't mind having the opportunity to travel back and forth. In general, he does not have any goals for the future: their children are well-established. However, he did emphasize that his enjoyment of life has not decreased in the least bit. He plans to enjoy every moment of life with friends and family.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: One of the major blessings of God; one should value it. "to the level that one can think well, walk well, eat well, see well, no diminished eye sight, to look at nature, concentrate mentally.... If the rooh is unhealthy the physical aspect of a person cannot be healthy.

In Iran he didn't think about health, because he was "young, strong, and full of life."

Narahati-i-roohi: Not being able to think well. Everyone is crazy in their own way, i.e. troubled mentally.

Depression: major causes: gorbat (being away from home country), from children, parents, family, friends.

Crazy: "As described to us a person who does not have a natural temperament, does abnormal things, does mischievous deeds, perhaps maybe harmful to others. Those who do need chains are those who are harmful to others, otherwise any person in any shape or form has created some kind of torment for oneself."

Addiction: Not specifically defined, cigarettes, coffee, heroin were used as examples. The reasons for addiction are not valid at all. And it is the most dangerous factor which threatens the new generation of 2000.

2. Before Relocation:

Medical care:

Had a few check-ups because of employer's persistence. His chronic condition was not diagnosed in Iran.

Saw physicians for illness.

Overall, disillusioned with the medical system in Iran. In general, physicians were God like entities.

Preventive medicine:

More recently cleanliness could be found in houses. Because of fear from infectious diseases, hands were washed meticulously and all fruits and vegetables would be disinfected. No dietary precautions, because he was young. He also exercise a lot, both recreationally and to maintain his health.

Alternative methods:

Somewhat careful of hot/cold categories. In childhood, alternative ways were used as principal treatment modalities. However, before emigration did not believe in herbal medications; it is an outdated modality.

3. Currently:

Medical care:

He is very pleased both with the level of medical technology which exists in the U.S. and the patient-physician, nurse relationship: they are truly and genuinely concerned. His physician would allow him to empty his heart out.

Expectations from physician: not be God-like; not only knowledge but kindness and compassion.

Preventive medicine:

Follows a strict diet; has cut down on fatty foods, etc. Much less exercise because of pressures of life and chronic illness.

Alternative methods:

Does not accept them.

insurance: good coverage.

4. Health in Iran:

"In Iran physicians were so harsh. Even though I had very good friends among the surgeons and physicians, but normal physicians because of their vanity, conceit, arrogance, thought themselves to be God."

"Those physicians would write a prescription based on touching the chest wall or listening to it with a stethoscope. And they would quickly get rid of a patient."

"Because in general, Iranians are a very emotional and sensitive group, one cannot deny that an ill person would be visited."

5. Health in the Iranian community in the U.S.:

"(Iranians) have not lost the feelings that are in the Iranian nature: very emotional.

"More check-ups here because the financial pressures which develop here torture them mentally (roohan), and make them ill, and subject to high cholesterol levels, blood pressure, which are constantly talked about on TV, radio, etc. This forces them to see a physician every year, six months, or three months. This is among my own friends."

"Most of the Iranians who came here, and I am one of those, perhaps we came here to find heaven. Perhaps, in some ways it is heavenly, incomparable to anything else anywhere else in the world, but we were defeated in one way. And that is the line of work we have chosen for ourselves."

"There have been a lot of successful people, who have been able to overcome these odds... Even if we were defeated in business, we were able to away from home fend for ourselves."

"The closeness which existed in Iran, does not exist here:" lack of trust.

6. Health in the U.S.

"The system that exists in the States was absent in Iran. In response to "Doctor, my heart aches" immediately you are taken to have an EKG, different image studies, blood tests, etc. done."

Americans are much more respectful and caring towards other things, as is manifested by their behavior towards pets and the handicapped or elderly.

There are good and bad in all societies.

C. Concerns among the population (recent immigrants):

a) 20-30 year old. lack of experience; language.

b) 45-65 year old. English; laws & regulations.

D. Recommended Programs for Iranian Groups:

Could include a library, which contains laws and regulations, or counselors who could counsel people on these regulations.

Case 13:

Age: 45-65

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class (major improvement since childhood)
Had moved extensively before settling down in one place about twenty years ago.

U.S. educated.

Knew English;

2. Decision making:

Reason: they were asked to leave; "I wasn't that happy to leave."

Whose decision: government's.

Feelings/expectations before immigration:

Very few expectations. "I knew the environment and I knew to a certain

degree the nature of my work. In general, this area was my second home.

3. Relocation:

Difficulty leaving: relatively easy.

Difficulty entering: relatively easy.

On arrival: Began to work shortly after arrival and has continued to do so until currently (18 hours/day). "The environment in the U.S. is one of work;... if you want to work to support your wife and family, and to have your children be around you, you probably have to work 18 hours."

He had to start all over again; most likely his problems were fewer than most other Iranians.

Problems and concerns:

Lack of job security;
Obligation to serve country, because his knowledge and expertise is required more in Iran than the U.S.

4. Currently:

"I don't know how I am with respect to others, but I try every day to alleviate my flaws. Everyone has flaws. I have lots of problems, but in that I try to resolve them, I am content."

Attitudes/feelings now:

U.S.: He accepted the relocation when he first came. U.S. is second home. "But life in Iran, in my opinion, was a lot better than life is here, but I don't have too many complaints." After second visit he has developed a new perspective about the U.S.: before he was "shortsighted and thought that everything in the U.S. was correct and whatever problem existed was because of Iran and the cultural backwardness. Now, he sees the same problems existing here such as bribing politicians, stealing library books, red tape.

He is not concerned about children growing up in the U.S. environment, because family environment is the most important factor in the children's education.

5. Future:

"Create a comfortable life for my family. And have a job through which I can help others. And most importantly, be healthy until I die." He will most likely stay in the States.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "Until a person has not developed a serious or chronic illness the person is healthy, unless some short lived illnesses, such as flu or headaches occur, and those are not that important." Diseases which can stay for a long time need to be seen by physicians, and those can also be minor problems; Serious problems are life threatening conditions such as cancer.

Mental illness (ravani): physiologic etiology. Mainly assabi (neurologic in this context) problems; miscommunication in the nervous system. Symptoms: behavioral; or do things that they know others consider wrong.

Depression: not a mental illness; due to stresses; he has experienced them several times during his or her life time. There is a reason for it. He does not understand the type which require psychotherapy.

Crazy: "Sever case of mental illness; harmful to others; kept in asylum."

Addiction: "When one is unconsciously drawn toward something and does not have much control over it. Loss of personal control.... Power to abstain depends on person will power." He does not interact with nor has respect for drug addicts (heroin, opium). Those who became addicted to nicotine and caffeine before they knew they were addictive substances are in a bind, and are having a difficult time kicking the habit. He does not have much respect towards those who become addicted to such substances in this day and age.

2. Before Relocation:

Medical care:

No check-ups; children received regular check-ups.

Physicians among friends and colleagues.

Regular access to physician and medical care;

Preventive medicine:

Balance: lived a moderate life: moderate amount of food and balanced food content (from all major food groups); also his body automatically cannot accept too much from a food group; avoided the known factors which are thought to cause disease, for example, he did not smoke, nor drink alcohol, didn't drink too much coffee; exercised much more because of the situation.

Alternative methods:

"Alternative methods were the main method of health care in childhood; gradually shifted to Western medicine. Very limited use: badyoon (phenyl)

for bloating. Hot/cold food groups probably automatically balance because of balance in food groups.

3. Currently:

Medical care:

Much less access to physician care; mainly nurse practitioners.

Yearly check-ups due to increased age and job requirement.

Family members receive regular dental and medical check-ups. He does not have time for dental check-ups; visits very infrequently. Avoids medications as much as possible. From pharmaceutical book: "All medications are more or less poison."

Expectations from physician: Search for an illness, discover it, and then treat it.

Preventive medicine:

Please see "before relocation." He believes in exercise, just doesn't have time: "A healthy intellect resides in a healthy body."

Alternative methods:

Please see "before relocation."

He is involved with family problems involving close relatives who live in the area.

insurance: HMO coverage.

4. Health in Iran:

"Herbal and traditional medicine (were used) to resolve the situation. And when it developed into a more serious condition, which they could not take care of, then they would seek a physician."

Attitude towards illness: Very concerned.

Attitude toward mentally ill: Severe forms were put in an institution and they were not treated well. Nazdeekan (close family and friends) tried as much as possible to take care of mild forms in home.

Stigma exists for obtaining psychiatric help, be it here or in Iran. "I think if a person goes and sees a psychiatrist the person would try to keep one's file confidential because it may create some career problems, or other problems."

"Opium was used as a painkiller in the elderly population."

5. Health in the Iranian community in the U.S.:

Attitude toward ill: still very concerned, but because of lack of time, the chance of expressing those concerns are relatively less.

The Iranians who are here belong to two categories: 1) hard working people, who do not have time to be depressed 2) jobless, have time to be homesick, etc.

In general, avoids borrowing money. Prefers to borrow from friends so they could get the interest. If not possible from banks.

6. Health in the U.S.

"The financial aspects of medical care like other sectors of this society is weighted more heavily than the maanavi (spiritual) aspects." Physicians are the same way. "Because they have to give a lot of taxes, and insurance, they are more concerned with money and try to optimize their time. Secondly, they cannot use their personal judgement a lot, because of the danger of law suits.... Physicians no longer use their personal judgements, which may be difficult to develop in a computer."

"Telegraph residents are financially stressed; they have caused these for themselves via drugs... One form of mental illness happens naturally and then there is one form which they have caused by using drugs."

C. Concerns among the population (immigrants who have been here as long as he has):

Much better now than when he came.

a) 20-30 year old. very few. It is like transplanting a young tree; would not cause too many problems.

b) 45-65 year old. a) social problems: Iranians are well-established in this regard; b) professional type.

D. Recommended Programs for Iranian Groups:

a) 45-65 year old. Iranian professionals should organize.

He does not insist for his children to remain true to Iranian culture. That culture is good only for those people who want to return. It seems artificial to try to force his children to like and appreciate Iranian culture, when they did not have an opportunity to appreciate them in Iran, i.e. the roots of liking Iranian culture needs

to have been sown in one from Iran. Instead they should develop a "universal perspective."

Case 14:

Age: 45-65

Sex: Male

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class;

Educated abroad;

Has changed place of residence extensively in the past; though, last place in Iran was thought to be the final one.

Very well versed in English

2. Decision making:

Reason: Increased activity of opposition groups under the revolutionary banner; because of Western ideologies was left in the defensive during the revolution; difficult job environment in Iran with a simultaneous offer from the U.S.

Whose decision: His and wife's collectively.

Feelings/expectations before immigration:

The move was considered temporary. Expected the funds brought to support family for a prolonged period of time; (in reality adequate only for a few months).

Was familiar with the U.S.

3. Relocation:

Difficulty leaving: Relatively easy

Difficulty entering: Relatively easy

On arrival:

Stayed with an old friend for a month and a half.

Children's education was continued without any disturbance.

Worked at different academic jobs until finally decided on a job in the private sector; due to financial concerns.

Problems and concerns:

Financial concerns;

Education of the children;

Uncertainty of the situation;

Homesickness;

4. Currently:

Personal perspective:

He "belongs to a small percentage of the educated of the country, education in the classic sense of the word, and afterwards I remained in my field, in contrast to many who studied just for the degree and then pursued their own goals and objectives." Respectful of Iranian culture, but wished to improve some of the shortcomings of Iran by using some of the Western technology." He has a strong sense of national history, culture, and class dependent attitudes and practices. Learned from this experience:

Personally : "I think that if history repeats itself I would become more farsighted. Like many of my countrymen, until the last day we did not allow for the possibility of this change occurring."

As a nation:

".... Possibly if the level of general education increases and if they are taught their past history, perhaps eventually it will finally enter the Iranian race, that emotions cannot be the only factor in accepting a system or in decision making and one must to a certain degree think of what will happen down the road."

Financially stable now.

Attitudes/feelings now: "The Iran that now exists is completely foreign to us. Our absence of ten years and the media and visitors foretell that if we make a short trip to that country, we might go into complete shock." However," the familiarity with the culture (by virtue of his upbringing) makes me aware of the psychological perplexities and behavior, if the need for my help should arise."

5. Future:

Few more years left before retirement; He does not want to give up Iranian nationality based on financial concerns (the majority of jobs in his field are for U.S. citizens); has not entered the system completely, in hope of the time when the situation becomes more stable when he will be given the opportunity to fulfill obligations to relatives and to his country, either by living there or by travelling to Iran unimpeded.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "The classical definition, to have a balance with the environment and other such definitions. Absence of psychological and somatic diseases." But believes the human body has the capacity to withstand many variations in diet, influenced by genetic, environmental factors, and stress.

Mental illness: (mareez-i-ravani): In Iran was limited to junoon (schizophrenia); now

accepts various degrees of mental illness, not necessarily harmful to others as was believed before.

Crazy: In childhood synonymous with mental illness; not defined specifically."

Addiction: not defined specifically; aware of culturally dependent attitudes towards different substances and use patterns based on national history.

2. Before Relocation:

Medical care:

Physicians among colleagues and friends;
No "check-up" perhaps due to age;
Access and use of physician care very regular;
Family support for illnesses;

Preventive medicine:

Diet: eat food whose preparation history was known: balance was very important: bread, meat, vegetables, fruit, etc; and staying away from sources of infectious diseases. Job related exercise.

Alternative methods:

Herbal medication and alternative modes of therapy used extensively in childhood; Very much aware of different categories. Aware of hot/cold categories and herbal medication, but very infrequently used in adult life.

insurance: government insurance.

3. Currently:

Medical care:

Received regular check-ups the first years after emigration, and one recently at HMO. His wife also gets limited check-ups every couple of years.

Expectations from physician: listen to complaints and ask pertinent question; preferred the physician with his own knowledge to make the diagnosis and decide; no prescriptions necessary.

Being raised with the social stigma against mental illness, he would have a difficult time seeking out a counselor.

Preventive medicine:

Similar to before relocation, except more careful of meat and fat content and makes an effort to exercise three to four days a week.

Alternative methods:

Used very infrequently and on the side.

insurance: has been insured regularly since arrival: employee's insurance and later HMO.

4. **Health in Iran:**

In childhood and traditional Iran:

"Coldness' or 'hotness' were not pertinent to acute problems, but for a chronic ailments such as weakness, or pain, not fever. But for fever, and such aspirin and antipyretics or herbal medicine was given."

Referring to traditional methods: "Many of these paractitioners were specialists, and those persons who corrected the fungal growth, or set bones, had their unique specialties. There were a few old women,..., who were considered to be general practitioners, had a large clientele which came to her from distant villages."

"In my early childhood it (opium) was not a vice, because I remember my own three uncles being addicted to opium but perhaps a decade or two later this stigma developed."

"My impression is that in our social setup, depending onthe severity of the ailment, there was a short period of denial, and the person tried to get along with it or listen to advice. After finishing this period, they looked around for a person who was recommended by others and finally he/she ended up with a physician."

"Sometimes people prescribed a puff of opium to relieve earache or bone pains, which eventually could cause addiction."

"Children hid in their houses to avoid vaccination. Because inour family and other families whenever they wanted to frighten children they would say that we will have someone come give you the small pox vaccination."

"Before the revolution, it had not changed that a typical Iranian who went to a physician expected a pill, a syrup, an injection, and food order." If any of these were missing physician's credibility would be reduced. " Also, quick diagnosis and treatment were expected. "If you take a pot that has a hole in it to a messghar (copper worker) he quickly fills the hole."

Treatment for depression: "diet was one suggestion, but in general they did not perceive it as significant. Every one gave some advice, such as go to a pilgrimage, or go to the mountains more often, but it was a personal

problem."

Modern Iran:

"Dietary prescriptions had taken the back seat."

"Programs were available in hospitals, but it was for the lower class, because it was so degrading; a few wards of a hospital were set aside for this problem. Those who had the economic means could keep a lid on it, and they could also buy their supply."

"Psychiatry is a new field in Iran."

Iran in general:

"The general practitioners have limited knowledge and it is mass production for them and frequently they have written their prescriptions in advance for three or four diseases and after talking to a person for a short while place the person into one of those categories and give him/her the appropriate prescription."

Depending on the family situation, extended family interference could worsen family problems or help to resolve them.

Offering a possible explanation for perceived rarity of mental illness among Iranians: "Perhaps because from the first day their lives have been planned for them, in contrast to the children here who come from separated families - often one parent families."

5. Health in the Iranian community in the U.S.:

"The best, the most educated, the hardest working subgroup (of Iranians) have come to the U.S."

"... some have done jobs which they would never have considered doing in their home country, in order to provide food and housing for their families. And, very rarely, I know Iranians who have become freeloaders of the American System and use welfare for example or soup line or soup kitchens."

Secret of success: "Perhaps in general their plans have not been grandiose plans They have wanted mostly to be able to support themselves at a minimal level."

Support system: "Repetition of these problems to each other and commiseration for their miseries." Might see turn of events fatalistically. However with further discussion agreed that the fatalistic point of view is used in negative circumstances, but it rarely impedes progress.

"Support systems really do not exist for Iranians. Some of it is that Iranians think very individualistically and selfishly..... The support system when it comes to money ends, but with respect to giving advice, or listening, or commiserating, yes, every one does that. But when it comes to doing something practical, they refrain from participating.... this is of course, my personal opinion."

Psychiatric help seeking: "It has definitely changed. But I am unaware of anyone who is using such services, or is willing to confess to it. I think that the situation has to become very serious, such as a legal problem that would cause a person to see a psychiatrist/psychologist."

6. Health in the U.S.

"Based on my limited experience, the physicians' emphasis here is on laboratory data rather than signs and symptoms. And perhaps over there take more risk, and are more imaginative, due to the absence of lawsuits. Therefore, if the possibility of one percent should exist for a remedy to be helpful, they will use it whereas the physicians here because of their fear of lawsuits might not."

C. Concerns among the population (for immigrants who have been here as long as the subject):

- a) 20-30 year old. bicultural (once worked out can be positive);
- b) 45-65 year old. Cultural, most importantly child rearing in a different environment: children are rebellious or disrespectful; parents feel helpless and inappropriate; being away from relatives and not fulfilling obligations towards them;

D. Recommended Programs for Iranian Groups:

"Learn sharing and concerns for others through community and social activities... recognize others as having problems."

Case 15:

Age: 40-65

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: upper middle class; comfortable.

Higher education in U.S.

Had lived in the U.S. for longer than ten years before returning to Iran; after return, had visited the U.S. regularly. In a way, readjusting to Iranian culture was an issue rather than adjustment to the U.S.

Children attended international school;

Very well versed in English

"Our life in Iran was not 'Iranian.'"

Social interactions mostly with Iranians who had studied abroad, therefore,

not typical practices.

2. Decision making:

Reason: "Could not tolerate the government's attitude toward women; a teacher represents a school of thought, and I just couldn't do it." Long term consideration precipitated with a government decree to wear scarfs to class.

Whose decision: She initiated but collective decision with husband.

Feelings/expectations before immigration:

Familiar with U.S.; Difficult to leave Iran, because it was imposed on her; that makes one stubborn. Secondly, financial considerations.

3. Relocation:

Difficulty leaving: Uncomplicated; at that time easy for foreign residents to leave; had done it before.

Difficulty entering: Very easy entry; green card.

On arrival: Received a job offer within a month and half; relatively easy transition.

Problems and concerns:

Financial;

4. Currently:

A realist: she does not want to miss the moment, therefore, she doesn't compare what life could have been; non-judgemental. Does not like to generalize, only spoke about personal experience.

Attitudes/feelings now: She stays away from Iranian crowds, partly because of the obsession Iranians have with mourning, i.e. Farhang-i-Rozehkhooni (mourning culture). "I just refuse to attend any Iranian functions, because I think we have to go on with our lives."

Learned from this transition: "not to keep all your eggs in one basket. That is the lesson that comes to my mind. And then how raise one's children to think of the world as their place to live, rather than one country, so there is no loss."

5. Future:

Expects to live in the U.S. ; hopes never to become dependent on anyone (utmost fear in life). "I would like to visit, but to live there, I don't know. I don't think so, but to say never..."

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "Symptom free, no complaint, and by appearance, e.g. pale, swollen, etc." Personally, she feels healthy if she has "no need for medication."

Mental illness: A person who "cannot face the challenges of life. If they can't cope, they can't adjust, and face the challenge."

Symptoms: "if they become nonfunctional, they can't perform normally, for an excessive or prolonged time period."

Depression: "non-communicative; difficult to engage them in any kind of interest reflects that they are depressed for that day." Different degrees of depression exist.

Crazy: "out of touch with reality, not necessarily dangerous."

Addiction: "if you can't function normally without any substance or any life style; that becomes abnormal."

2. Before Relocation:

Medical care:

Physicians among friends and colleagues;

Children received annual check-ups;

Access and use of physician care very regular;

No home remedies.

Family support for illness: "We don't overindulge, but no one neglects." "In any crisis, they are very supportive, but not over indulgent."

Preventive medicine:

Proper diet: low fat, low red meat content, no additives (one of the children); exercise in her part mildly, her children avidly; avoiding contagiously ill patients.

Alternative methods:

None.

Psychological counseling was recommended within social group for family problems or such; no stigma.

Personally, she is not judgemental about addiction, given that it will not affect their relationship. If really cares about person, would try to help; but no experience with that.

Insurance: did have insurance; never used it.

3. Currently:

Medical care:

Obtains regular check-ups through HMO; uses fee for service plan for visits to referred physicians for serious illnesses.

Expectations from physician: Key word is confidence: she is very picky and shops around; therefore, content with treatment and diagnosis.

Interaction is cut off with friends who are using heroine, cocaine; less than that try to talk to them about it.

Preventive medicine:
Similar to before relocation.

Alternative methods:
Similar to Iran.

Attitudes toward physical, and psychological illness, including addiction, same as in Iran. Helps those close to her intensely, but is not responsible to help everyone.

insurance: two types: 1) HMO coverage 2) fee for service.

4. Health in Iran:

No generalizations.

5. Health in the Iranian community in the U.S.:

No generalizations.

6. Health in the U.S.

No generalizations.

C. Concerns among the population (recent immigrants):

Cultural conflict between the younger and older generation. "And I think it is the problem of parents who cannot grow up with their children. But again first hand, I can't say that because one the question of Iranian morality was nonexistent in my family, no inhibition, no tradition..... For example, they ask me how I handle my daughter. Well, I don't handle her. She handles herself."

a) 20-30 year old. Please, see above.

b) 45-65 year old. Please, see above; loneliness, financial security; the language; joblessness.

D. Recommended Programs for Iranian Groups:

Initially, "I am not the person who can see what they (programs) can be." After pursuing it, "A change in attitude is what they need first. And that is not easy. Some are still living in a dream that, "everything will improve and we will be able to return. It touches me, it makes me sad, it makes me angry at them. Mixed feelings when I see it. And I have decided that since I can't do anything about it I rather walk away from it."

Case 16:

Age: 40-65

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: upper class; husband a physician: specialty training in U.S. Had lived in the U.S. off and on; used to relocation and the U.S.; current move though is thought to be the last.

Very close family relations

Familiar with English

2. Decision making:

Reason: 1) one son was reaching the draftable age 2) didn't want the children, in the U.S., to be alone longer than they had been 3) children's education.

Whose decision: collective decision with husband.

Feelings/expectations before immigration:

In Iran husband was physician, and they were relatively comfortable. The only reason they came was for the children.

Familiar with the U.S.

3. Relocation:

Difficulty leaving: Relatively easy to leave;

Difficulty entering: Arrived with an expired green card; still in the process of obtaining visa for one family member. "We just came."

On arrival: Stayed with relatives for a few months. Husband until recently stayed in Iran and supported family.

Problems and concerns:

Being away from Iran and relatives;

Financial (nonexistent compared to other Iranians here)

4. Currently:

Very Fekri (thinking) person: worries about how things could have been; this trait is innate to her character.

Husband just recently came; family back together. Facing economic uncertainty.

Attitudes/feelings now: "Even now I very much like to live in Iran, after all it is my country and I very much like to live there, especially because my family lives there.... Well, here there are other things, the kids go to school, life is easier, but one is far away from one's family." Not worried about children being raised in this society: "No, we are not at all unhappy, as a matter of fact we are happy for them to be here. That is why we came."

5. Future:

Expects to live in the U.S., because the children would have been raised in the U.S.; hopes that conditions would allow easy travel to and from.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: Absence of physical and mental disease; temporary conditions do not seem to play a role in this definition.

Mental illness: (mareez-i-ravani): "Person has deficiencies in his/her life, and has certain thoughts, and his/her thoughts are disturbed, that person is mentally ill, but is not crazy."

Depression (afsordeghi): "has to do with families, and how they were raised. Were they treated well? Have they seen love from the people around them, or have they had deficiencies. I think these factors lead to depression in later years." Not considered a mental illness. "If a person is kept busy it helps a lot, because it helps to distract the person." It is mainly the person's responsibility to snap out of it, think about the children, etc.

Crazy: "The person has to do all these things together, to be confused, and talk to oneself, and in the winter walk naked in the streets, and in the summer wear a warm coat." Not necessarily harmful to others.

Addiction: When one needs to use more of a substance the more one uses it.

2. Before Relocation:

Medical care:

Husband a physician; also, had family physician.

Had regular check-ups at least once a month;

Very familiar with medical concepts and treatments;

Access and use of physician care very regular, including dental care;

Family support for illnesses;

Preventive medicine:

Eating adequate food; not too much, not too little. Type of food: low fat (never liked it); vegetables; protein, especially vegetable protein; exercise: did 3 to 4 hours of walking. No hot/cold acceptance; staying away from sources of infection, e.g. sterilization of utensils, isolation of patient.

Alternative methods:

Never accepted such ideology. Even though mother used some for bone pain, and received temporary relief for it--not longlasting relief though.

Attitude towards addicton: "Heroin and the sort are very different from the others, are very dangerous. Some people use opiates for fun at gatherings, and that doesn't really cause harm, but if they use them on a daily schedule, on specific hours, sure they are considered addicts."

With respect to family support for family problems: "Husband and wife should try to solve their own problems. If they are unable to do so after talking about it, they can go to their parents, who will probably be unable to solve it for them."

3. Currently:**Medical care:**

She has not had a check-up in five years;

Access has lessened considerably due to financial concerns; but will definitely take to a physician if symptoms don't clear after home treatment (she may be called a "half-doctor" from what she learned from her husband)

Expectations from physician: to discover the reason for their discomfort and treat accordingly; does not expect quick diagnosis, nor prescriptions; actually prefers not to be given a prescription.

Preventive medicine:

Similar to before relocation, except amount of exercise has decreased considerably due to other commitments, namely children; tries to get in 30 minutes of aerobics/day.

Alternative methods:

Similar to Iran.

insurance: none

4. Health in Iran:

"Others (less cultured and less open minded) are very impatient, and think

that as soon as they visit a physician they should become well. Or that a spoonful of medicine should immediately improve them. But they are wrong. It takes a while for a physician to make a correct diagnosis or for the treatment to influence the condition."

In Iran, "if he is told that there isn't anything wrong with him or her or that he doesn't need medication, the patient doesn't take it very well. And says, 'What doctor was this to say that; he didn't give me anything nor write a prescription.'"

"Children were good and obedient. It was very rare that a child would change his course and not pay attention."

She remembers opium use in family. And considered them to be addicts.

5. Health in the Iranian community in the U.S.:

"Sure there are quite a bit of people who are under financial stress, but they have adjusted their lives in spite of it. For example, they work two to three shifts, so they can earn a living."

"Here there are many families which are separated..... In families which are together you seldom see a child who acts this way (disobedient)."

"I would have liked to do have (social) interactions, but because of the limitations of our apartment I didn't see it fit to invite twenty to thirty people in this small place."

6. Health in the U.S.

No general comments.

C. Concerns among the population (for immigrants who have been here as long as the subject):

a) 20-30 year old. no problems, perhaps financial.

b) 45-65 year old. difficult for a single woman, who doesn't have any sponsor. nguage; loneliness; how to raise children in a foreign culture. "They have to not only adapt to a whole new life style, but to a whole new system of thinking."

D. Recommended Programs for Iranian Groups:

Financial concerns lie at the heart of the problem; perhaps social gatherings to help younger generation find partners, or older generation to get out of loneliness.

Case 17:

Age: 40-65

Sex: Female

A: Adjustment to culture:**1. Before relocation:**

Economic status: middle class;

Changed places of residence, many times; had finally settled down. Her husband was in the armed forces.

Financially dependent on own resources or bank, for home loan, but in cases of true emergency had asked from relatives.

Familiar with English alphabet from French courses in school;

Before last trip sold everything (their "lives") at a low price;

2. Decision making:

Reason: For children: Three trips to the U.S. within two to three years in order to get out all of the younger children. First time brought one child (before the war): felt that education abroad was superior. Second time came to stay with the child; also try to obtain visa for another child; Third time finally managed to get out all of the younger children. relative in U.S. told of comfortable life style; also guaranteed visa.

Whose decision: Collective decision, including relative abroad and children. She thought that all family members should be together; Husband felt that a few should first go scout the area, which resulted in this complicated process of relocation.

Feelings/expectations before immigration:

They had a comfortable life in Iran; left just for the children. She did not expect anything from the U.S., other than given her children an opportunity to study.

3. Relocation:

Difficulty leaving: First two times uncomplicated; Last time very difficult.

Difficulty entering: Relatively easy all times for herself. However, green cards had not reached them after first return and caused later difficulties in getting all members to the U.S.

On arrival: Stayed with relatives initially.
 Attended language courses, for six months not very regularly. Interrupted by visitors. Decided to work instead. And is currently a full time worker.
 Initially difficult to adjust to American culture, because it is the exact opposite of Iranian culture.

Problems and concerns (after last arrival):
 English.

Financial.
Resettlement.
Cultural adjustment.

4. Currently:

She is content: No problems for myself nor for my children; "What do you think one wants from God? Health is the most important thing." Comfortable with her English. Children have grown up and have selected a path; none has been influenced by the American culture.

Attitudes/feelings now: "There is good and bad among both Iranians and Americans, and they are not responsible for their culture being such. This is the way it was for them, and that is the way they were raised. So one cannot hold that against them." She is very impressed by her co workers and boss: "I don't think we, who claim to be Moslems, would give a job to an American and then treat the person as they treat me."

Bank is financial resource at times of need.

5. Future:

Expects to live in the U.S., partly because children are here. However, hopes for the time when travel would become easy.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "A person whose sleep hours are normal, namely sleeps on time and gets up on time. And one's diet is good: not eating too much, but with an appetite. If the person doesn't have an appetite we cannot call him/her healthy. And one's rooh (closest translation: soul) should be happy, not be constricted and sad (kessel)--have a tendency more towards happiness than sadness. One should like nature and scenarios. One's heart should be happy."

Mental illness: (narahati-i-ravani): "But if a person is not well physically, then the rooh also becomes narahat and constricted. 'Will I become well or not?'" Also, "narahatis are because of too many thoughts, or problems which one has had to face." Symptoms:

When one is not able to think well about life, about one's children, about the childrens' future, about the health of the children, about one's health, and pressures of life.... It is not healthy to sit and think." Not synonymous with craziness. Afsordeghi is considered a subtype.

Depression (afsordegheh): Be constricted and sad, etc. Not defined in detail; a narahati-i-ravani.

Crazy: The most severe form of mental illness; non sensical behavior; not necessarily harmful; has to be institutionalized.

Addiction: Craving for a substance from prior use; chemical substances were used as examples.

2. Before Relocation:

Medical care:

Very familiar with herbal and traditional medicine: learned from mother. Familiar with courses of different diseases; e.g. measles does not require a physician; needs cold food, etc.

Extensive use of home remedies; however, for severe trauma and prolonged illnesses would take to physician.

No check-ups in Iran, not regular physician care; she remembers seeing physicians in childhood.

Family support for illnesses; e.g. for fever "food, cleanness, the person's room should be taken care of so the person could improve as soon as possible."

Preventive medicine:

"Cleanness is number one, then exercise, and dietary balance; one shouldn't eat too much, nor eat too little. Find out as much as possible what food is good and what isn't. Definitely, this has a bearing on health. One should try to keep one busy, not be without work, because worklessness produces illness.... Recreational outings are good for the health."

Alternative methods:

Herbal medication extensively. Very familiar with hot/cold categories of food; However, very much against opium use as a pain-reliever for chronic illness. Golvazaboon as a method of relieving mental pressure. Please see beginning of this section.

insurance: military insurance.

3. Currently:

Medical care:

Had a thorough check-up a few years ago; pleased with physician care here. The only complaint she has is having to wait for a long time in light clothing for the physician to come; concerned about catching cold.

She still would seek medical care, be it physical or psychological, after it is indicated after personal assessment.

Expectations from physician: to do a complete first examination, and to be good natured; medical prescription is not necessarily, as long as it is explained.

Has the same support system, personally.

Preventive medicine:

Similar to Iran, except she is now aware of some food groups which are not healthy and has changed diet accordingly: low salt, low fat, low red meat.

Alternative methods:

Used less frequently than Iran, because the situation has not arisen, e.g. no hot summers to require khaksheer. However, there is a supply of herbal medication in case.

She is aware of social stigma against seeking psychological care, but personally thinks that a person should seek help at an early stage before it gets worse, just like any other illness.

insurance: Recent HMO coverage.

4. Health in Iran:

"There were private physicians who would come to one's house. And without any tests or lab values would write prescriptions, medical or dietary (parheez-i-gazai; lit. trans. food avoidance."

"In Iran you didn't see a physician unless you were sick. But here, everyone is so worried about their health that they have regular check-ups yearly."

"One of the elders would say if a child has earache, one should smoke it into the ear and the pain would be alleviated."

Extended family interference, in her experience, could either lead be positive or negative in dealing with marital situations.

5. Health in the Iranian community in the U.S.:

Increased mental pressure in Iranian community. She knows of an afsordeh person who is unwilling to seek psychological care.

She is aware of children who have become disobedient under the American system; fortunately, though hers have not.

6. Health in the U.S.

"... Here you have to get yourself somehow to the physician despite your condition and then they run a number of tests, and without those results no prescriptions are written." She finds one of these to be a positive attribute,

"because sometimes a person can prescribe a medication without knowing the situation, and they don't know what the illness is, and that prescription is worthless."

C. Concerns among the population (for immigrants who have been here as long as the subject):

- a) 20-30 year old. Financial, if studying; difficult to do both.
- b) 45-65 year old. Language (can lose all money if one doesn't know the language); financial; cultural adjustment;

D. Recommended Programs for Iranian Groups:

- a) 20-30 year old. Financial help.
- b) 45-65 year old. Language; guidance and advice from friends or family members; not the kind that has resulted in deception and financial loss by some relatives or other Iranians.

Case 18:

Age: 40-65

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: upper class;

Had visited the States twice before; had visited Europe frequently.

Very close social network;

Comfortable with English (had taken two years of English courses), but not fluent.

2. Decision making:

Reason: A son was reaching the military service age; also husband had always wanted to live in the States.

Whose decision: Both.

Feelings/expectations before immigration:

In Iran she was content with her life style; she was happy with the culture and the way of life her children would inherit. Maanavi (spiritual) aspects have always been very important in her life. She did not think about the U.S. much; she just went along for his family's sake. She gets used to a new environment very slowly; she was leaving the place she loved.

3. Relocation:

Difficulty leaving: Relatively easy.

Difficulty entering: Relatively easy.

On arrival: Never thought she would have to work like this. Initially, had a very difficult time accepting her new place of residence. She began her business immediately, to avoid thinking about her loss and to be of financial help.

Problems and concerns:

Homesickness;

Financial;

Cultural differences: children growing up alone; not in the close social network (agrees that this might not be the children's concerns)

4. Currently:

She was hesitant to brag about herself: sensitive, detail oriented, pours most of her worries within, rarely shows them. She is very concerned about everyone and everything. "I like the people I like, from the bottom of my heart, and am very protective of them. I am sensitive to injustice." Religious, believes in God deeply, honest and fair. Cannot harm anyone, rather harm myself.

Attitudes/feelings now: She is used to the situation much more than she was during her first days in this country. At times she even feels a fondness towards her house. She thinks that her children are missing out on the Iranian culture, with all its strengths and weaknesses (even though it may not be the case from the children's perspective). This relocation has made her a stronger person.

5. Future:

Expects: an average life, for the children to reach some level of success, God willing, attend universities. Understands that her children would probably want to live in the States, and hopes for the ways to be opened, so they could spend some time in the States and some time in Iran.

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "Absence of physical problems (long term illnesses) and roohi problems. It is possible for a person to develop occasional headaches, or foot aches, and such, but no serious illness."

Mental illness: (narahati-i-ravani): More severe form of roohi (if it begins affecting others).

Narahati-i-roohi: e.g. depressed, nervous condition, be worried all the time. Or the

environment might create problems, e.g. have a family problem, etc.

Depression (afsordeghi): due to environment, loneliness, loss. Symptoms: "The bottom of the heart cannot be happy;" irritable; taciturn; no appetite; Example: postpartum depression (perhaps due to low iron, hormonal)

Reaction to afsordeghi: People try to occupy one's time.

Crazy: Very severe form of ravani; absence of control over one's behavior. The harmful type needs to be kept in mental asylum.

Addiction: One can become addicted to anything: "One cannot abstain from a habit, needs to pursue it." In general, addiction may be due to human weakness. Her family has always condemned addictive substances, including alcohol, partly because of religious reasons. Cigarettes are more acceptable, as a close family member is in the habit of smoking, but regularly tells him and his wife to stop him.

2. Before Relocation:

Medical care:

No check-ups; children had check-ups. They saw an excellent pediatrician who gave as little medication as possible.

For children medical care was readily sought.

For herself, she would wait a couple of days or so, and seek care depending on the outlook.

Over all, she was content with the physicians in Iran. "It should be said that since we have HMO physicians it is a bit different. All that time, in Iran we had private physicians, the best. If you needed anything you would immediately go to the specialist. Plus you wouldn't see any physicians without any references from family or friends. "

Family support for illnesses;

Preventive medicine:

Diet: she was not conscious about fat content, however did provide balanced meal; exercise: a lot of walking. Felt her organs to work better and her roohieh (mood: best translation) to be refreshed.

Alternative methods:

Herbal medications were sometimes used, as mother prescribed and also physicians supported. She was aware of hot/cold food categories, but in terms of decreased calories or other Western terminology.

insurance: no.

3. Currently:

Medical care:

Regular check-ups with insurance coverage.

Here physicians are pre-selected. Therefore, you don't know the physicians and you don't have much confidence in them. Or you think that insurance physicians might not be the same caliber as private physicians, because if they were they probably would have their own offices."

"Believe it or not, since I have been here, I have developed an illness every winter." Physician care was extensively sought even when they did not have coverage.

Family support system: tries to provide the same support system for illness, but due to lack of time does not feel satisfied with the final outcome.

Expectations from physician: for the physician to give you information with regards to your condition, even if the physician should not know the diagnosis; to talk to the patient and ask questions and explain some of the reasons of some of the things that are happening. Would prefer a shorter diagnosis, but it is not necessary. Prescriptions are not expected either.

Preventive medicine:

Healthy diet: vegetables at least twice a week; fruit juice, food with fiber and appropriate vitamins. Very low fat content; exercise but has less time for it and less possible due to physical illness.

Alternative methods:

Herbal medications are generally accepted (see "before relocation"); but not used here at all.

Personally, somewhat believes in psychologists but does not know how effective they can be.

insurance: HMO two years after arrival.

4. Health in Iran:

Attitude toward ill person: "They try to avoid irritating the person, unnecessarily. Personally, I am the kind of person who does not like to prove to a person that one's condition is more severe or dangerous (than is believed by the person). I try to help the person mentally (roohi).

Nursing: "They do much more than here, but that varies from family to family. For example, the concern and care my mother showed in nursing my father is unparalleled."

"The meat content of Iranian food is much less than American food."

"Older generation thinks more about hotness and coldness."

Some families were more comfortable asking for money from family, some from friends. Banks were rarely used.

5. Health in the Iranian community in the U.S.:

Financial help is mostly obtained from banks. She has heard of Iranians deceiving other Iranians.

Aware of two children who developed mental illnesses (ravani): 1) had been sent for education and could not get used to loss in social status. He is still here.

2) had been sent for education but could not get used to the environment. He was sent back and is reportedly in better condition.

6. Health in the U.S.

Please see medical care, current.

C. Concerns among the population (for immigrants who have been here as long as the subject):

a) 20-30 year old. With family very few problems; without family lack of both spiritual and financial support.

b) 45-65 year old. Financial, which can lead to family problems and loss of family unity.

D. Recommended Programs for Iranian Groups:

a) 20-30 year old. Stay with a family and receive emotional support.

b) 45-65 year old. Could not suggest anything.

Case 19:

Age: 40-65

Sex: Female

A: Adjustment to culture:

1. Before relocation:

Economic status: upper class;

Very stable environment;

had lived abroad for in one country for two years and in another for a few months about thirty years ago;

They had also been to the U.S once when dropping children off;

Older children were studying abroad;

Familiar with English: had attended English courses before arrival;

Before emigration sold everything (their "lives") at a low price;

2. Decision making:

Reason: For children; Long term decision: initially they had decided to go live with child abroad but roads were shut down. Later their decision mainly involved their younger children.

Whose decision: Collective, mainly hers.

Feelings/expectations before immigration:

Iran was very inadequate for the children to live in, but they themselves did not have that many problems. They really wanted to leave. She had been to the States on one occasion; "I liked it a lot, ..., but it was only a dream."

3. Relocation:

Difficulty leaving: Very difficult; had several attempts

Difficulty entering: Relatively easy; relatives had prepared green card.

On arrival: Stayed with children;
They did not work;
Family was supported by parents' investments and the children's salary.

Problems and concerns:

Financial;
English;

4. Currently:

She did not want to boast. She is a very sensitive person. And very caring towards others, especially the ill, because a sick person mainly needs emotional support (roohi) than physical support. She tries very hard to perpetuate selflessness in her own family and to prevent them from becoming American. Her husband is having a more difficult time adjusting, because he has lost all social status, and cannot work. English courses improved his attitude to a certain extent. This relocation has taught her that truly some of the spending they did there was wrong. And that one should plan ahead.

Attitudes/feelings now:

"The life that one has in one's country cannot at all be found here, especially in this society." There is too much freedom and looseness; and truly if my children were not here I would return to Iran.

5. Future:

"No one knows about the future," but will be with her children, most likely

in the States. She expects (hopes): "I am doing all this for you for my future. Because truly every one grows old. When I grow old don't you put me in with all these sick people. Keep me among yourselves."

B. Adjustment to Health Care Practices:

1. Definitions:

Health: "Truly depends on the mental condition of a person. If your nerves are irritable (narahat) all other diseases can follow." In Iran she did not have this definition. Instead, she closely linked her health status with her life style.

Mental illness: (narahati-i-ravani = narahati-i-roohi): a) crazy b) due to life's pressures and hardships, which cannot be endured any more. One person could become depressed another person could have a heart attack.

Depression (afsordeghi): symptoms: complete silence, feels very constricted (gerefteh), and feels a very deep and true sorrow.

Crazy: could kill someone.

Addiction: Each person is addicted to something. One person is addicted to alcohol, another person is addicted to her children, like myself. She dislikes anything that takes one out of the natural state. She does not associate with those persons who are addicted to serious substances (such as heroin, opium, alcohol), and very aware and sometimes chiding of less serious substances (cigarettes).

2. Before Relocation:

Medical care:

Regular physician care;

She had regular check-ups, perhaps because of her chronic illness. All of her children received regular check-ups in early childhood.

Preventive medicine:

Diet; regulation of temperature: kept the house warm, proper clothing; exercise (aerobic class)

Alternative methods:

Does not follow hot/cold guidelines in daily diet, but is aware of them for an illness. Used herbal medications and believed in them.

A family member used acupuncture.

insurance: military insurance.

3. Currently:

Medical care:

She is content with the physicians she has seen;
 Physician care is available for illnesses;
 Until last year did not have time to get a check-up.
 She has developed severe migraine here;

Expectations from physician: to listen, to examine carefully, and to prescribe.
 I believe much more in things that are available to use in our own country than here.

She provides the same support system for family members.

Preventive medicine:

Similar to Iran; exercise is recommended by physician.

Alternative methods:

Still believes in herbal medication--not as many indications exist here. She has used acupuncture and herbal medicine (some from Chinese shops) to treat her migraine. Also, sees a physician for those.

She is aware of social stigma against seeking psychological care, but personally thinks that a person should seek help at an early stage before it gets worse, just like any other illness.

insurance: From the day of migration, however extent of coverage has been decreasing.

4. Health in Iran:

It is very important to provide emotional nourishment more so than physical nourishment to an ill person.

"In Iran it is customary to see a physician for illnesses; no check-ups."

"Prescriptions were expected."

5. Health in the Iranian community in the U.S.:

"Depression has increased greatly due to increased life stress. Most of the people who come here had a life and a position back in Iran." Therefore, it is extreme change in social status which has produced such a stress. Father's intention was to come and stay temporarily; now has not accepted life here.

Divorce rate has increased in the Iranian community. But she accepts this more than how it was in Iran, because couples had to suffer till the end of their lives. Also approves of young men and women socializing within limits

to get to know each other. "If you cut down on your losses at any point it is a profit."

6. Health in the U.S.

"People here only think of themselves. They first say, let us think of ourselves, and our comfort. Even if another person falls and breaks one's legs, they say, 'well, if we have time we will get to that person. And I am very disturbed by this.'"

"I think the internists here are zero (know nothing). They don't attend to the patients' needs, don't write prescriptions. I don't know if it is because they are afraid of getting sued. Here, surgery is excellent, but truly their internists are zero. (At this point, she brought an example of a young boy who died due to a misdiagnosis).

C. Concerns among the population (for immigrants who have been here as long as the subject):

- a) 20-30 year old. Financial; lack of emotional support.
- b) 45-65 year old. Financial; (unfortunately Iranians here are not coordinated. Misfortune of the Iranians here is that they look at each other's appearance rather than at a deeper level. No one says that this person (referring to another person) with such shakhsiat (personality in its social context) is living such.

D. Recommended Programs for Iranian Groups:

- a) 20-30 year old. Social groups.
- b) 45-65 year old. Programs which would distribute money in a secretive manner - not to show off.

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