Filipino Migrant Nurses in the United States:
An Analysis of Family Adjustments and Conflicts

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science at George Mason University

By

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Fall Semester 2008
George Mason University
Fairfax, VA

DEDICATION

It is with the support of Filipino families that I do this research and it is through their model and inspiration that I pursue it. They give these pieces of paper hopelessly groping for space in the GMU archival shelves more profound and deeper value and meaning. Because of this I dedicate it to them and theirs.

ACKNOWLEDGEMENTS

This research would not have been possible without the assistance and participation of so many couples and families who were willing to spare their time and lend their expertise to the project. The interviewees who shared their migration story with such candor and generosity so as to give rich narratives that would otherwise be unavailable to the public or policy makers. Your participation in the research has made me understand the plight of Philippines Nurses and their families in the United States. I also thank Zylma Madrinan Sanchez and Reynaldo Rivera for their two shores insights on the macro condition of Global Nurse Migration.

I thank Dr. Kevin Avruch who found time amidst his many responsibilities to guide me through this project. I thank Dr. Lolita O'Donnell whose encouragement has always kept me confident and true to my cause. Dr. Carlos Sluzki whose work has inspired me throughout this project. I also wish to thank Dr. Joseph Maxwell for his patience in explaining and assisting my knowledge in qualitative research.

All in all, this has been a family effort. I thank the Filipino Community in Virginia, my family here in the US who have given me support and have only been so willing to assist me and my wife in all situations. They continuously helped the research by introducing me to their Filipino Migrant Nurse friends. Special thanks to Tita Lina and Tito Ben, Jun and Susan, and Sonny and Menchu Siasoco who not only supported and guided the research but invigorated my spirit while studying in George Mason University.

I give my heartfelt thanks to my brothers, sisters and mother who supported this academic path and have always been there for me and my wife during times of research and financial needs. Carrie Jose was always there when I needed materials and transcription work done in the Philippines. Menchie Jose put her life on the line to make sure that any subsidy from the Philippines were transferred for expenses here in the US. Raffy and Ramon Jose supported and believed in the path even if they were unsure of the end results. Cynthia, and Cristina, my elder sisters always cared about my progress in their own way. My mother Belen Siasoco Jose made sure that we remained strong both physically and emotionally and stayed true to the values our faith. To my late father, Nestor Lopez Jose, the principled businessman, the family man and the genuine conflict analyst and resolver in both our nuclear and extended family.

None of the research would be possible without the moral and technical support of my wife Leilani Urbano Jose who has kept a nurturing and practical eye and hand on the progress of this research whilst I was a student at the Institute for Conflict Analysis and Resolution. Time and again, her strength of mind has proven to be my rock of stability and the true North of our relationship. I am fortunate that a human being of such inner and outer beauty has chosen to share her life with me.

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ABSTRACT

FILIPINO MIGRANT NURSES IN THE UNITED STATES:
AN ANALYSIS OF FAMILY ADJUSTMENTS AND CONFLICTS

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George Mason University, 2008

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This is a qualitative study about cross cultural, as well as family conflicts that affect Filipino Nurse Migrants as they immigrate to the United States to work as nurses for different institutions. To report and document the conflict narrative of Filipino Migrant Nurses in the United States from the standpoint of the Nurses themselves. The ultimate goal of this project is to build a program of conflict prevention embedded in the recruitment of Nurses from the Philippines. 12 Migrant Families, 1 official of national organizations and 1 government official participated in the completion of this project between the dates of winter of 2004 to the summer of 2006. The narratives were heard and their personal, data audio recorded in the interviews. The interviews were then transcribed and the text analyzed.

The focus of this analysis is the different conditions and experiences of the families and the specific, culture consonant ways in which a Filipino Migrant Nurse copes with a new environment.

The study also concentrates on the different conditions and policies that prevail amidst shortage of nurses and the recruitment of nurses in the Philippines. Research suggests that the current recruitment process has led to worker overload amidst the nursing shortage and wage abuses as new recruits wait for their immigration documents.

The study traces the historical and personal conditions that led Filipino Nurses to the choice of migration. This information is also triangulated between the different members of their partners and family members. The findings suggests that although various family conflicts are commonly experienced by migrant nurses as they move to the United States, there are very few institutions, private companies and hospitals addressing adjustment issues and related conflicts.

In the midst of a nursing shortage, there are significantly more elements of migration than can be addressed by the current national security centered immigration approach. Institutional coordination and sensitivity to internal and external conditions from the different private and government agencies in both the Philippines and the United States is due. But before solutions are put forward, this study examines what adjustment issues Filipino nurses encounter as they have historically immigrated to the United States. Before any price can be put on their service, it would only be prudent to examine what price they pay in the process.

Chapter I
Introduction

Currently, nurses are travelling and working in many foreign cultures. However, they often realize, by cultural shock or in other way that people differ in the way they view professional nursing and client care needs. Nurses are almost forced to consider the role of cultural factors in client care (Leininger, Reynolds, 1993).

The United States currently faces an unprecedented shortage in the nursing industry within the coming years. Twenty percent of today's registered nurses are expected to retire within the next ten years. The demand for health care practitioners is rising with the number of baby boomers reaching retirement age. The number of new entrants into the nursing profession is insufficient to replace those leaving, much less cater to increasing demand. The shortage of nurses is forecasted to worsen steadily through 2014-2020 (Rosseter, 2006).

The main factors affecting this shortage are the anticipated demand within the next twenty (20) years. This coincides with an industry that currently suffers from recruitment and retention issues due an insufficient number of instructors, an aging workforce, and stressful workplace conditions. The current shortfalls of the industry work to aggravate forecasted shortage.

One of the historically used solutions has been to recruit internationally-trained registered nurses to augment periods of nursing shortages. The current ratio stands at 3.5 to 4% of the total number of U.S. nurses.

International recruitment is a complex issue because it is inescapably a humanitarian and immigration issue as well. Although the figures may vary from year to year, one thing has remained constant since the 1920's. Most of these internationally trained nurses are Filipinos. The emotional and psychological issues that accompany their emigration and immigration lives are the subject matter of this study.

The context of the study introduces the current Registered Nurse (RN) shortage condition of the healthcare industry in the United States and the current global conditions and implications. It elaborates on the actual number of Filipino registered nurses and their history in the United States. Considering the macro-conditions, the chapter finishes by asking how these forces redound on the personal and relational conditions.

The theoretical framework lays down the foundation from which the phenomenon of Filipino Migrant Registered Nurses in the United States could be understood. The conflicts themselves were observed at the micro or personal level but the commonality of manifest features led to the use of theories that could better explain the more general phenomenon. The theories used were numerous because of the need to explain etiological elements that ranged from micro-macro forces acting on the phenomenon.

Chapter IV explained the rationale and details of the research methodology. The research was conducted using qualitative methods. Eight respondents were interviewed and their frames of understanding were interpreted in consult with various insiders of the

nursing sector. The commonality of emic frames paved the construction of an etic or researcher based frame. An etic frame is the identification of underlying, structurally deep and transcultural forms expressed in terms of certain descriptors that are putatively capable of characterizing across all cultures (Avruch & eds., 2004, p.63).

Given the importance of deriving resolution from within a sector, the importance of emic approach or the identification and use of a personal or institutional terms as the key organizing concept for description and analysis, is emphasized. Culture is heterogeneous though and contestants who are supposedly "even from the same culture" may share some, but not all interpretative frameworks (Avruch and eds., 2003, p.144). Given this heterogeneous nature of culture, it became necessary to understand the individual frames of the respondents and how they perceived and dealt with conflict conditions. The analysis proceeded given these qualified understanding.

Chapter V, Coming to America, explains the initial stages and conflicts that a Filipino Migrant nurse may encounter or initiate. It explains the sense of loss often encountered at the initial stages of immigration. It explains the often used instrumental-affective split that migrants go through in the initial stages. It explains the psychological process of relative deprivation and how this may affect one's perspective about the new environment. It explains how the new but compressed social network may occasionally turn out to be the new reference group and target of feelings that are derived from a relative sense of immigrant deprivation.

Chapter VI, Living in America, identifies the important factor of role models and behaviors. It explains the effects of the initial stages and other more enduring factors.

Relative deprivation is the gap or discrepancy between past condition, standards and norms internalized by the individual vs. an interpretation and or evaluation of current conditions. Considering the comparison points and cognitive cues of role models, conflicts often manifested at the more compressed social network level developed and streamlined during the initial stages of immigration. The conflicts were often attributed to interpersonal causes. Unique factors of different individuals and families were at various points. After comparing the stories of eight respondents, the commonality of conditions used to inspire such conflicts, surfaced. Deduced were macro-conditions of short sited immigration views and stressful work encounters in a shortage ridden work environment. After submitting to this view and conditions, the respondents and their targeted members within the social network chose to displace and engage at the interpersonal.

Chapter VII is the analyst's relevant perspective given existing data. The etic analysis and conclusion takes on an interactive frame between macro and micro forces and concludes at different levels. Empowerment or regaining agency of one's situation and personal conflicts comes with some level of awareness of these conditions. The stakeholders of this issue are many and shared between two shores. The research concludes that agency for resolving these conflicts is shared between the stakeholders and can be initiated at any time and on multiple levels and forms. From this research's perspective, the will (that ranges from political to personal) that drives actions and choices will ultimately be driven by interpreted discrepancies between aspirations and expectations, between interpretation and environment. The transformation and or

resolution will depend on reconciling these forces. This all begins with an introduction of the acting players and forces. This is currently where the issue is at.

Chapter II
Research Context

Throughout the duration of this research, contextualizing the current conditions of the Filipino Nurse Migrants became more and more necessary. An understanding of the complex conflicts and immigration was better done within the timeframe and context it was situated. It is with more current conditions that this paper begins.

The United States Shortage of Registered Nurses

On July 10, 2001, the Government Accountability Office (GAO) sent out a report titled Nursing Workforce: *Emerging Nurse Shortages Due to Multiple Factors*. Here, based on social and nursing industry demographic trends, they conclude that;

> Impending demographic changes are widening the gap between the number of people needing care and those available to provide it. Moreover, the current high levels of job dissatisfaction among nurses may also play a crucial role in determining the extent of current and future nurse shortages (GAO, 2001, p.13).

The American Association of Colleges of Nursing (AACN) declares that the United States is in the midst of a nursing shortage that is expected to intensify as baby boomers age and the need for health care grows. Compounding the problem is a recruitment issue. Nursing colleges and universities across the United States are struggling to expand enrollment levels to meet the rising demand for nursing care.

According to a February 2002 report on health workforce shortages, prepared by First Consulting Group for the American Hospital Association and other trade groups, the average nurse vacancy rate in US hospitals was 13%. Over one in seven hospitals reported a severe RN vacancy rate of more than 20%. High vacancy rates were measured across rural and urban settings and in all regions of the country. Survey respondents indicated that a shortage of personnel is contributing to emergency department overcrowding and ambulance diversions.

American Association of Colleges of Nursing (through a report by Robert J. Rosseter in September of 2006) has confirmed this report and has put the shortage numbers as follows:

Projections from the U.S. Bureau of Labor Statistics published in the November 2007 *Monthly Labor Review*, more than one million new and replacement nurses will be needed by 2016. Government analysts project that more than 587,000 new nursing positions will be created through 2016 (a 23.5% increase), making nursing the nation's top profession in terms of projected growth.

In the report of Dr. Peter Buerhaus and AACN colleagues published November 2004, they found that "despite the increase in employment of nearly 185,000 RNs since 2001, there is no empirical evidence that the nursing shortage has ended. To the contrary, national surveys of RNs and physicians conducted in 2004 found that a clear majority of RNs (82%) and doctors (81%) perceived shortages where they worked" (Rosseter, 2006). The numbers simply do not add up. One hundred and eighty five thousand (185,000)

between 2001 and 2006 reflects less than half of the mean trend needed to address the more than one million nursing shortage by 2016.

Adding to the perspective are findings by the survey conducted by the National Council of State Boards of Nursing (NCSBN) on licensed registered nurses. It recorded for the first time in history, that between 2000 and 2001, the number of licensed registered nurses in the United States actually decreased by 537 individuals instead of increasing by its more than normal five figure annual increments.

In the year 2000, the International Council of Nurses (ICN) put the total number of practicing US Registered nurses at 2.9 million with anticipated incremental increase of 8% between the years 2000-2004. In the same year, the NCSBN puts the recorded licensed and practicing US-RNs at 3.1 million. Accounting for the difference would be the nature of data collection process of both institutions. Whereas NCSBN records practice on the basis giving out licenses to practice as US-RNs, the ICN accounts for actual employment.

According to the NCSBN, the figures increased by as much as 83,436 (2.7%) between 2001 and 2002 and increased by as little as 23,576 (.07%) between 2002 and 2003.

Overall, the actual RN application trends (which are normally higher than actual employment trends) indicate that it will not meet the 23.5% or 587,000 new applicants needed to fill the shortage by 2016. It would be prudent to use the word unprecedented to describe the coming supply and demand deficit.

One would ask if the problem actually was in the early retirement of registered nurses rather than recruitment. All indications say this is not the case. The current average age of registered nurses is 45, whereas 20 years ago, it was 40.3 according to the 2000 National Sample Survey of Registered Nurses, the results of which were released in February 2002. If anything, indications are that registered nurses in general are staying longer in the practice in response to the shortage.

More recent findings by the National Foundation of American Policy give a deeper view of the dissatisfaction and retention issues within the industry and the shortage cycles;

"Dissatisfaction can and does result in nurses leaving the already dwindling workforce" (Albaugh, 2003, p. 193). Nurses face many different factors that lead them to job dissatisfaction. A commonality in the dissatisfaction of nurses is their inability to provide the kind of patient care they feel the patient deserves. This is due to increased workload and stress on the job. Some of these stresses include new diseases and high patient-nurse ratios, feelings of inadequacy, and feeling unimportant to the organization as a whole (Albaugh, 2003).

When managers were questioned about recruitment and retention together, the most effective strategies were specialized orientation programs including preceptor, internship, and mentoring programs. Mentioned less, but still frequently, were wages, scheduling, and positive social support (NCCN, 2002).

Retention of new graduate nurses continues to be a struggle for hospitals nationwide. Many new nurses leave their place of work within the first year of employment due to poor orientation and lack of social support (Marcum & West, 2004).

The Complexities of Recruiting Internationally Educated Registered Nurses

On the one hand, in a position paper on health care workplace planning and the recruitment of foreign educated nurses adopted by Georgia Nursing Association 2000 House of Delegates, they declare that;

During previous shortages, one of the first responses by the hospital industry had been the suggestion that increased recruitment and use of foreign educated nurses is a viable solution. "ANA strongly believes that the United States should not recruit foreign nurses when the real problem is the fact that the domestic health care industry has failed to maintain a work environment that is conducive to safe, quality nursing practice and that retains experienced American nurses in patient care. Therefore, the practice of changing immigration law to facilitate the use of foreign educated nurses is a short term solution that serves only the interests of the hospital industry, not the interests of patients, domestic nurses or foreign educated nurses (ANA, 2000, GNA 2001, Foley, 2001)."

On the other hand, the global nursing shortage is even more complex, as the November 2004 ICN report makes clear. The report surveys the causes, nature and effects on patient care of nursing shortages throughout the world. It discusses the "critical challenges" of HIV/AIDS, internal and international nurse migration, and health sector reform and restructuring, and it makes general policy recommendations to address these critical problems. One of the most alarming trends discussed in the report (and many

current news reports) is that many of the most skilled developing world nurses migrate for much better paying positions in developed nations with shortages. It notes that this has a devastating impact on already overburdened health systems in the poorer nations.

The report notes that the nurse population ratio varies greatly in different nations. The average ratio in Europe is ten times that in Africa and South East Asia, and one recent estimate is that sub-Saharan Africa is currently short over 600,000 nurses needed to meet Millennium Development Goals. Some nations, particularly in Central and South America, actually have more physicians than nurses. Many nations also reportedly suffer from a poor distribution of nurses, with few nurses available in rural and remote areas.

The Philippines is no exception to these findings. In countries such as the Philippines, where a nurse in the city makes about $50-150 per month, the potential exponential financial gains of getting $6,500/month in the U.S. have long contributed to the migration of these nurses. Due to the history of the Philippines as a former colony of the United States, it appears though that they bring bigger motivations beyond financial gains. Patient loads and working conditions are much worse in their homeland. Therefore, conditions which seem to drive American nurses from the field, pale in comparison to the conditions the Philippine recruits experienced back home. Considering the relative economic difference between of the Philippines and United States economies has widened since the early 1900's, the question of why some stayed and why some left has varied over the years.

The Philippine Overseas Employment Administration states that nearly 34,000 nurses went abroad between 1995 and 2000. The once bottomless source of qualified nurses has now created a more specific shortage issue in the Philippines.

Ireland once had a plentiful supply of local nurses, but now looks to the Philippines to alleviate its own shortages, further depleting nurses from the Philippines. The same goes for the United Kingdom, Australia, Japan and Middle East countries.

There is rising concern about the specific nature of the shortage of registered nurses in the Philippines. "In absolute terms, there is actually no shortage of warm bodies. There are enough graduates here, but there is a shortage in terms of quality," said Dr. Marilyn E. Lorenzo, director of the Institute of Health Policy and Development Studies and professor at the University of the Philippines College of Public Health.

The ones who have left are the skilled and experienced nurses. Most of those still here are relatively unskilled and inexperienced, and go overseas after one to two years of gaining experience. This poses serious implications for the quality of health care that they provide (Lorenzo, 2001).

The government is the single biggest employer of nurses and pays better than private hospitals, but it has not opened new positions and resulted in a staggering average nurse-to-patient ratios are from -- 1:30 to 1:60 (Lorenzo, 2001).

From a cursory level, where then did the recruitment of Filipino Migrant nurses begin and how is it relevant today?

The Historic Pull

As recorded by historian Catherine Ceniza Choy, the US has been one of the primaries, if not, the most frequent destination countries for migrants with at least one registered nurse in the family since the early 1900's. Initially, the primary motivators were noted as either to go on an adventure, work in different environments, or to earn higher pays (Choy, 2003, p.70).

Since that time, the demand for internationally trained registered nurses from the Philippines has fluctuated in numbers and between countries. It went down after the enactment of the 1934 Tydings-McDuffie Law (also known as the Philippines Independence Act of 1934), specifically targeted Filipinos and limited Filipino immigration to the U.S. to 50 individuals per year.

The history of Filipino Nurse Migration started with migration of the few unaffected nurses in the 1920's trained by its colonists and accredited in the United States. This trend had a sustained steady growth throughout the years until it was accelerated by a more massive flow in the late 60's to early 70's (Choy, 2003, pp.11-12).

Other choice destinations for Filipino Nurses have been countries like Ireland and Saudi Arabia. Choy records that time and time again, there were Filipino nurses willing to leave the Philippines to go abroad at least temporarily for higher pay compared to the Philippines. What has been distinct about departures to the United States after the 60's was that there had always been a higher proportion of Filipino nurses seeking permanent legal residency once they have landed a job in the U.S. mainland. Why was this so and how was it made possible?

The Baby Boomer Era

Sustaining America's economic growth over the years has depended partly on the supply of human capital to its territory. This was particularly true during the 1960's when the rapid economic growth provided a disjuncture between the number of existing US nursing sciences graduates and future human capital demands. This was particularly true for healthcare when Medicare and Medicaid were instituted.

During the Administration of John F. Kennedy (1961-1963) the middle class swelled, as did Gross Domestic Product and productivity. The U.S. underwent a kind of golden age of economic growth. This growth was distributed fairly evenly across the economic classes. Lyndon B. Johnson (1963-69) began new social programs such as Medicaid and Medicare. Labor Unions still had a strong influence on policies after the 1950's, after they peaked in membership. A collective demand for healthcare benefits from their employers combined with the induction of national healthcare system created an extraordinary, if not, unprecedented demand for healthcare practitioners of different kinds.

In the late 1960's, in what has been referred to as the fourth wave of Filipino mass migration (which came after the passing of the Immigration and Nationality Act of 1965), various other professions have been recruited to the United States to fill different professions. The initial migration of exchange Filipino registered nurses to the United States was the unintended, although historically significant outcome of U.S. cold war agenda and post World War II labor shortages. Particularly important was the establishment of the Exchange Visitor Program (EVP) through the Information and

Education Act. The primary purpose of the Act was to contain a "Hostile propaganda campaign directed against democracy, human welfare, freedom, truth and the United States, spearheaded by the Soviet Union and the Communist Parties throughout the world" that called for "dynamic measures" to disseminate the truth (Choy, 2003, p64). Ironically, the primary patrons of this program were those that already had pre-existing knowledge about and acceptable credentials in the United States rather than ones that were invited to know the "truth." Included in this lists were Philippine doctors, nurses, engineers, lawyers and military personnel.

Along with the cold war era and the Civil Rights movement came the Immigration and Nationality Act of 1965 and the fourth wave of Filipino mass migration or what has been negatively referred to as the 60's-70's "brain drain".

The Immigration and Nationality Act of 1965

The clauses of the 1965 Immigration and Nationality Act were an offshoot of the Civil Rights Act of 1964 which states under **SEC. 201. (a)** All persons shall be entitled to the full and equal enjoyment of the goods, services, facilities, and privileges, advantages, and accommodations of any place of public accommodation, as defined in this section, without discrimination or segregation on the grounds of race, color, religion, or national origin.

The Provisions of the Act eliminated the national origins quota system based on the Immigration Act of 1924 and the Immigration and Nationality Act of 1952. Under the earlier acts, national origin, race, ancestry was the basis for immigration to the United States.

The preference categories of the 1965 Immigration Act were initiated during the administration of John F. Kennedy, and eventually signed into law in 1968 by Lyndon B. Johnson. These preference categories included:

1. Unmarried adult sons and daughters of U.S. citizens;
2. Spouses and children and unmarried sons and daughters of permanent resident aliens;
3. Members of the professions and scientists and artists of exceptional ability;
4. Married children of U.S. citizens;
5. Brothers and sisters of U.S. citizens over age twenty-one;
6. Skilled and unskilled workers in occupations for which there is insufficient labor supply;
7. Refugees given conditional entry or adjustment — chiefly people from Communist countries and the Middle East; and
8. Applicants not entitled to preceding preferences — i.e., everyone else. (Center for Immigration Studies,1995)

The act was originally intended as a cold war strategy for attracting the best and the brightest from Communist ruled countries (which the Philippines was not) and not specifically targeting Filipino families wishing to migrate (Choy, 2003, p. 64). Nonetheless, the combination of various facets within this context eventually led to the fourth wave of Filipino Immigration to the United States. The combination of occupational preference (Sections 3 & 6) categories and family reunification clauses

(Sections 1, 2, 4, and 5) of the immigration act became a unique avenue for Filipinos professionals and family members in the 1970's.

Choy posits that things started to change after the enabling of occupational preference categories and family reunification clauses covered in the Immigration and Nationality Act of 1965. Choy notes that between the years of 1965-1988, at least twenty five thousand (25,000) Filipino Nurses migrated to the United States. By 1989, at its highest point, Filipino Migrant Nurses comprised seventy to seventy-three (70-73%) of internationally trained U.S. nurses (Choy, 2003, Spangler, 1992, p28).

By 1970, the new U.S. public law set new things in motion. Under the law, foreign residency requirements would be applicable in two situations;

First, if the exchange visitor participated in a program financed by the United States or his or her own government; and second, if the US Secretary of State designated exchange visitor's country of origin as clearly requiring the services of the exchange visitor at the time the visitor acquired his or her exchange status. Between 1966 and 1978, 7,495 Filipinos under the exchange visitor program in fact changed their status to become US permanent residents (Choy, 2003, p. 98-99). In comparison with other countries though why was credentialing and equivalency relatively easier for Philippine nationals? This is question answered more by historic national relationship, developed to developing economies relations and social behavior rather than national origin.

Professionals from the Former Colony

…two countries on the other side of the planet -- the Philippines and Indonesia. These neighbors both have large, poor populations and share many cultural similarities,

yet there are more than one million Filipino immigrants in the United States and only a handful of Indonesians, and annual immigration from the Philippines is routinely 40-50 times greater than immigration from Indonesia. On the one hand ties between the United States and the Philippines are numerous and deep, having ruled the country for 50 years and maintained an extensive military presence there for another 50 years. On the other hand, the United States has very few ties to Indonesia, whose people tend to migrate to the Netherlands, its former colonial ruler (Krikorian, 2005).

Some other historical factors that contributed to this accreditation of Filipino nurses were; First, the Philippines had retained and updated itself through the educational system, curriculum and even literature of the United States, its former colonist. Second, the Philippines had retained American English as a second language.

The implications of the former were that occupational specializations were defined and classified according to same criteria. Professionals (that progressed from educational specializations) in the Philippines, were given professional equivalency in the United States. Accreditation of profession in the 60's and 70's from the Philippines to the United States was uncomplicated and facilitated by the Exchange Visitor Program (EVP). Nursing sciences and practice was no exception to this rule and this transfer of accreditation was given a very specific yet peculiar title, "reciprocity." By virtue of reciprocity Filipino nurses were allowed to practice in the United States for one year prior to taking the local board's nursing license exams. The exam was broken into the sections of medical and psychology. After which, a Filipino nurse could continually practice

permitted that they, after five years, apply for permanent residency or in the 70's, an H1-B working visa.

The implication of the retaining American English as a second language was that Filipinos could communicate effectively with patients and within the US workforce.

Eventually, this gave a chance for family members who had already gained residency or citizenship through various "skills" or profession-related waves of migration to the U.S. prior to 1965 to file a legal petition for other family members to migrate under the family reunification clauses. The said members either qualified through (Sections 1, 2, 4 or 5) their relations or through (Sections 3 and 6) professional equivalency in the United States.

What was originally intended as a logical follow-up for civil rights legislation and a mechanism for indoctrination became the avenue for Filipino professionals and family chain migration into the United States otherwise referred to as the "fourth wave" of Philippine migration to the United States. On the other side of the Pacific, this coincided with the national conditions and encouragement of a historic push.

The Historic Push

In 1974, Former Philippine President Ferdinand Marcos encouraged the deployment of Migrants to assist the struggling economy. The framework for what became the government's overseas employment program was established with the passage of the Labor Code of the Philippines in 1974.

After Marcos was ousted by a non-violent revolution, dubbed EDSA revolution, his successor, former President Corazon Aquino declared that migrant workers were the

"*Bagong Bayani*" or New National Heroes of the Philippine Economy for providing the much needed remittances which contributed to the ailing Philippine Economy.

In more recent times, Gloria Macapagal Arroyo declares that nine (9) billion dollars of remittances from seven (7) million Overseas Contract Workers and Migrants contribute the Philippine Economy.

While the embattled Philippine economy has remained relatively depressed, politicians and the upper class elites have pre-occupied themselves with a differentiated and escalated blame game. In the meantime, emigration has played a key role Philippine economic narrative since the 70's to more recent years. In time though, the system that facilitated international registered nurse recruitment has become congested and ripe for abuse.

A Congested System Ripe for Abuse

On December 18, 1989, Congress passed the Immigration Nursing Relief Act.

"provides for the adjustment to permanent resident status of certain non-immigrants who as of September 1, 1989, had H-1 nonimmigrant status as registered nurses; who had been employed in that capacity for at least 3 years; and whose continued nursing employment meets certain labor certification requirements" (Consultwebs, 2004).

It exempted nurses H-1 (temporary working permit visa) nurses and their immediate family members from current immigrant visa numerical limitations and backlogs. The second major feature of the 1989 Act was the establishment of a complex, multifaceted attestation requirement for those U.S. hospitals interested in hiring new

nonimmigrant nurses. This feature required that these hospitals attest to a critical need for nonimmigrant nurses' labor, the absence of an adverse effect on the wages and working conditions of the hospitals' other registered nurses, the payment of the same wage rate for nonimmigrant RNs and other RNs similarly employed, and an active effort to recruit and retain American workers (Choy, 2003, p.186).

This short term approach to an otherwise historic trend and relationship effectively limited U.S. hospitals' recruitment of foreign trained nurses a decade before the AACN reported the nursing shortage. Congress members seriously took the opinion that changing immigration law to facilitate the use of foreign educated nurses is a short term solution" and the concerns of American nurses who claimed that hospitals don't provide an "environment that is conducive to safe, quality nursing practice and that retains experienced U.S. nurses within patient care." This effectively identified two roads that could not be taken, on the meso-level, facilitating and liberalizing the international recruitment capabilities of hospitals and on the legislative level, encouraging and finding ways and means for recruiting internationally trained registered nurses en route to becoming a long term labor force.

Regardless of massive volumes of available data on the shortage, the burden of addressing the shortage and proof fell squarely on laps of the private sector or individual hospitals. This gave rise to a fresh set of entrepreneurs that served the Human resource needs of different hospitals and healthcare facilities that took the actual burden away from the internal workings of the hospitals. The U.S. Government's prior need to monitor and control future migrations of foreign trained nurses to the US was essentially

relegated to individual hospitals and their internal departments. Hospitals relegated this task to less monitored agencies that coordinated with all the different institutions for processing the credentials and visa requirements of internationally trained registered nurses. Neither Congress nor the INS/USCIS had to change its positions and priorities particularly for nurses and immigration. Justifying the need became an individual hospital or Human Resource agency endeavor that simply fell in line with existing legislation and immigration priorities.

Cheryl Peterson, RN, senior policy fellow for international affairs at the American Nurses Association recalls the legislation and concludes it's not enough to just allow more foreign-trained nurses to work in the United States. "If we constantly pass legislation that provides short-term fixes to cycles of workforce demands, we never address the real problems."(Peterson, 2001).

On the one hand, the legislation improved the salary levels and working conditions since 1989. According to Legislative analyst's Office study of nurses in California, the average annual salary for a full-time nurse increased from about $52,000 in 2000 to $69,000 in 2006, an increase of 32 percent over the six-year period (NFAP, 2007, p.1). On the other hand, the shortage has persisted and the information is updated to the same message every year by the AACN since its worst recruitment decline in 2001.

One remaining fact is that despite the attempts to decrease the use of foreign nurses in the United States, the phenomenon of Filipino nurse migration has not abated (Choy, 2003, p187). The influx of Filipino nurses just kept coming through more short term and less stringent immigration avenues like tourism and the temporary working

permit H1-B process. The legislation also submitted Filipino Nurse Immigrants who kept coming to the United States after 1989 to abuses outside of the Act. Less than a decade after the maladies of the Act started to become more pronounce and more public. Take the example the case against Billy Denver Jewel, et.al:

On January 1998, Billy Denver Jewell, Holly Arthur Estreller Sidney and Veronica Hewitt and Haesok Kim pleaded guilty to illegally bringing in hundreds of registered nurses from the Philippines into the United States to work in convalescent homes and other medical facilities, expecting wages of $13 to $15per hour, these nurses earned as little as $5 per hour as nursing assistants.

Using the provisions of the 1989 Act, Jewell petitioned the INS and the Department of Labor for the use of Filipino nurses' labor in twenty nursing homes that he owned. However, the Hewitts and Kim recruited at least fifty of these nurses to work in medical care facilities throughout the country at substandard wages. The nurses paid Jewell $1,000 to 1,500 for each illegal visa. This complex system was profitable for Kim and the Hewitts because the Filipino nurse paid as much as $7,000 each to Kim and the Hewitts for these fraudulent visas (Seelye, 1998, Choy, 2003, p. 186).

From an economic perspective, muzzling the demand through legislation without due consideration of the existing massive flow of human capital eventually lowered one segments value in an already gendered and deprecated nursing labor force. This only set the precedent for an "invisible" segment of the labor force that settled for substandard salaries and working conditions given their disempowered conditions.

While the position against foreign trained nurses was held, the shortage persisted and worsened towards the new millennium. The short term rewards programs of higher salaries for those already in the industry eventually dissipated into what became the shortfalls of 2000-2001. Salaries though have improved since 2000.

Unlike those that became victims to the limits of legislation though, registered nurses who were able to practice legitimately were employed equitably. Ruth Levine, in a Department of Labor funded analysis qualifies the impact of foreign nurses on the United States registered nurses workforce. She concluded that "There was no evidence that the increased access to foreign nurses under the law had negative short term effects on the wages, benefits or working conditions in area hospitals… In addition and contrary to common beliefs, we found that foreign nurses were not paid less than US nurses (NFAP, 2007, p.1)."

The answer to whether foreign trained nurses (particularly Filipinos) were taking American jobs for lower compensation needed better qualification. Yes, they were foreign educated and trained registered nurses. Yes, they were getting less compensation for doing jobs that American's should be doing but no, they were not being hired as registered nurses.

In as much as precedent sections explain the precedent waves and problems surrounding International RN recruitment from the Philippines, this study is anticipating a worsening of the situation given what Catherine Ceniza Choy's depicts as an inevitable coming of a "Tsunami of Philippine Registered Nurses" to the United States and lack of movement on the immigration process. After 25 years of existence, the NCSBN began

the NCLEX testing in Manila, the capital city of the Philippines, at the international Pearson Professional Center on Aug. 23, 2007. Scheduling for examination appointments began on July 13, 2007 (NCSBN, 2007).

The second, as of the last update from the USCIS, Nursing immigration to the U.S. through Green Card sponsorship came to a halt in early 2007 because of Retrogression (backlog) in the EB-3 Green Card category. EB-3 or Employment Based categories are;

- Aliens with at least two years of experience as skilled workers;
- Professionals with a baccalaureate degree; and
- Other workers with less than two years experience, such as an unskilled worker who can perform labor for which qualified workers are not available in the United States.

While eligibility requirements for the EB-3 classification are less stringent than the EB-1 and EB-2 classifications, be aware that a long backlog exists for visas in the "other workers" category.

Retrogression occurs when there are more applicants than the number of visas available and then petitions either cannot be filed or cannot progress until more visas are available. The U.S. Department of State allocates 140,000 new Employment Based visas in total every year but, availability for applicants depends on applicant volume and processing times.

Taken for granted that the abuse of Philippine Migrant Nurses was the unintended consequence of short sited legislation in 1989, two questions remain:

1. How many internationally trained registered nurses are already in the United States?
2. Why are there more Philippine registered nurses still applying to become U.S. registered nurses despite legislative attempts to decrease the use of foreign trained nurses, current abuses and the risk of illegal stay?
3. Where are the effects of these macro-problems eventually manifested as conflicts?

How Many Internationally Educated Nurses – Origin, Quantity

In order to answer the first question, the first task was to collect data. For this study the task turned into turning the invisible into recordable populations.

Catherine Ceniza Choy posits in her book, Empire of Care that studies in the United States that lump Internationally Educated Registered Nurses from Asia, renders Filipino Nurse Migrants impersonal, faceless objects of study, an objectification that prevents an understanding and appreciation of these migrants as multidimensional historical agents and consequently hinders an identification with them as professionals, women and migrants (Choy, 2003, p.3). Arriving at the data is a fruit of two processes deduction and humanization. One is drawn from quantitative data and the other from a qualitative research.

An example of her contention on the Asian lumping of quantitative data about Filipino nurses can be seen in the invisible rendering of Filipinos in their racial classification as “Asian/Hawaiian: Other Pacific Islander (non-Hispanic) by the United State Health Resources and Services Administration (HRSA). What is ironic is that this particular general classification is the biggest nationality segment with Baccalaureate degrees (62.7%) of these “Asian/Hawaiian: Other Pacific Islander (non-Hispanic)” or those that have Baccalaureate degrees. There is no specific mention of Filipinos, except where it cites that “It should be recognized, however, that most Philippine-trained nurses (who are not classified in the statistics) had baccalaureate education as their initial nursing preparation. (HRSA, 2004)

There is little mention that a United States patterned baccalaureate degree is the only available degree in the Philippines when it comes to nursing sciences preparation. Consistent with Choy’s argument, Filipinos are classified as Asian/Hawaiians but rendered invisible for all their other attributes.

Collecting Representing Data

Collecting accurate data on Filipino Migrant nurse at the quantitative level like any other statistical collection is by qualifying a sample population.

Filipino Migrant Nurses generally go through a complex process of three (3) official doors or exams:

First, the Philippine Nursing Board Exams conducted by the PRC (Professional Regulatory Commission);

Second, the CGFNS (Commission on Graduates of Foreign Nursing Schools) exam; and

Third, the NCLEX-RN (National Council Licensure Examination for Registered Nurses) issued by the National Council of State Boards of Nursing (NCSBN) or what is more commonly known as the State Board Exams.

Because passing the NCLEX is usually the final step in the nurse licensure process, the number of applicants passing the NCLEX seemed an indicator of how many internationally educated nurses are gain their license to practice in the United States.

As of the 2003 data of the National Council of State Boards of Nursing (NCSBN), the number of licensed Registered Nurses in the United States was 3,210,456 individuals.

As of 2003 NCSBN data for 1983-2003, a recorded 42,766 Nurses Educated in the Philippines have passed the NCLEX.

As of 2005, Table 1 shows the relative number of Internationally-trained nurses form the Philippines in comparison to other countries' graduates.

In the last paragraph of a 2004 report by the Health Resources and Service Administration (HRSA) under the United States Department of Health and Human Services breaks down practicing international Registered Nurse by their country of education. The 2004 survey estimates that 3.5 percent of the RNs actually practicing in the United States (100,791) received their basic nursing education outside the United States mainland, not including the 0.3 percent received their initial nursing education in Guam, Puerto Rico, and the U.S. Virgin Islands or in unspecified States and territories. (HRSA, 2004)

The distribution and origin of internationally trained registered nurses that took the United States board exams for registered nursing (NCLEX-RN) in 2005 are seen in Table 1. Prior year's trends of Filipino Registered Nurses are seen in Table 2.

Table 1. 2005 First-Time Internationally Educated Candidates: Top Five Countries

2005 First-Time Internationally Educated Candidates: Top Five Countries (with respect to volume)1					
Volume	**Jan-Mar**	**Apr-Jun**	**Jul-Sep**	**Oct-Dec**	**2005 Total**
1st	Philippines 1,986	Philippines 2,320	Philippines 2,154	Philippines 2,721	Philippines 9,181
2nd	India 527	India 463	South Korea 461	India 844	India 2,282
3rd	Canada 325	South Korea 472	India 448	South Korea 506	South Korea 1,731
4th	South Korea 292	Canada 325	Canada 400	Canada 291	Canada 1,341
5th	Cuba & Nigeria 90	Nigeria 127	Cuba 138	Cuba 131	Cuba 464

In this table, the count of first-time internationally educated candidates includes both RNs and PNs.

The main countries where the highest number of these RNs received their education were: Philippines (50.2 percent of foreign-educated RNs) and Canada (20.2 percent) (HRSA, 2004).

Table 2. Annual Population of Filipino Registered Nurses over all Internationally Educated Nurses

YEAR	Pass Phil RNs	All Intl. Eds RNs	% Filipinos
	Total Filipinos	(Total Passed)	Int'l Educated
2003	5,052	9,264	54.5
2002	3,625	7,070	51.2
2001	1,957	4,256	45.9
2000	1,259	3,517	35.8
1999	522	3,041	17.2
1998	286	2,717	10.5
1997	1,717	6,574	26.1
1996	2,689	7,986	33.7
1995	6,526	11,068	59.0
1994	3,462	7,215	48.0
1993	1,860	5,596	33.2
1992	2,025	5,858	34.6
1991	1,971	5,523	35.7
1990	1,504	4,264	35.3
1989	1,503	4,203	35.8
1988	488	4,239	11.5
1987	1,014	2,751	36.9
1986	1,270	2,777	45.7
1985	812	1,974	41.1
1984	1,824	3,014	60.5
1983	1,400	2,564	54.6
Totals/Ave	42,766	105,471	38.4

According to the ANA, a much smaller percent of RNs received their basic nursing education in other countries such as the United Kingdom (8.4 percent), followed at a distance by Nigeria (2.3), Ireland (1.5), India (1.3), Hong Kong (1.2), Jamaica (1.1), Israel (1.0), and South Korea (1.0). An additional 12 percent of RNs received their training in 47 other countries. In contrast, in 2000, the Philippines (43 percent of foreign-educated nurses), Canada (16 percent), United Kingdom (8 percent), and India (10 percent) were the main countries of origin for foreign-educated nurses (GNA, 2004).

Between the surveys conducted by NCSBN to the HRSA on RN's, the actual practice the numbers seem to follow; three to four (3-4) of every one hundred (100) registered nurses in the United States are an internationally educated Registered Nurse. One to two (1-2) of every three to four (3-4) internationally educated Registered Nurse is a Filipino. One to two (1-2) in every one hundred (100) registered nurses in the United States is educated in the Philippines. One to two percent (1-2%) of registered nurses in the United States is a Filipino Registered nurse.

From a cursory look at the data as well, one would come to the conclusion that Filipino Registered nurses are staying longer in the practice, considering 38.4% passed the exam, and 50.2% are in the actual practice.

From a quantitative perspective then, there seems to be little chance the total of 3.5% internationally trained nurses could be taking the jobs of the 96.5% of the local registered nursing population. From all indications, the conclusion might be that they are

staying longer and augmenting the shortfall of an occupation that is suffering a slight retention and major recruitment issue.

In the midst of global competition for internationally educated nurses and the need for Human Resource benchmarking, though, there is great value in understanding the human stories behind the more general issues. Without an emic-based qualitative or narrative based study of workforce conditions, any attempt to address workplace issues that accompany the recruitment of internationally educated nurses as shown in the past will be at best superficial and ephemeral, at worst, racially differentiated.

Given an anticipated national shortage of 1,016.900 by 2020 as reported by the HRSA, the shortage shows no reprieve.

The context and quantity of Filipino Migrant Nurses in the United States may be partially explained but other questions remain unanswered;

2) Why are there more Philippine registered nurses still applying to become U.S. registered nurses despite differential legislation, current abuses and the risk of illegal stay and;
3) Eventually, where are the abusive effects of these macro-problems manifested as conflicts?

These questions were better answered by the nurses themselves and in light of the issues they face. It is at this level that guiding theories and frames become necessary.

Chapter III
Theoretical Framework

The presumption of conflicts analysis, and possibly, its transformation or resolution is that "an appropriate analysis leads to options for resolving or transforming a conflict from a disruptive, dysfunctional or destructive into a more harmonious, if not well-balanced relationship." A good resolution is derived from a good analysis. An emotionally balanced workforce is a more effective and efficient workforce. The approach can be seen from a mix of social work and human resource management.

This project did not begin as a study of history and economics of International Nurse Migration. It started as a humbler project that tried to understand and arrive at resolutions for conflicts and adjustment issues between individual Filipino registered nurses, their family members, and their social network, as they began their new lives the United States.

On one level, the theories used in this paper developed as counseled conflict conditions started to involve facts and facets beyond the intra-personal, interpersonal and micro-network level. Through case study and multi-level comparisons, larger and more historic forces surfaced as common experiences.

On another level, understanding the condition of Internationally-trained Filipino Migrant Nurses to the United States entailed the understanding of the various factors that

surrounded their very classification. They are Filipinos. They are Immigrants in various conditions. They are professional registered nurses. They are in the United States and not in another country. Majority of the population are female. It was important for this study to account for these different factors relate in different experiences and at different levels.

A Nested Approach to conflict authored by Maire Dugan accounted for the different levels that gave context to a conflict. It was the first theory used to inform the subject matter.

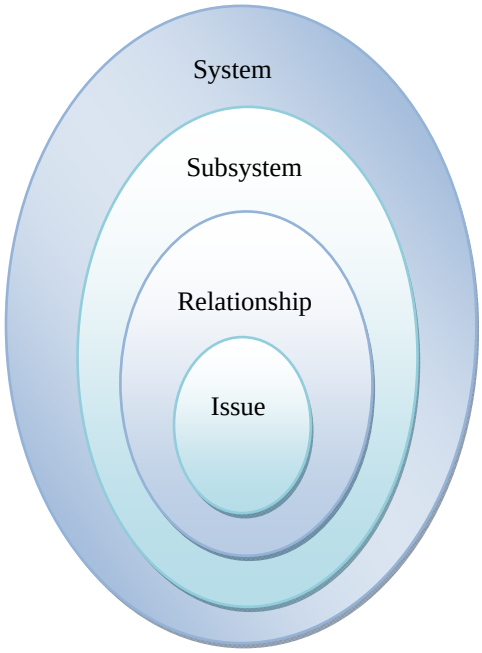

Figure 1. The Nested Paradigm of Conflict Foci (from Dugan 1996, Lederach, 2002)

The Nested Approach to Conflict

Maire Dugan presents a nested model approach to account for the role of the environment to a conflict. Cognitively constructed perceptions are not generated in a vacuum. There are realities by which these constructions are based or may even be contingent on. Macro-Systems, Sub-systems and Relationships play a small to large influence on any ensuing conflict depending on how these conditions are perceived. Maire Dugan's Nested approach to conflict does not presume that all issues are caused by systemic conditions, but that most conflicts occur within a larger context which may or may not act on the parties' perceptions and subsequent issues of conflict.

Decisions of interpreting and acting upon these external matters are still driven by an inter-subjective relationship between choice and circumstance or a process derived from the "the two distinct heads of nature and nurture" (Galton, 1874).

What influences the construction of meaning? A nuanced view of Culture and Social Identity formation explains how meaning is constructed, contrasted and mobilized in conflict situations. It is a branch of conflict analysis called ethno-conflict theory.

Culture and Social Identity

Kevin Avruch and Peter Black's ethno-conflict theory provided an anthropological parameter for analyzing the role of culture in conflict dynamics. The theory is based on certain axioms.

Social identity (race, ethnicity, nationality, caste, etc) is a social construction. Culture is always a lens through which differences are refracted and conflict pursued. Culture should not be mistaken for nationality, race or ethnicity which from history has

served to objectify a publicly projected political agenda rather than an anthropological observation. Culture is not a genetic manifestation but an expression of a perception of self and belongingness to a social group.

Culture is not homogenous, stable or singular. It is not only distributed socially across a population but is also psychologically dispersed across individuals within a population. Culture as well is situational, flexible and responsive (Black, 2003, Avruch 2004).

Culture ultimately provides individuals with a cognitive and affective framework, including images, encodements, metaphors and schema for interpreting the behavior of the physical and social environment, "socially inherited solutions to life's problems".

Applied to this study, immigration situations prove to be incongruent cognitive schemes for interpreting the new environment, especially, if negotiated with the new social setting. They give rise to moments of sharp relief where responses can often prove insufficient if not generate unintended side effects rather than readily solve or resolve life's problems. Specifically though, how does culture and the formation of a social identity affect the recruitment of internationally educated or trained Registered Nurses in the United States? Madeleine Leininger explains the relationship within the Nursing Profession.

Leininger's Sunrise Model of Transcultural Nursing

Summarized, Leininger explains that:

…the model symbolically portrays a rising sun…The model conceptually depicts the worldview, religion, kinship cultural values, economics, technology, language, ethno-

history and environmental factors that are predicted to explain and influence culture care. Thus it serves as a cognitive orientation to obtain a complete holistic and comprehensive way to examine the theory (Leininger, 1993, p26).

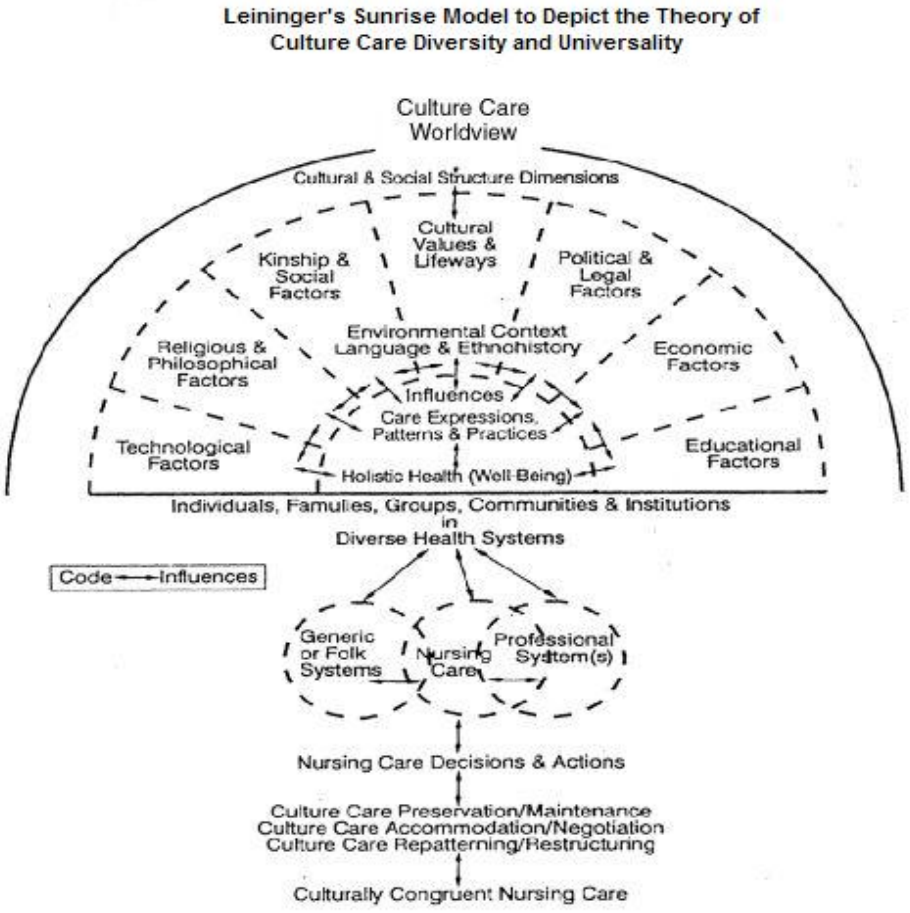

Figure 2: Leininger's Sunrise Model

Leininger referred to culture as the "missing link" in nursing theory, and determined that care and culture were inextricably linked together, and, could not be separated in nursing care actions and decisions (Leininger, 1988a, p.153). Culture is

always the lens through which differences are refracted and conflict pursued. All identities, all selves are multifaceted – being constituted in some mix of various attributes as well as those that are more strictly idiosyncratic (Avruch, eds. Cheldelin, Druckman, 2003, p143).

Particularly significant in the study of conflict were the last four stages of her analysis, namely:

1) Cultural care preservation or maintenance;
2) Culture Care accommodation or negotiation;
3) Cultural Care repatterning or restructuring; and
4) The formation of Culturally Congruent nursing care.

She defines **Culture care preservation and maintenance** as "assistive, supportive, facilitative or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant care values so that they can maintain their well-being, recover from illness or face handicaps and/or death."

Leininger uses a two-headed arrow to depict the interactive relationship between "code and influence." It accounts for the role of culture in the formation of new cognitive schemes and behavior that spans from client to individual, all the way to the adaptation of new culture care world views.

Leininger forwards definitions that guide her theory. **Culture care accommodation or negotiation** refers to those "assistive, supportive, facilitative or enabling professional actions and decisions that help people of a designated culture to

adapt to or to negotiate with, others for a beneficial or satisfying health outcome with professional care providers."

Cultural care repatterning or restructuring refers to "assistive, supportive, facilitative or enabling professional actions and decisions that help clients reorder, change or modify their lifeways for new, different or more beneficial health care patterns while respecting the client's cultural values and beliefs and providing a better or healthier lifeways than before.

Leininger posits that the three step preliminary process ultimately leads to the formation of **Culturally Congruent nursing care**. Cultural congruent nursing care refers to those cognitively based "assistive, supportive, facilitative or enabling professional actions and decisions that are tailor-made to fit with an individual's, group's or institutions cultural values, beliefs and lifeways in order to provide meaningful, beneficial and satisfying health care or well-being services.

Leininger's sunrise model provides the study with an industry based frame for understanding the role of culture. Listed in Leininger's major ideas is one on cultural conflicts encountered in the practice. In a more general sense, the model was designed to provide a guide for the study and analysis of the major variables found within different cultures in order to obtain a "Transcultural health care perspective of health-illness systems (Leininger, 1976, p.17)." With the idea of Transcultural health care perspectives is the idea of "Cultural care Universality" or the common, similar or dominant uniform care meanings, patterns, values, life ways or symbols that are manifested among many cultures and reflect assistive, supportive facilitative or enabling ways to help people,

another individual or group that are derived from a specific culture to improve or ameliorate a human condition or lifeways (Leininger, 1991, p.47)

Leininger posits that there are ways of renegotiating this culturally based need in place of values and beliefs which might be better (or healthier) lifeways than before (Leininger, 1993, p20).

The importance of culture cannot be underestimated in terms of international recruitment since the internationally trained nurses are complex cultural characters as much as they are cultural care providers.

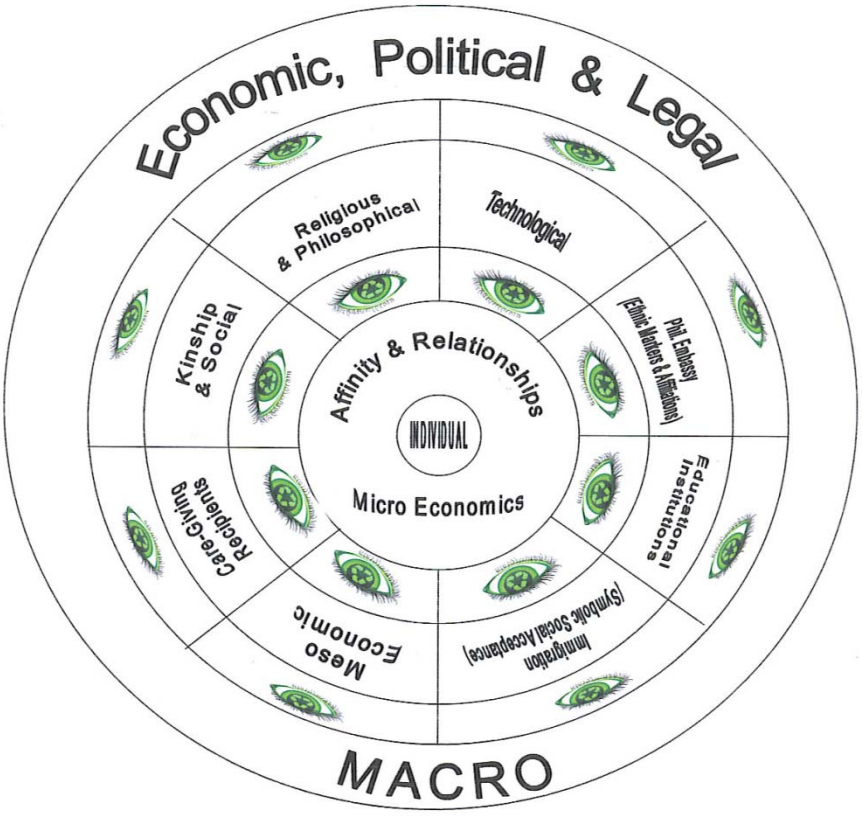

Figure 3: Nested Cultural Lenses Model

Nested Cultural Lenses Model

Culture is socially and psychologically dispersed across individuals within a population. Culture is not a genetic manifestation but an expression of a perception of self and belongingness to a social group (Black, 2003, Avruch 2004). It is this sense of self and belonging that is disoriented in the act of immigration.

Although culture should not be mistaken for nationality, race, the act of immigration puts culture into sharp relief between socially inherited solutions to life's problems which seemed functional just hours earlier before departure and negotiating with a new set of social parameters in a new environment. Since it is the cultural lens that mediates how relationships (from immediate family to macro economic, social and political) levels are perceived, it is also the lens through which differences are refracted and conflict pursued. Before latent and manifest conflicts can be observed and discussed, how first does culture play out in the act of Filipino nurse immigration. Zenaida Spangler Ph.D. R.N. examines this in Transcultural Care Values and Nursing Practices of Philippine American Nurses.

Transcultural Care Values and Nursing Practices of Philippine American Nurses

In 1992, Zenaida Spangler Ph.D. R.N., published a cross-cultural study titled "Trans cultural Care values and Nursing Practices of Philippine American Nurses" for the Journal of Trans-cultural Nursing. Using Leininger's sunrise model as a guide, the study focused mainly on the behavior of Philippine immigrant nurses then working at American Hospitals.

Spangler categorized respondents according to number of years they had lived in the United States:

A) less than five years;

B) between five to ten years; and

C) over ten years.

Here she observed three unique patterns namely:

1) An expressed seriousness and dedication to work;

2) Attentiveness to patients physical comfort needs; and

3) Respect and Patience as caring modalities.

In terms of expressed seriousness and dedication to work, Spangler posits that;

The Philippine-American nurses related that nursing, as a duty, was part of their school's enculturation. But their emphasis on duty and service was also undoubtedly influenced by their culture's hierarchical and authoritarian social structure where the common good outweighed the individual desires and rights. The Philippine-American nurse's dedication and commitment to service are consistent with Philippine cultural tradition which emphasizes respect for authority, social acceptance and communal interest.

In terms of Attentiveness to Patients Physical Comfort Needs, Spangler posits that: The Philippine-American nurse's "attention to patients" physical comfort to establish relationship was consistent with the self-giving cultural value of the theme *obligation to care*.

One Philippine-American nurse intimated that she was aware of the low status American nurses attributed to physical care. Z.R. Wolf posited that for American nurses, care involving the body was considered menial manual work with low symbolic prestige (Wolf, 1990).

In terms of *Respect and Patience as Caring Modalities,* Spangler posits that the Philippine American Nurse in her study cited the cultural values of respect and patience as caring modalities which they had learned early in life and which prevailed in their service to patients. All Philippine informants described how their families inculcated the value of respect when they were growing-up. The Philippine nurses learned these cultural ways of caring in the structure of their immediate family and society. Respect was shown in their tone of voice, in the careful manner in which they took care of their patients, in the way they addressed their superiors and at times by silence and not answering back.

As Spangler observed the respondents who had been in the United States for less than five years, were those that encountered the most conflicts with the host culture. Many, she says, were acutely aware of their foreign status. Several had hostile encounters with American born nurses and exhibited “fight or flight” responses.

Another more ethno centric study which focused more on the responses of Filipino Cancer Patients towards Filipino Nurses was conducted in 2007 by the team of Margaret T. Harle, RN, MSN, OCN, Rebecca F. Dela Cruz, RN, BSN, OCN, Guadalupe Veloso, RN, BSN, OCN, Julia Rock, RN, BSN, Jay Faulkner, RN, BSN, and Marlene Z. Cohen, RN, PhD, FAAN. The study was also conducted using Leininger’s major ideas

on trans-cultural nursing practices. Although lacking a comparative control group, there was sufficient data within that study to validate Leininger's theories on culturally congruent culture care values present both with the nursing professional and the patients.

On the one hand, as shown in the study, there were unique care-giving contributions by the respondents in the study regarding care-values infused in their practice. Spangler reports that these were behaviors and values derived from "how their families inculcated the value of respect when they were growing-up." The Philippine nurses learned these cultural ways of caring in the structure of their immediate family and society.

Since these values are generated outside the profession, and inside the family structure, this study aims to discover how and what factors in the migration process affect the family itself. In relation to prior theories and studies it initially asked;

1) How and under what standard is cultural congruence established;
2) How enduring can these care giving values be given the absence of origin country environmental reinforcement;
3) What value orientation coincides and what conflicts with the social and professional structure of the United States;
4) How are care values retained, restructured and repatterned when reinforcing social network or environment of the origin country is all but disrupted if not becomes totally absent in the process of immigration?
5) How can positive values be reinforced locally so that they contribute to the development of care giving modalities within the US healthcare industry?

To answer these questions there was a need understand the dynamics of the new social environment and the psychological stages of immigrant assimilation. The theory that guides Immigration conflict and adjustment stages comes from Carlos Sluzki's Migration and Family Conflicts frame of analysis.

Families and Migration – A Study of Immigration Adjustments and Conflicts

Carlos Sluzki's cross-cultural work on Migration and Family Conflicts in 1979 serves as a guide on psychological factors activated during the process of immigration. It serves to compartmentalize the varying stages of immigration adjustment and assimilation. He plots the stages by which these factors become activated and the dynamics of how they could lead to various conflicts either within the family or the workplace.

In the study, Sluzki categorizes migration adjustment into six major stages:

1) preparatory stage;
2) act of migration;
3) period of overcompensation;
4) period of decompensation;
5) re-equilibration; and
6) trans-generational phenomena.

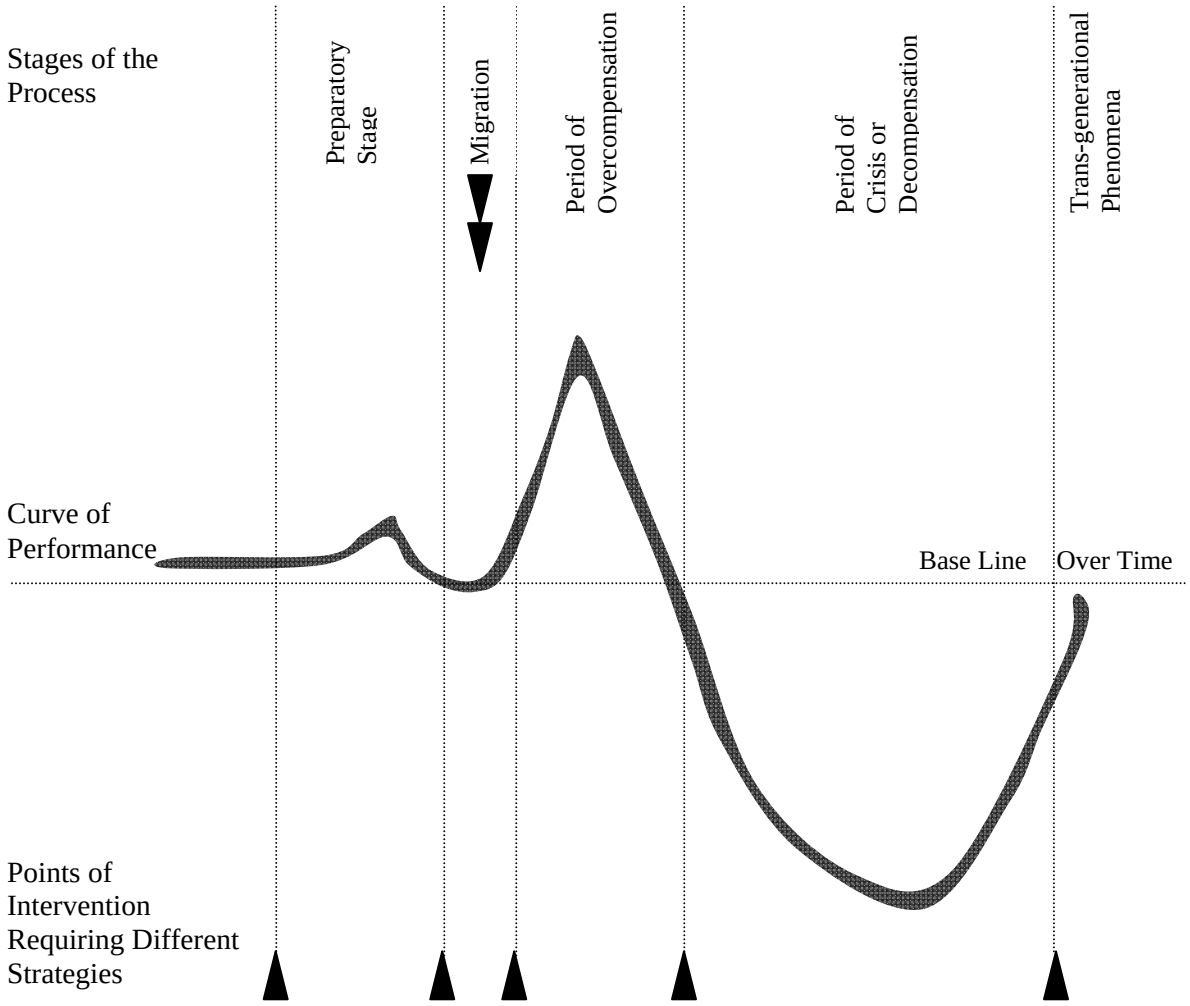

Figure 4: Migration and Stages

He qualifies that different families could undergo these adjustments at varying speeds. Some may have a compressed temporal appreciation of their situation and some may go into prolonged periods in one or another stage depending on various socioeconomic and psycho-social (class) perceptions and conditions. Each step presents

has distinctive characteristics, triggers different types of family-coping mechanisms and unchains different types of conflicts and symptoms (Sluzki, 1979, p 379).

Each step implies a normal level of conflict for the family, and each has the potential of triggering family crisis. The nature of the crisis depends on the family's own style and resources, and the presence of environmental support, or added strain (Sluzki, 1979, p 379-389).

Stage three or the period of overcompensation is a period in which a heightened task-oriented efficiency can be noted, aided by a strong increase in the split between instrumental and affective roles or between servicing basic survival needs and adaptation in an environment that is for most part alien. The cumulative effects of this stage are felt much later in the migration process (Sluzki, 1979, p.384).

Of all the stages, Sluzki differentiates the qualitative value of Stage 4, the period of decompensation. He posits that this is normally a stormy period, in which conflicts, symptoms, and difficulties abound. The majority of the migrated families that are brought to the attention of family therapists can trace back their problems to this phase of decompensation. In it, the main task of the recently migrated family takes place: that of reshaping itself in its new reality, maximizing both the family's continuity in terms of identity and its compatibility with the environment. These two facets of the task sometimes compete and require a reasonable compromise for their accomplishment. It is indeed necessary for adaptation to retain certain family habits, even though they differ from those of the new context, while “getting rid” of other traits because they go too much against the grain of the culture of adoption or because they would require an

extended family no longer available. It is at this phase where the families feel a cumulative sense of mourning of what has been left behind and integrate constructively into a blend of old and new rules, models, and habits that constitute their new reality. The balance is delicate and difficult to reach (Sluzki, 1979, p383).

Respondent's stories revolve around the various points of "balancing" that they went through in the immigration process.

On the one hand, Sluzki, much like Spangler's study, laid the foundation for temporal classification of subjects. On the other hand, as Sluzki posited some migrants suffer long term psychological consequences of the initial stages of migration long after their departure from origin country and some adapt relatively conflict free. Although perceptions of time may be compressed or expanded and rates of adjustment may vary in their long-term impact on family dynamics, Sluzki observed commonalities of emotional impact at each stage.

For this reason, temporal classifications served a valuable yet flexible guide for understanding the phases the respondents were confronting. The appropriate methodology for the research was informed by the need to understand the specific contexts by which Filipino Migrant nurses immigrate to and adapt in the United States.

Summary

Maire Dugan identified the conflict divisions between forces. Avruch and Black posit how culture functions as a lens through which we go about solving life's problems. It is a cognitive guide by which we engage the process of social exchange. Leininger posit how Technological, Religious, Kinship, Cultural Values, political legal, economic,

educational factors affects and influences society's and the individual's care-giving modalities. These are facets that are configured differently from culture to culture, individual to individual or origin country and the destination country.

Caught in a situation where there is an absence of social and environmental stimuli and response for origin country modes of behavior, the respondent tended to react through two modes; 1) limits social interaction to a more successfully negotiated relationships; 2) confronting perceived rejection from an expanded social network. The phenomenon is commonly referred to as a "fight or flight" response.

In this new setting, Sluzki writes of the compression leads to an overload of the new social network and the nuclear family. Sluzki observed that latent and manifest conflicts were found around the different phases of immigration adjustment but most pronounce in the period of decompensation. At this phase, there was a sense of cumulative mourning for lost social networks (which includes micro-macro social network), and the ability to conduct one's life based a set of behaviors and habits guided by more cognitively consonant norms, rules, models. The loss of this leads to variable kinds of affective disorders ranging from depression to aggression.

The questions then remain; what cultural lens was used and why does it become less effective in dealing with the new environment? What sets of meanings were attributed to certain events phases and why? How do these attributions become the raw material for escalated conflicts? Finally, how can these conflicts be transformed into

more constructive micro-meso and macro relationships between the individual migrant and his/her new environment?

Chapter IV
Research Methodology

Rationale

Catherine Ceniza Choy posits in her book, Empire of Care, that studies in the United States which lump Internationally Educated Registered Nurses from Asia renders Filipino Nurse Migrants impersonal, faceless objects of study, an objectification that prevents an understanding and appreciation of these migrants as multidimensional historical agents and consequently hinders an identification with them as professionals, women and migrants (Choy, 2003, p3). This in fact is can be seen in the invisible rendering of Filipinos in their racial classification as "Asian/Hawaiian: Other Pacific Islander (non-Hispanic) by the United State Health Resources and Services Administration. What is ironic is that this particular general classification is the biggest nationality segment (62.7%) of these "Asian/Hawaiian: Other Pacific Islander (non-Hispanic)" or those that have baccalaureate degrees. There is no specific mention of Filipinos except where it cites that "It should be recognized, however, that most Philippine-trained nurses (who are not cited in the statistics) had baccalaureate education as their initial nursing preparation.

There is also little mention that a United States Patterned baccalaureate degree is the only available degree in the Philippines when it comes to nursing preparation. In

accordance with Choy's argument, Filipinos are classified as Asian/Hawaiians but rendered invisible as South East Asian, Filipinos.

International recruitment especially the recruitment of internationally educated registered nurses is by its nature a multidisciplinary endeavor. Other disciplines that might take an interest in the study would include; Organizational Behavior delves into the cross cultural behavior in a diverse workforce. Industrial Labor Relations tackles the class interests of nurses in the workplace. Human Resource Management in the midst of a shortage has very little choice but to understand the intricacies of international recruitment. Healthcare Management is always in search for benchmark cases for which to base its mission and vision on. Global Economic Studies can shed light on the economic advantages and disadvantages offered by movement of workforces and capital (both human and resource) between nations. Migration Studies can shed light on the different historic patterns which explain if not shows possible futures for immigrants and the nations that utilize their skills and services. Because Registered Nursing is a female dominated industry, Feminist Studies could look into disempowerment issues that have historically plagued the nursing industry, especially the immigrant population. Finally Conflict Analysis and Resolution, analyzes and potentially forward options for resolving some of the conflicts that surround the issue of the recruitment of Internationally Educated Registered Nurses.

Especially in care giving professions, care values that drive behavior become a tangible resource. Without a qualitative or narrative based study, any attempt to understand and address recruitment, workplace and immigration issues simply from an

economic supply and demand of human capital perspective tend neither to capture the long term social implications of international recruitment nor the individual impact of such a phenomenon. Ultimately, the solutions based on limited understanding fall short of sustainable results.

A Qualitative Approach - Research Design and Strategy

Given the need for a thick description of circumstances and conditions, a flexible design using semi-structured interviews, case-study, participant observation and secondary data gathering procedures were employed. The methodology also provided flexible follow-up questions and great latitude for clarifying critical issues.

The collection instrument is structured into five (5) different levels:

Level 1– Historical;

Level 2 – Point of Encounter

Level 3 – Cognitive Repatterning and Restructuring;

Level 4 – Frame and Strategy Pre-evaluation; and

Level 5 – Social Externalization

Level 1 was designed to gather data on circumstances of migration. Level 2 was designed to parse out meaning given to these circumstances of cultural encounter. Level 3 was designed to determine how these meanings were acted upon. Level 4 allows the subject to self-evaluate based on history whether, he/she is adapting new strategies or simply repeating old strategies. Level 5 allows the subjects to socially impart a major migration lesson either based on a positive or negative personal experience.

Research Questions

The fixed interview questions were as follows:

Level 1– Historical

1. When did you come over to the United States?
2. Why did you move from the Philippines?
3. Why did you choose the United States?
4. Narrate the process you went through.
5. Where did you go as you got to the United States and why?
6. What were your expectations for or from various groups as you got to the United States?
7. Describe the conditions you encountered in (Specific Place and Conditions).

Level 2 – Point of Encounter

8. Were there particularly positive experiences you encountered?
9. Were there stressful conditions that stood out when you moved?
    - Please explain why these situations were particularly stressful?
    - How did these conditions come about?
    - How did you deal with these situations?

Level 3 – Cognitive Repatterning and Restructuring

10. What are your expectations now as compared to when you first arrived?
11. What are your plans from this point onwards?
12. How do you intend to accomplish these plans?

Level 4 – Frame and Strategy Pre-evaluation

13. What are the particular conflicts that stand out in your life today?
14. How do you currently deal with these conflicts?
15. Please narrate the advantages and disadvantages of this approach.

Level 5 – Social Externalization

16. What lessons and insights can you share with other Filipino Migrant Nurses who are about to embark on the same journey?

Follow-up Questions

17. Clarificatory questions pertaining to certain events throughout the interview included;
    - How did this make you feel and why?
    - I realize the difficulty of revisiting these events given the conditions you went through. This is how I understood what you said. (researcher's interpretation) Please correct me if I've mistaken anything.
    - In your opinion, how could the situation have gone differently if not better?
    - How do you expect to resolve the situation in the future?

Written transcripts were made of all interviews.

Determining Comparable Profiles

In terms of networking, some level of snowballed affinity or character endorsement was required to establish rapport. The cases were compared at multiple

levels, depending on their interpersonal, intra-personal, social, economic and psychological complaints.

A survey questionnaire was first given to a wide variety of Filipino Migrant Registered Nurses through the internet. The questionnaires originally comprised of one page of demographic questions. Since the design involved some level of participant observation, proximity to Virginia or long term access to the respondent was a selection criterion. The surveys were sent out to serve as a demographic classification tool for ruling out excessive subjects rather than as a data gathering instrument.

The cases were initially classified using their demographic profile and complexity of migration issues. Age, gender, civil status, number of children, and their children's age were also considered facets of the subjects' profile. More categories were employed to give context to situated meaning and other questions as they became relevant to the subject and the study.

These categories included number of extended family present in the United States, specific relationship with these family members, the subject's sibling order within the family and years or practice in the Philippines and the United States as a registered nurse.

The final criteria for selecting respondents included complexity of cases and willingness to share information (Yin, 2003, p79).

Limitations and Access to Information

The study limits itself to the stories of eight (8) Philippine immigrants and their family's experiences. The primary respondents were the nurses themselves and if applicable, their partners.

Other immigrants may or may not share the same experience and perceptions. Since the work of differentiating individual cultural appreciation and experiences of individuals proved enough of a challenge, the study of other professional and national groups begs further studies.

My base of research is Fairfax, in Northern Virginia. It is located in the East Coast roughly 20 miles West of Washington DC and the study ran on limited finances. For this reason, trips made to different parts of the United States and the Philippines in as much as they might have been needed, were fairly limited. There were twelve (12) individual sources of information. Most were interviewed within concentrated four hundred (400) mile radius of Northern Virginia. Some of the respondents were selected because they had undergone various stages and different places for migration. This provided a sufficiently thick description of the immigration condition of Filipino migrant nurses despite limitations.

General respondents came from as close as New York City to as far as San Diego California. Other people contributed their inputs but only in a consultative manner. Such people were involved with the Philippine Nursing Association in America in New York, New York. Another was a former member of the Philippine Regulatory Commission in the Philippines, but currently does not serve an official post.

Language

The languages used for the interview were Tagalog and English. In some cases, conversational Cebuano was also used. There are varying cultural influences and levels

through which individuals expressed themselves. Speaking in two languages served as valuable data gathering tool.

Willingness of Human Subjects

The subjects granted permission to conduct in-depth interviews and participant observation. Week long visits or re-visit with subjects were intermittently permitted. This also allowed the respondents to explain the context or structural problems that surrounded their situation and how these conditions were being addressed.

External Validity

Multiple sources, documents, other literature, interviews and archival records were used. They served to verify and triangulate findings, formulate analysis and conclusions, ultimately establishing external validity.

Internal Validity

Preliminary findings were returned to the subjects and consulted with key respondents of the nursing industry for verification in the research to establish internal validity.

Alternative explanations to the observed phenomena were also consulted and re-consulted with key respondents and participants throughout the study.

Frame of Analysis

Particularly important in the field of Conflict Analysis and Resolution is the need to differentiate the cognitive scheme of the conflict participant and adapted frames by the intervener that are forwarded as modes of transformation or resolution. The differentiation of the etic and emic perspective clarifies whether the cognitive frames

were those mobilized in the conflict or those that are seen by an observer. The emic frame identifies and uses the native term or institution as the key organizing concept for description and analysis. The etic approach is the identification and use of underlying, structurally deep and trans-cultural forms, expressed in terms of certain descriptors that are putatively capable of characterizing domains across all cultures (Avruch 2004, p60-63).

Asking when and how these conflicts materialized led to the identification of key events and themes, namely; Social Network Loss; Social Network Reconfiguration; Establishing a functional social identity; Acculturating to America; Acculturating to Local Practice; Acculturating to Local American Practice; Acculturating Family to Local family structures; Gaining opportunities to attain aspirations; Shocked by Profession; Shocked through Class Perceptions; Shocked by Reference Groups and Local family structures; Dysfunctional Individual Adjustment and ultimately Dysfunctional Local family adjustment .

1) Social Network Loss
    a. Leaving family in the Philippines
    b. Death of Family back in the Philippines
    c. Having no close friends in the United States
2) Social Network Reconstruction and Reconfiguration
    a. Communicating back with the Philippines
    b. Living in another country with no relatives and no help
    c. Finding an alternate Support Group

3) Establishing a functional social identity

   a. Navigating through the legal immigration process

4) Acculturating to Local Practice

   a. Establishing or re-establishing a career Conflicts with employers

   b. Discrimination

5) Social Network Reconstruction Failures

   a. Support Group failing to deliver

6) Acculturating to America

   a. Invalidation based on differences

7) Acculturating Family to Local family structures

   a. Gendered Role Modifications

   b. Acculturating Family to Local family structures - Managing Family Culture Shock

   c. Acculturating Family to Local family structures - Raising a family in a new environment

8) Gaining opportunities to attain aspirations

   a. Getting their first job

9) Shocked in Profession - Losing Job

10) Shocked through Class Perceptions - Conflicted Class perceptions

11) Shocked by Reference Groups and Local family structures - Conflicts with extended family

12) Dysfunctional Family Adjustments

a. Communication Breakdown between partners
b. Communication breakdown between Immigrant and Philippine Family
c. Domestic Abuse
d. Infidelity
e. Hostile nuclear Family Relations
f. Hostile extended Family Relations
g. Intergenerational Conflicts
h. Compulsive behaviors
i. Displaced (verbal and physical) Aggression
j. Various cases of Depression
k. Alcoholism
l. Pathological Deception
m. Financial Management Problems
    i. Major Credit Card debts
    ii. Shopping Compulsion
    iii. Premature Home purchases
    iv. Status symbols acquisition

The interviews were then revisited to analyze how these events were individually framed. Cases were compared for analysis and common conflict conditions led to the etic identification of more general frames and models that could be used to understand and deal with the Filipino Migrant issues.

Chapter V
Stage 1 - Coming to America

Relative Gaining and Losing

The initial adjustment phase of Philippine Nurse Migration centered on the loss of past condition was concentrated around the first five years after arrival. It was characterized by a trial and error process of, calibrating social-interaction skills, establishing professional equivalency, seeking out means for physical well-being and most importantly, social network reconstruction. After some five to ten years, the respondents started to adapt and accept their conditions. They thought less about past life conditions (e.g. a more complete social network, lack of needed resources, etc). Described and illustrated below are various points of conflict and distress encountered in the process.

The task of reconstructing the personal *social network* proved to be the most challenging for the migrant nurses. The *social network* can be defined as the sum of all relationships that an individual perceives as personally relevant, or the collection of social ties that differentiate the individual from the anonymous mass of "the others", contributing to the individual's sense of identity, well-being, competence and agency, including his/her health-related practices and adaptations during crisis (Sluzki, 2008, p.3).

Carlos Sluzki explains the vacuum of social networks as a major challenge to incoming immigrants;

Trans-national immigration will launch people into a socially stressing situation while dramatically disrupt and impoverish the social cocoon of the individual, his/her main support system, that is his/her personal social network. People necessarily leave behind a good part if not all of their social support, including their extended reference group of friends and acquaintances, the relationally soothing world of the extended family, and not infrequently their nuclear one, spouse, parents, siblings and offspring. They leave behind a familiarity of environment, customs and people whose presence was taken for granted all their life, and in that way leave behind part of their history, their memory and their identity.

Upon arrival, the respondents recall feeling surprisingly lost in the new environment. "What caused emotional distressed and occasional relational instability throughout the process of immigration?" This question was easier answered through an understanding of **relative deprivation.**

Relative Deprivation - Definition

Ted Robert Gurr defined *relative deprivation* as "the actor's perception of discrepancy between their value expectations and their value capabilities or a negative discrepancy between legitimate expectations and actuality." A person's point of comparison for values may be his or her own **past conditions, an abstract ideal or standards articulated by a leader as well as a "reference group** (Gurr, 1970, p24-25)."

Gurr surveys the responses to the frustration induced responses to relative deprivation. They include; **submission, dependence, avoidance, regression, fixation, resignation and finally aggression** (Gurr, 1970, p34). As observed in this study, these

adaptive mechanisms were all used to respond to the stresses of relocation and immigration. Gurr posits that, the frustration induced behavior or the response often become ends in themselves for the actors, unrelated to goal oriented behavior (Gurr, 1970, p274). Addressing the cause of these stresses becomes a more complex task.

The initial questions for the immigrant pertain to points of comparison. As posited by Gurr these are either past conditions, abstract ideals or standards were articulated by a leader or reference groups. How did these forces interact in the process of immigration? First of all, though, who were the active reference group and why were they so important in the RN immigration process?

Reference Groups and Immigration

Douglas Massey forwards the theory of circular cumulative causation highlighting the often ignored value of social networks against more individualistic and rational developing-developed motivations. Circular cumulative causation provides this study more details in explaining Philippine chain migration to the US.

Douglas Massey debunks the individualist assumptions of the most influential and widely used approach in migration, the individual cost-benefit model (Todaro 1989; Todaro 1986). He reveals that the assumptions of this model, in which migration decisions are based on the calculations of a rational individual who weighs her expected gains (e.g. employment or higher salary) against possible losses (e.g. deportation), are faulty. Rather than isolated agents, people are linked to one another through social networks. These connections have a ponderous effect on migration. The two central ways they shape migration include: 1) making migration less risky for individuals by

circulating information among potential migrants, and 2) feeding subsequent migration, since kinship networks allow migrants to send remittances home, making migration a viable household strategy for diversifying economic risk. Thus, the nature of migration changes dramatically over time. The initial associated high-risk declines for individuals as more of their family and friends migrate. This is because denser networks of migrants provide potential migrants with increasingly reliable information about the opportunities and dangers associated with the place of destination and the migration process (Portes and Bach 1985; DaVanzo 1978; Massey 1990; Stark 1991). People in one's network also offer needed assistance, such as helping one find a job or a place to live. This facilitates the choice to migrate, making migration progressively more likely, which is what Massey refers to as "circular and cumulative causation" (Massey 1990:4).

Actual respondents intimate how their own reference groups contributed and influenced their decision to immigrate to the United States.

Rosa

Rosa was 33 years old at the time of the interview in 2006. She got her Bachelor's degree in the Science of Nursing from Centro Escolar University (CEU) when she was 20. She passed her Philippine Board Exams on the same year that she graduated. She immigrated to the US in the latter parts of 1994. After more than a year of working in the US in various odd jobs, Rosa took and passed the NCLEX-RN on her first attempt in December 1996. She has been working as a nurse supervisor at various nursing homes in Connecticut since 1997. She has been married to husband Mike for the past nine (9) years. They have two children, Elian and Eliza.

Rosa traces some of her expectations from stories back in the Philippines. She explains that she had no intentions of leaving for America while her mother was still alive, because she knew that her mother was too frail to come with her. When her mother passed away in 1993, things started to change.

It was at this time that Rosa's father, who was an immigrant, encouraged her to go to America. He believed that since two daughters of his (Rosa and Vicky) were Philippine nurses, they would have no difficulty in finding work. He also believed that they would not have difficulty in getting their immigration papers. Rosa wanted to work on her relationship with her father who had been in America during most of her adult life. She was also going to the United States to experience the things she only heard about from other relatives and neighbors living in America who raved about their experiences. Life, as she expected, was going to be better than the empty conditions she knew after her mother's death. She expected to be reunited with a father whom she knew only from birthday and Christmas packages, and tape-recorded messages mailed to them. The father she only knew from the money that was sent to her mother back in the Philippines. In jest, she recounts that she expected to see this father will take her to Disneyland and Universal Studios just to make-up for all the years he had left them.

Terri

Maria Therese de Guia's case depicts a more active role played by her reference group that eventually led to her own departure. Maria Therese or Terri's story is that of a registered nurse with extensive experience as an Operating Room nurse in the Philippines. Terri's from Balagtas, Bulacan (an hour north of Metro Manila). She is 44

years old, the youngest among her six siblings and is married to Virgilio. She has two sons (Jojo, age 20 and Jerry, age 13). She served at the Bulacan District Hospital in the Philippines, as an operating Room nurse for 20 years. As of the interview in April 2006, she was working as a nurse aide for a nursing home in Bristol, Connecticut.

Terri was convinced by her elder sister in California and younger sister-in-law (Vicky Camacho) to come to the United States to reunify her family. Her husband who was held in high regard by his siblings was immediately needed in the United States to attend to a crisis involving his siblings. In the pre-departure stage, both threat to family separation and the opportunities available in becoming a US-RN, were pointed out by Terri's reference groups.

Terri intimates that she and her children initially had no reason to leave. Her husband had just arrived from a two-year contract from the Middle East, just four years prior, did not shake the stability of their family. She had a stable career, just bought a house and their son, Jojo, was about to go to college on a pre-paid educational plan. Terri's sister attested that, her husband's joining siblings in the United States, is a totally different situation and that her family would be ruined by it.

She recalls that, there was not much time to consider all the details of becoming a US-RN. The fact of the matter was that, Terri's sister-in-law, Vicky, was already a US-RN by 2003, despite her grueling beginnings. This was hard evidence that becoming a US-RN was possible. The line of reasoning was that Terri had been an Operating Room nurse in the Philippines for the past 20 years. According to her reference groups, there is no way she would fail the NCLEX-RN, get a well-paying job, and get her family

sponsored as immigrants. So, with a combination of threat to aspirations in the origin country (a metaphorical PUSH), and raised expectations in the United States (a simultaneous PULL), Terri's whole family departed for the United States in 2003.

This was the general understanding of the respondents prior to their departure for America. As Terri intimated, "*I sincerely believed then, that we were going to have a better life when I became a nurse in the US."*

New and old Social Networks as Reference Groups

This strategy relies on the assumption that migrants and non-migrants are linked through networks of obligation and shared understandings of kinship and friendship. These assumptions are not unreasonable, but shared understandings and obligation are likely to vary across members of a network (Massey, 1990, p3-26).

Although reasonable, there are variable ways of understanding modes of social exchange from one place to another. Kinship ties in the origin country may, or may not be, supported by the new conditions and resources in the destination country. Stripped of the contingent social network (i.e. the eldest brother who may have been the patron and patriarchal figure back in the Philippines, could be totally destitute and without influence in the United States). These are events and developments that are discovered and interpreted only when one arrives in the destination country.

Sluzki posits that, in spite of the fact that migration is usually the result of a collective decision, some people tend to be labeled as "responsible" or motivators of the migration. The anecdotes that consolidate roles of heroes and villains, victims and

perpetrators, remain frequently as family myths and appear repeatedly as themes of family feuds or as the unmentioned “skeletons in the closet” (Sluzki, 1979, p.381).

Terri took the NCLEX-RN thrice and failed to pass. She eventually had to take odd jobs that devastated her self-esteem. Her husband took a month and half long nurse aide program and their family of four had to live on his meager income after getting employed. The fees for taking the tests, and cost of living expenses, kept coming so they started digging early into their life savings. Her husband’s self-esteem was also devastated, because he felt he lost his comparatively high social status in the Philippines. Terri’s son, Jojo, could not get into college right away because of the time needed to certify his school records combined with the need to raise money for his out-of-state tuition.

All this disappointment and actual hardship, soon led to conflicts between Terri and her husband, and Terri and her son, whom she convinced to come. Terri went into a depressed state along with her son who shut the doors literally and metaphorically on his relationships including their extended family. This coincided with multiple social gatherings with the Filipino community, most of whom were registered nurses who were already established and practicing. Terri blamed her husband who was also going through his own esteem issues. Then, blame fell squarely on the original reference groups, particularly Vicky, for her role in the pre-emigration stages. Both sides put-up a defensive stance, and set-off a major conflict between Terri’s husband and her sister-in-law, Vicky, that manifested itself during a social gathering.

Although Massey's theory on circular cumulative causation was that the "strategy relies on the assumption that migrants and non-migrants are linked through networks of obligation and shared understandings of kinship and friendship." Oftentimes though, the difference in resource and relational expectations (often a toss-up between origin and destination country) led to a conflict centered on unmet expectations or unexpected arrival conditions. This was despite supposed "understandings" on obligations, kinship and friendship that fed only into the act of relocation. Although the function of the reference group mechanisms remains the strongest factor in circular cumulative causation, it is often, not a conflict free process.

In such cases, the original reference group that inevitably turns into the new and compressed social network, is not only overloaded, but ironically targeted and vilified for unanticipated immigration variables and conditions that were beyond their knowledge and control.

Relative Contentment and Reference Groups

During interviews respondents often remember a period of perceived **relative contentment** in the origin country. Relative contentment is a perceived state of satisfied needs and expectations or a positively evaluated value position. A segment of Terri's interview emphasized this difference;

TDG: *Failing the NCLEX-RN meant that I was respected, and wasn't a failure, only in the Philippines. My success in the Philippines is a failure here in the United States. I felt like a whole person already, and then I suddenly disintegrated. It was very hard to accept that. I couldn't accept that my professional journey was*

not yet done. Considering what was happening to my family at that time. That was the last bastion of my security. Back in the Philippines, we were content with what we had and where we were headed. I guess one, indeed, can't have it all. I think that was the most painful experience of my life… that after all the years of work as an O.R. nurse, the NCLEX-RN would evaluate and fail me. I blamed myself for aspiring for more and coming here to the United States. I consoled myself by thinking that maybe, it wasn't time yet. It wasn't my time… It wasn't charted out for me to succeed. I always console myself with that thought.

Why then, does one immigrate away from a state of relative contentment? Gurr posits that "it is likely that perceived value potential is considerably more important than present value positions." The attained value position of a group may be quite low with respect to the value expectation. He concludes that it is ultimately value potential that determines present behavior (Gurr, 1970, p70)."

Applied to the immigration process, perceived value position is based on personally defined state where existing personal ecology of relationships are able to deal effectively social and environmental conditions in the origin country. An event or a mix of events, whether relational or social, continually acts upon this worldview in a less noticed balance. Balanced environmental exchanges and value positions or a state of relative contentment is often taken for granted until it is put conditions of sharp relief (i.e. immigration). The gap between taken for granted value positions and value potentials, otherwise called attainable expectations, become a discrepancy in the origin country because of interpreted events. The "gap" between what Sluzki views as "negative

motivations and connotations to leave the origin country and positive connotations of relocating to the destination country is then constructed." This gap is then perceived as bridgeable, through, the relative easy process of interviewing for a US visa and the cost of a plane ticket.

Aspirations do not evolve into immigration expectations in a vacuum. They normally had to be validated by the significant personal experiences of reference groups with links or actual presence in the destination country (e.g. travel agents, fellow nurses, trusted family members, etc). This personal links turns faint aspiration into justifiable expectations in destination country.

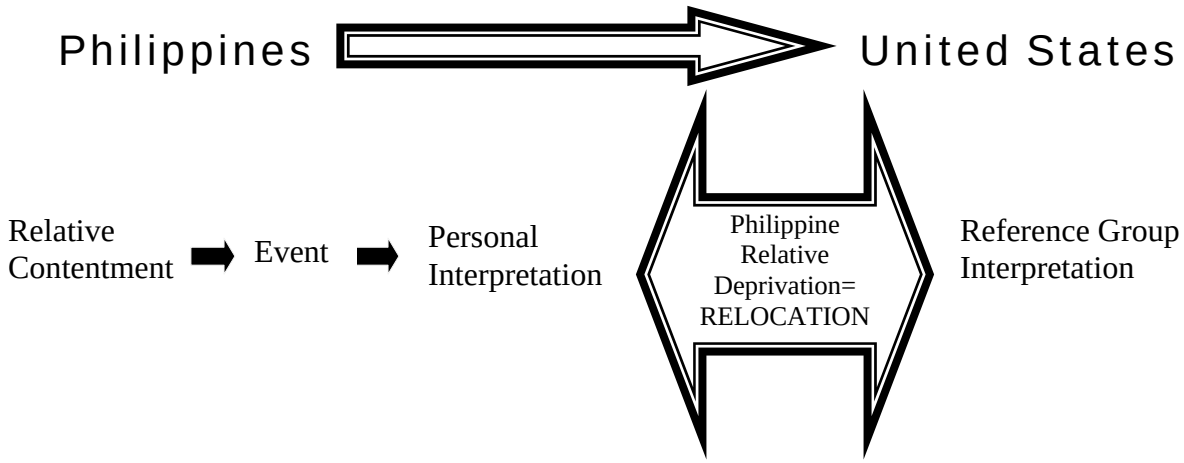

Figure 5: Relative Contentment of Immigration Model

Gurr posits though that in order for relative deprivation to be set in motion, faint aspirations have to be interpreted as justifiable expectations based on perceived value capabilities (Gurr, 1970, p27-28). A Philippine registered nurse must have some

significant evidence to believe that his/her personal aspiration could be justifiably expected through certain personal capabilities (i.e. RN credentials, nursing experience, relative intelligence, or a daring sense of adventure).

The two cases mentioned follow a general pattern seen in most respondents. Respondents spoke of certain stages encountered prior to their departure for the United States. There was a reframing of an individual's relatively perceived value position or state of relative contentment. The reframing was often contingent on an ambivalent event, a personal interpretation consulted with a reference group with associations to the destination country, a sense of deprivation based on the "gap", an agreement on an abstract ideal and an interpreted solution associated with a geographical location (i.e. relocate).

First, is an event that included, but not limited to; a nursing shortage in the United States; family difficulties in the Philippines; the retirement of a patriarch in the US or Philippines; a significant nurse getting her immigration papers, buying a house or simply gaining economic mobility; national deficits; ballooning national debt; runaway inflation; personal and family economic difficulties; political squabbling; death or loss of a family member; career stagnation or failure; a violent war in the home province, etc. As events, they served limited immigration significance until the second stage.

Second, is a personal interpretation of the event, either as crises or vague opportunities. On the negative, they included personal to socio-economic failures, all the way to the potential or actual loss of a loved one or social network. On the positive, news may be interpreted as reconstructed friendships, kinship ties and even personal

opportunities in the registered nursing profession. Mediating the second and third stage is a discussion between individuals in the Philippines and the United States that centered on ways of framing an event.

Third, is a reference group deficit interpretation associated with the origin country from personal, relational, social, political and cultural reason, which there was no shortage of. For this stage, agreement between the potential immigrant and reference groups proved most important. Reference groups provided a different frame for understanding and addressing events, happening some six thousand miles away, the most stark being geographical difference. On the other side of the Pacific, there was a need to verify the validity of aspiration with those that were already on the ground, so to speak. It is at this stage, that motives often get mixed-up with the need for specific details. With a mix of sympathy, encouragement, the desire to reunify one's family, empathy distress and sometimes the need to validate one's own existence in the United States, specific information (e.g. exact time needed to complete the permanent residency documentation), that may be of great importance to the immigration process was often overlooked by the reference group. The general idea revolves around the possibilities, considering more than two million Filipinos have been able to successfully immigrate to the United States.

On a more enduring basis, it coincides with Massey cumulative circular causation. The continuous reassurances that 1) made migration appear less risky for individuals by circulating information among potential migrants; and 2) feeding subsequent migration. Since kinship networks allow migrants to send remittances home, making migration a

viable household strategy for diversifying economic risk. Things don't always go as planned and responses can vary depending on situations.

Respondents reported varied reference groups. They included family, friends and relations, schools an individual applied for, employers, a travel agent, a recruiter, an authority back in the origin country, etc. All of them were assistive in the process of formulating expectation in the destination country. Some of the expectations were delivered, and some expectations were not depending on the context. Conditions that gave rise to conflicts paved a way of understanding another facet of Gurr's relative deprivation, particularly abstract ideals.

Abstract Ideals and Actual Conditions

The new environment became an imbalanced and frustrating mismatch between abstract ideals formulated in the origin country and the immigrant's lack of opportunities, their family's survival needs, and the new social network's ability to facilitate. The condition is particularly aggravated by extended periods of career options shortage, relative comparison between one's personal conditions against social circles, and the awkward need to examine and test new social network.

This period coincided with what Sluzki refers to as a period of overcompensation, particularly and heightened task–oriented efficiency aided by a strong increase in a split between instrumental and affective roles within a family, in the service of basic needs for survival and adaptation in an environment and a culture that is, to greater or lesser extent, alien (Sluzki, 1979, p382). What then drove this cognitive split?

Rosa explains how she reacted after being disappointed by affective and financial expectations about her father. Asked whether her father was able to deliver on her expectations, she answered;

RV: *No, he did not! Nothing happened! The only thing that fulfilled any expectations was that I could buy signature clothes. I could only afford clothes that didn't exceed ten (10) dollars for the longest time. Well, what do you expect for ten dollars? I couldn't rely on the quality. So there, I felt that compared to others, my clothes were inferior and I was inferior. So I vowed that when I completed the process, when I became a registered nurse in the United States, I would be able to achieve… everything I was expecting. I would be able to buy everything I wanted to buy.*

Despite gendered stereotypical notions about shopping, this all too common narrative, explained more about the need being satisfied in the act. A sense of social acceptance based on mythologies about America crafted in the origin country. Much like Terri and her elder sister, Vicky, Rosa could not confront her father about her frustrations because of kinship hierarchies inside the family. Rosa resorted to toning down her family expectations and submitted to wider U.S. mythologies.

Respondents intimate that abstract ideals kept them focused and emotionally detached from situations. They reported that, sustaining an instrumental-affective split is effective, for as long as the abstract ideals were not challenged.

Vicky

Vicky Camacho is a 43-year old Registered Nurse practicing in Connecticut. She is married to Marlon and has three children, Marivic, Melinda and Marlon Jr. She came from the first batch graduate second coursers in Nursing Sciences from Dr. Yanga Colleges Inc. in Bocaue, Bulacan in 1990. She currently serves three Nursing Homes in the Hartford and New Britain area of Connecticut. At the time of the interview in 2006, she had been in the United States for 11 years. She remembers the sense of loss she felt on her departure from the Philippines and the eventual considerations for pushing through with her trip to the US.

VC: *My daughter Marivic was only three (3) years old when I left her. I'm telling you, getting on the plane was the most painful part of the experience for me. I was a mother and a daughter, a wife, and lastly, an aspiring nurse in the Philippines. I left my daughter! I left my family. I was on the stop-over in Korea, when I called home… I cried the whole time. There were two doors. I had to choose between the arrival and the departure door. One was going to the US, and the other was going back to the Philippines. I prayed for the Lord to give me guidance on that moment. I was in tears over that decision. I wanted to go back home but I also thought about how much my father had spent for us to come over. That was what prevailed, so I got on the plane to come over here. When the plane took off from Korea and landed in Alaska, I realized how far the plane had gone. I couldn't go back anymore. I just stayed strong with the thought that I was doing all this for my daughter. I also thought that maybe one day our family would become*

prominent back in our small town… that some day, I would become well-known and respected back home.

While preparing for the NCLEX-RN, Vicky's father, who was one of modest means in New York, could not provide for them. Vicky took two jobs, as a pool cleaner and as a nurse-aide. She had to share their trailer home with her stepmother (whom she met for the first time) and two other sisters. Vicky is a diabetic and went into hypoglycemic shock in one of her jobs. After failing the NCLEX-RN once, she went into a depressed state and had a bout with alcoholism for a year. She recovered from this state when her husband Marlon and her daughter were able to get tourist visas to come to the United States. Vicky passed the NCLEX-RN on her second attempt soon after. After 13 years in the United States, her family finally got their immigrant visas in 2008. Throughout the years her marriage has been through volatile shifts and her family relations and career have gone through difficult transitions.

Rosa and Vicky's hard beginnings during a major registered nursing shortage in Connecticut, sheds more light on the all too common plight of internationally trained nurses in the United States.

Case 1 – Acute Care Procedures

RV: *Okay, so they started to orient me, but of course that was itself problematic because of the slang they used and the fact that English wasn't really my primary mode of communication back home. They put me in as a supervising nurse but I didn't even know how to speak in front of a group in English. Then, there was*

also the fact that I was the first Filipina to be employed at that nursing home. Aside from the fact that, it was the first time they were going to encounter Filipino accent, they were curious about what was expected of this… little girl, as they called me.

BJ: *Why, how old was everyone compared to you?*

RV: *They were much older than me. They ranged from twenty-five to forty, around that age. So, they were wondering what was expected of me. I was actually shorter and smaller than everyone else. So that added to it. And then metaphorically, I really felt small because I really had limited experience from the Philippines. The LPNs had more experience as a nurse in America.*

BJ: *And how was that experience for you?*

RV: *How was this? Oh my God! First it was ok, because there was somebody to orient you. So there was some form of guidance.*

BJ: *Who oriented you?*

RV: *An LPN.*

BJ: *So there was no steady Registered Nurse in the Nursing Home?*

RV: *There was nobody before me. That's why they desperately needed someone to take the job. So, they oriented me for about a month. And then, when I was by my self, when things started to happen. They say in the practice, that, it is when you're alone that something you don't expect will happen. It is then that you have*

cardiac patients or who had chest pains, at the same time a fracture also happens…so in that situation I didn't know what to do. I was new and I panicked. I was all by myself!

BJ: *By yourself?*

RV: *Yeah, I was the Nurse-in-Charge.*

BJ: *There were no other nurses?*

RV: *There were, but they were CNAs… I had to decide what to do. I didn't have anyone higher whom I could ask questions from. I hated having to make decisions. My decision making skills back then were bad in those situations… Even though I knew what should be done in theory, I still panicked. And then a person… a person in another unit, complained that I didn't know what to do in that situation.*

BJ: *So what happened?*

RV: *Yes, I didn't know what to do and I just wanted to leave that place at first.*

BJ: *I mean what exactly did you do in that situation when you had these simultaneous types of medical conditions?*

RV: *For the chest pain, I gave nitro. That I knew, and at the same time I had to … Nithrowave for chest. So I didn't really know the procedure after that… after giving that medication, what next? I didn't know that I was supposed to monitor every 5 minutes. I needed to check and see if the medication was having an effect*

on the patient …that was not even a consideration for me then because I really didn't know. There's really no perfect feeling, and then there was the fracture, I simultaneously had to address the fracture of the patient. But I also had no experience on what to do in America when there is a fracture.

BJ: *So according to procedures, what should you have done?*

RV: *You shouldn't move the patient. I was not oriented on that protocol. The person that oriented me gave me mostly briefing on medications. There was no orientation on the protocol for acute care. So, that incident got to the head of our department and they decided that I still need more orientations. So they put me back for… another month of orientation.*

Case 2 – Medical Error

VC: *So, I got a job in Lexington. After just two 2 weeks from the time I started...this was my first job as a Nurse, I had a medical error. The medication I gave to a patient led to a coma. I was very upset then because I would lose my license. I caused harm to a patient. I had a medical error two weeks into the job! Nobody wanted to accept me because the system is all connected to each other. There are also Filipinos here who spread the word once such a medical error happens. I didn't have a job for three months. Marlon had a job in housekeeping. We managed on Marlon's salary of $170 a week. Imagine…, our rent alone was 450 a month.*

BJ: *I know this must be difficult for you to revisit but do you still remember what how the medical error occurred? Did the patient make it out of the coma?*

VC: *Yes, the patient survived. What happened there was that the patient didn't have any identification. I was supposed to give the medication to the person in the room and he was the only one there. Basically, I gave the medication to someone else who was not supposed to be in that room. I was two weeks into the job and the person that oriented me let me go on my own.*

BJ: *How was this situation dealt with by the State Board of nursing?*

VC*: During my inquest, I told them that there was no identification on the patient but there was medicine allocated for the only person in that room. I was still, supposedly, getting trained. I was supposed to be under my supervisor. So they asked me if I asked anyone when I found that the patient had no identification. I said "no". That was where I agreed with them that I made the mistake. We have five rights in Pharmacology; the right patient, the right medicine, the right amount, the right route and the right time. I was pregnant then. I lost my second child. I had miscarriage because of the stress and the implications of the medical error on my family's future.*

Case 3 – Patient's Death

RV: *The CNA's normally didn't talk to me and when they did talk to me it's to make a decision … I was the RN and I had to know what was going on inside the building*

before I could make a decision. They don't even notify me… I eventually find things out during the evaluation when they need someone to blame. And then it's a big responsibility because, what if it were my life and the people in charge are not informed.

Like in one instance, one of my patients died. That patient was under my care, but was in another unit. By the time I checked on the patient, it was too late. There was blood on the covers. Obviously, for the whole shift, nobody even checked on that patient. With two units or 60 patients under me, if CNAs don't check on the patient, such things never get reported to the charge nurse. The events of that case justified terminating me from the job.

BJ: *What were the details of that case? Were you fired for that incident?*

RV: *Yes. What I think worsened the situation was that common Filipino reflex... You call the family in a time of loss which I should not have done. They saw the blood and they were traumatized by that.*

BJ: *They were traumatized…*

RV: *Yes, because the patient had blood all over the sheets. I also cried because he was my patient. That was the first time I saw my patient in that state and I guess I tried to share my grief with the family. Bottom line is I got fired.*

BJ: *What were the circumstances of the patient's death?*

RV: *The patient had Cardiac Arrest, at the same time, there was an open wound. So after the patient died, there was a profuse bleeding through the wound. The bleeding itself was not the cause of death but heart failure. So ironically, they fired me because the rule is not to bring the family in immediately.*

Such cases were often encountered during major RN shortages. The difficulty perhaps in applying abstract ideals or focusing on value potentials as a defense to feelings of loss, depression and deprivation was that they would eventually come face to face with circumstances that proved them achievable or not. Although the NCLEX-RN is conducted for the purpose of testing basic nursing knowledge, the conditions on the ground required way more local experience than was unaccounted for in the current credentialing process and lack of mentoring infrastructure. Respondents from the 90's to date give their various feed-backs on the experience of taking the NCLEX-RN.

Experience vs. Testing

Terri's four attempts at the NCLEX-RN is one of two cases of a more widely reported phenomenon. Registered nurses from the Philippines with longer years of experience have more difficulty passing an NCLEX-RN. Whereas the NCLEX-RN is designed as a basic knowledge and theory requirement for practicing as a US-RN, most experienced nurses in the Philippines have more complex knowledge and invested emotion in their practice in the Philippines that are not easily shaken off or set aside. Reconstructing or reconditioning a cognitive frame from years of experience became a

difficult process. There were two major differences between Terri's case and another experienced nurse, Nora.

Nora

Nora's story is that of a registered nurse with extensive experience in the Philippines and some in Botswana. Nora as she prefers to be called was born Maria Elnora Chiangco Tuazon. She was 53 years old at the time of the interview in 2005. She is the eldest among her six siblings. She has one daughter and one son by her ex-husband Wilfredo. She got her associate degree in nursing in 1975 and worked as staff nurse in Zamboanga del Sur immediately after. In 1990, she was being groomed to become an Administrator and the Department of Health Representative. The position required that she get her bachelors degree in Nursing Sciences and additional units for the position. She got her Bachelors in the Nursing Sciences in 1991 and got her Master's degree in Public Administration soon after. She also have a post graduate diploma in Sustainable Development from the United Nations Development Program nursing exchange program, while she worked as the Philippine Representative exchange student nurse in Gaborone, Botswana in 1997-1998. The last position Nora held was that of Chief Nurse of Aurora General Hospital in Aurora, Zamboanga del Sur. Chief Nurse or Director of Nursing, as they are called by the Philippine Department of Health, is the highest position a nurse can attain in the hospital set-up.

In as much as there was one common event, failing the NCLEX-RN, there were two relatively different aspirations, paths, ramifications interpretations and emotional states that followed.

Terri came to the US by virtue of the negotiated meanings between her and reference group (sister and sister-in-law) and the intent of improving her family situation. Nora came to the US with the intent of getting a slower paced job, after almost 30 years of service. Terri got a housekeeping attendant job in a nursing home. Nora got a job as an office assistant for a healthcare agency. Terri says that her worldview was shattered because of the odd jobs she took after failing the NCLEX-RN. Terri describes the experience; "it felt like heaven and earth had colluded against me". Nora says that, "I am contented with what I'm doing." Terri became depressed, recluse and avoided social interactions. Although occasionally experiencing seasonally influenced bouts of depression, Nora remains sociable and retains a positive attitude about her work and life in the U.S. Terri passed on her fourth attempt at the NCLEX-RN. Five years after, Nora is still considering taking the NCLEX-RN for the second time.

Nora's case proves most interesting with regard to the issue of mentoring. When asked what the source of her contentment was, she answered, "Because I'm serving in position where I'm needed." Nora first elaborated on the challenges (updating technological knowledge), limitations (giving authoritative instruction), and what she cannot do legally (e.g. touch the patient, sign for nurses, etc) as an office supervisor. She intimates that fresh registered nurse graduates constantly call her for consult on how to

perform basic procedures. She qualifies that RNs are presumed to know all the procedures and practice after taking a two year associate RN degree or a bachelor's degree in the US. But from thirty (30) years of experience, she intimates that she has had to guide RNs for over three years before they can become confident enough for all situations. She qualifies that the hospital she worked for in the Philippines was high traffic and toxic, so the turn-over rate was high considering options abroad. An on-call mentoring culture was the only thing that kept people in their positions.

Summary

Abstract ideals based on origin country mythologies temporarily ease feelings of oppression, relative deprivation and even drive an instrumental-affective split towards accomplishing objectives. The surrounding meso (passing the NCLEX-RN, statewide shortage, lack of mentoring program, etc.) and macro conditions (immigration quotas, economic conditions and priorities, etc.) though, ultimately determine whether they are achievable or not. The running paradox is that the bigger the "gap" or discrepancy between these ideals against the actual conditions, the more they tend to lead to a sense of rejection, depression and internalized oppression. The general themes of these abstract ideals were family reunification, professional acceptance and ultimately financial emancipation. These were abstract ideas promulgated by the Civil Rights movement that was eventually enacted in the Immigration and Nationality Act of 1965. These same abstract ideals are proliferated by reference groups who were either recipients or exemplars of the effects or simply wish it for their progeny, friends and acquaintances. Applied to current conditions, the intent of these historic events and acts has all but been

effectively blocked in the backlog of immigration quotas on both family and professional fronts.

On the micro level, feelings will tend to be, to say the least, internally discomforting and simply waiting for externalization in one of two ways. First, submission to obstacles and aggressively pursuing activities associated with social recognition and financial emancipation. Second, seek an external response targets that can be associated with feelings of deprivation. In most cases for the initial stages, this will either be the compressed nuclear family, partner or new social network.

On a systemic level, the irony from a nursing standpoint of course is that the NCLEX-RN is designed for US-RN beginners and the actual conditions require experience.

On a programmatic level, this has very little to do with race, culture or the fact that they are internationally trained. But that there are limited regulations, laws or even recognition of the importance of extended mentoring programs for incoming nurses that ultimately have larger scale implications on the U.S. nursing shortage.

In as much as retaining the abstract ideals or mythologies fed instrumentally practicing as registered nurses in the United States, most cases cross the line between a relative perspective and an actual condition of international trained nurse assistance, acceptance and mentorship deprivation in the United States.

It leaves disempowered internationally trained nurses who are currently in the United States, with pending immigration papers with one institutional response. They are

forced to submit to an industry that differentiates and vilifies internationally trained nurses and existing national legislation. This existing law buys into this idea of differentiation instead of addressing the nursing shortage issue that currently plagues the United States.

On the “other side”, there are internationally trained nurses seeking social acceptance through an economic system that appears to accommodate and satisfy more modest abstract ideals of the American Dream (the difference between developing country-developed country mythologies) promulgated in the origin country yet repressed in the nebulous initial stages of immigration. Overlapped against further stages of the immigration conditions, the runaway effects of are discussed in the succeeding chapter.

Chapter VI
Stage 2 Living in America
(Five Years and After)

"I became a monster because of what I had to endure in the process of immigration. I just look forward to the day when I can become myself again."

Respondent, 2005

To review, a person's point of comparison for values may be his or her own **past conditions, an abstract ideal or standards articulated by a leader as well as a "reference group** (Gurr, 1970, p24-25)." For the migrant nurse, awareness for past conditions could surface after five years, a twelve to sixteen hour plane ride, or even sooner.

On the one hand, abstract ideals as respondents intimated, energized their drive to achieve and overcome personal and professional obstacles. On the other hand, these ideals were often challenged by the gap or discrepancy of circumstances which led a set of responses and a depressive condition beyond their control.

The role of reference groups were emphasized in the earlier chapter, from the way that they contributed or inspired the act of immigration to being new comparison groups for evaluating current value positions in the destination country. They were also discussed as the well-meaning yet unwitting targets of palliative responses to relative

deprivation. The articulated beliefs, deeper past conditions, and values articulated and exemplified by a leader for immigrant nurses, are yet to be discussed.

Aside from the repressed abstract ideals that centered on financial emancipation discussed in the earlier chapter, there is something more complex that goes into the more long-term yet stealthy manifestations of relative deprivation, role behavior. Role behavior is an amalgamation of all these facets of comparison.

The Second Stage

The second stage of registered nurse immigration was characterized by:

- Gainful or adequate employment;
- Professional survival, focus and mastery;
- Reconstruction of a functional social network;
- Pursuit of extended and nuclear family objectives;
- A two shores formulation of abstract future ideals; and
- Formulation and pursuit of financial driven activities.

The personal complaints ranged from various forms of depression, compulsive aggression, marital miscommunication, manic shopping behavior, compulsive vacationing, credit and financial issues, and work difficulties particularly in keeping-up with extended work hours.

The observed manifestations of conflict were;

- Spousal abuse,
- Infidelity;
- Extended Family conflicts; and

- Inter-generational Conflicts.

For this stage, the means, becoming registered nurses in the United States puts the ends "having a better life" into question. In as much as the question of "at what cost" is put into contrast by the symptoms, the bigger question for this paper was what criteria are used for evaluating the life one eventually attains. Other theories and the story of the different respondents help answer this question better.

Role Behavior, Relative Deprivation for the Immigrant Professional

Pat Keith and Robert Schafer's 1985 study on the *Role Behavior, Relative Deprivation and Depression among Women in One and Two Job Families,* documents one major response to relative deprivation.

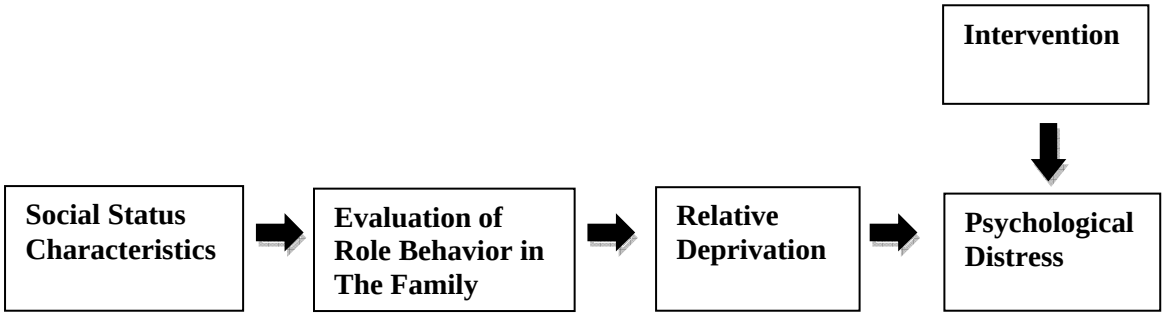

Figure 6: Keith and Schafer's
Model of evaluation of role behavior, deprivation, and psychological distress

Their research examined how assessments of role behavior in the family and relative deprivation in work-family situations were linked with depression among women in one and two-job families. Data was obtained from interviews with 130 homemakers and 135 employed married women. Evaluations of role behavior and relative deprivation

together, were more salient in fostering depression than were outwardly observable social status characteristics. They posit that, the study has implications for practice, since perceptions and subjective assessments should be more amenable to intervention than some of the more enduring status characteristics. The first stage is the person's perception of the environment. This included perceptions of how well women felt they filled various family roles, the satisfaction they derived from carrying out these activities and the amount of disagreement between them and their spouse over family roles. The second stage, then, that may intervene between status characteristics and well-being can be "labeled as the fit between the situation, as perceived by the individual, and the standard against which the individual measures that perception" (Marans and Rodgers, 1975, p. 302). At this stage feelings of dissatisfaction and deprivation, then, may emanate, in part, from a comparative process in which individuals evaluate themselves or their experiences relative to those of others (Crosby, 1982).

They theorized on the basis of the following three hypotheses:

Hypothesis 1: Relative deprivation suggest that feelings of deprivation and dissatisfaction are relative and not absolute (Crosby, 1982; Merlon, 1957), indicating that how individuals believe they fare relative to others may be more significant determinants of psychological well-being than are objective status characteristics.

Hypothesis 2: Perceptions of less competent role behavior, greater role disagreement, and greater dissatisfaction with roles would be associated with higher levels of depression.

Hypothesis 3: Perceptions of deprivation drawn from general social comparisons of work and family situations would go beyond the discomforts of feeling deprived to foster a response as severe as depression.

They qualify that competent performance of housekeeping tasks may be perceived to make little difference to mental health because of their low salience or unimportance to individuals. One study, however, found that almost one-half of the wives experienced role strain over the quality of their performance of housework and about three-fourths of a sample of both men and women placed a relatively high value on housekeeping and defined good performance as extremely or quite important (Slocum & Nye, 1976). When a role is defined as important, failure to perform it competently may be distressing, and more generally it has been theorized that role competency may provide psychological benefits within the family (Nye & McLaughlin, 1982).

Their findings reflect that negative evaluations of role behavior in the family were important enough to be linked with a response as severe as depression among employed women and homemakers, and attributions of relative deprivation also contributed to the distress of employed women. For the most part, evaluations of behavior in the family were more salient in fostering depression than were objective social status characteristics. Depression, they ironically concluded “occurs not when things are at their worst, but when there is a possibility of improvement, and a discrepancy between one's rising aspirations and the likelihood of fulfilling these wishes" (Keith and Schafer, 1985, p.232).

The succeeding stories illustrate how one stage of relative deprivation carries into another.

Rosa and Vicky

Rosa and Vicky who came in during a nursing shortage in Connecticut, faced the biggest challenges on the job. It came with a mix of a limited sense of professional direction and social legitimacy. In as much as they passed the NCLEX-RN and got their licenses, they came in as tourists so they still had to undergo the legal process of visa status conversion that was contingent on employer sponsorship. In the short term, they remember that getting their employment authorizations was easy enough when they passed the NCLEX-RN and got their nursing licenses.

They rarely thought, as they remember, of long term options because the process seemed too expensive in terms of legal and application fees and cumbersome both for them and their employers. Vicky admits that she hardly thought of it until her father brought up the implications on her daughter's collegial future.

The system of employment sponsorship was more complex and entailed multiple factors. There was a need for an institution that knew how to do it and would want to do it. An institution would want to do it for a specific registered nurse who was already in the United States given the impression that there would be alternative employees, and that the registered nurse would want to stay long enough in a particular institution for the duration of the sponsorship process. They state that it was better just to resign to the fact that it was not going to happen rather than feel disappointed.

Rosa and Vicky admit that considering the shortage, there were more than enough opportunities and offers for better compensation. They recall that higher compensation for the same job load was always an incentive for shifting from one employer to another. So this was how they engaged the profession at the time. When the offers flattened out, they simply took more hours.

After mastery of their professions and the daily operation of nursing homes, Vicky and Rosa started taking 72 to 80 hours per week between different employers. This phenomenon of overworked internationally trained nurses has been around for many years. The first respondent who reported this trend was Sylvia, a nurse who came during the 70's.

Sylvia and Ronnie

Much like most respondents, Sylvia follows a demographic profile that a good cluster of nurses share. Female, aged 20-35, married, and graduated from a Bachelor's degree of Nursing Sciences in the Philippines. Her husband, much like the rest, was a Filipino who immigrated either with or before her. Their common objective was to improve personal or family (nuclear or extended) well-being through comparatively higher wages or salaries.

Sylvia Castro is an occupational nurse for the World Bank in Washington, DC. She graduated for the University of the East in 1968 and has been in the United States since December 18, 1972. She is now a U.S. citizen. She is married to Esmeraldo (Ronnie) and has three children.

Their relative immigration process also falls along more general lines. They had an existing status in the Philippines. There was an event. The event was framed and interpreted to have implication to personal aspirations. They had a set of significant reference groups with either association and or experiences in a destination country. This reference group (either passively or actively) inspired the formulation of a discrepancy frame. This discrepancy frame or gap is individually or collectively addressed through relocation or immigration.

In 1969, Sylvia applied for the Exchange Visitor Program for nurses. In that same period, she discovered that she was pregnant with their first child, Eric. She did not want to give birth to her child in the United States, so she opted to postpone their departure until 1972.

In September of 1972, Martial Law was instituted in the Philippines through Presidential Decree 1081 and repressed press freedom. Under Martial Law, only a handful of news outfits were allowed to publish their newspapers. This affected the graphic arts, printing and printing machines business in which Ronnie's family was heavily invested. He had a potential career in this business as the chief sales representative. Sylvia was then a nurse assistant for a doctor's clinic at the time. As she narrates, she didn't want to go to the United States at first because she wanted to stay with her parents in the Philippines. Eventually, reasons to go outweighed reasons to stay.

Ronnie started moving on their US migration since Martial Law had disrupted their family business and stifled his sales opportunities. Sylvia also started considering migration which was widely popular among her nurse colleagues. She was in close touch

with her peers during that time and they relayed positive experiences from their stay in the United States. By 1972, her Exchange Visitor Program or J1 visa had already expired. So she applied through another program that granted the first H1 or temporary working visas.

Upon the advice of their founding Dean at the University of the East, Sylvia sought out positions in a Teaching Hospital in the United States. Her dean attested that there were wider potentials for learning and growth in such institutions. Such an opportunity presented itself in Touro Infirmary in New Orleans. As Ronnie narrates, by the end of 1972, their family of three was on their way to "improve their lives."

Under the H1 program, a nurse from the Philippines could work under reciprocity between the United States and Philippines for one year. Within this period, a Philippine registered nurse was required to take the State Board Exams if she had intentions of practicing longer. After passing the state boards, she could apply for permanent residency and practice mostly anywhere in the United States, through what she referred to as state-to-state reciprocity. She followed this process, and a year after passing the State Board exams in New Orleans, she was able to file for her family's permanent residency.

When the couple moved to New Orleans, Ronnie was holding a dependent visa and was not legally allowed to work. He did not work for the first two years in the U.S. He applied for work to a couple of places, but was declined because he was either over-qualified or did not have appropriate immigration documents. Ronnie narrates that anybody could be given a social security number in the 70's and restrictions were not as tight. So even if he did not have complete and legitimate documents that would entitle

him to work in his own field, he pursued job opportunities wherever they were available. After two years, he was able to get his social security number and was able to land a job at Orkin, a pest control company. In 1974, Sylvia's contract in New Orleans was up and she had the opportunity to move to a better position in Texas, so they moved.

In 1975, three years after their arrival, the couple started looking to buy a house in Texas. This desire to buy a house after a little more than two years in the United States pushed them to seek, if not maximize job opportunities and higher wages that would make the dream come true. Ronnie had started working for an Orkin branch in Texas and Sylvia started to take evenings to get higher pays from night differentials.

Ronnie recalls that he was ready to take on any job that was available in the market but he had difficulties telling his family back home about what he was doing. As he relates, the perception back home was that, "male or female, your parents put you through college to pursue a career, not get a job." Ronnie says that he had to "sacrifice" because they were then aiming to buy a house. He withheld being an exterminator from family back home. When asked, he often disguised and bantered that he had a "license to kill" which was subject to popular James Bond-like connotations for being a government agent. Ronnie never disclosed to his mother that he was an exterminator in America until she died. He said he could not explain it in way that she would understand.

He attributed difficulty in adjustment in the United States to his upper-class orientation in the Philippines. Under this type of upbringing in the Philippines, one would normally have helpers who take care of maintaining the house and cooking for the family. His role in the family was to concentrate on his education, find opportunities and

establish himself within his field or be of use to their family business. As he confides, he didn't mind that he was an exterminator or during periods of unemployment, cleaned up after his wife and children. Despite the shock from back home, he knew that it was an important part of their survival in the United States. It was negotiating Philippine-based expectations, which he admitted to having himself that was personally difficult. Then again, as he says, it was a sacrifice he was willing to make. The couple admits that this is a condition that came with its ups and downs for their relationship. In hindsight though, they resigned to the fact that this is the life they chose when they emigrated from the Philippines to live in the United States.

Sylvia emphasized that she made sacrifices during their immigration, but these sacrifices are better articulated by Vicky who is still coming to terms with the specific nature of her issues.

Vicky and Marlon

Marlon, Vicky's husband does a fairly good job at maintaining their household and Vicky has very little to say on that front. Vicky traces their difficulties from another aspect of the ideals she had set out to accomplish in the United States.

VC: *Marlon was also working, but I forced myself to work more. He asked me why I was working myself to death. He was concerned about me.*

I sent money back to the Philippines, and bought stuffs to put in the balikbayan box (cargo box) to send back to the Philippines. I also had the utang na loob

(debt of goodwill) to pay back my step-brother and his wife here in the US. Marlon knew there was nothing he could do to stop me.

I also bought us a new mini-van. Seeing as how I was already buying stuff, he also bought a new truck. That was the cause of a big conflict between us, because that didn't fit into my plans. Our credit was approved, so we also bought a house during that time. Suddenly all the payments just piled up.

BJ: *Aside from your agreed expenses, did Marlon know what your financial priorities were?*

VC: *No! Around 2003-2004, my father already admired how I was able to give my family a good life. My siblings and I were starting to get established in our town. We started to earn his recognition and respect. Then Marlon buys a huge car and we're buried in debt again. I treated him like the cross in my life.*

In the previous chapter, Vicky imparted the mother-daughter relationship and social status characteristics that aided her drive to immigrate to the United States.

There were two doors when I landed in Korea en route to the U.S. I had to choose between, the arrival door and the departure door. One was going to the US, and the other was going back to the Philippines. I prayed for the Lord to give me guidance on that moment. I was in tears over that decision. I wanted to go back home, but also thought about how much my father had already spent for us to come over. That prevailed, so I got on the plane to come over here. When the

plane took off from Korea and landed in Alaska, I realized how far the plane had gone. I couldn't go back anymore. I just stayed strong with the thought that I was doing all this for my daughter.

Vicky imparts a strong visual representation of the path between abstract ideals and actual conditions, the split between instrumental and affective split, two doors. One door led to an actual life she lived and the other door leads to objectives to be accomplished. Despite more celestial recourses for the situation "*I prayed to the Lord*," she ultimately had to make an extremely difficult "*I was in tears over that*" decision.

Vicky explains that, as she and her seven siblings were growing up, the roles between her parents were delegated separately. Emotional needs were more satisfied by their mother, and financial needs were more filled in by their father. Her parents eventually resolved their difference by living separately, with her mother staying with them in the Philippines, and with the father moving from one province to another in the Philippines or another country altogether. Her relationship with her father is described repeatedly as one that lacked emotional and actual presence due to immigration and the pressures of providing for a nuclear family of eight and extended family in a developing country. As she later confides, her goal was to become financially independent as a registered nurse so that her father can emotionally rest. Now that she is financially independent, she feels that she is freer to have a more constructive relationship with her father even if it was disappointment bordering hate that she felt for him on her arrival in the United States.

VC: *When my sisters and I stayed in his house, he was always fuming mad. Even if we made him dinner or did the laundry, he constantly asked, "When are you going to start getting real jobs?" I didn't see any support from him too while I was reviewing for the NCLEX-RN. I guess I was expecting the same type of reassuring support that I got from my mother before she passed away. So we eventually felt like we were imposing rather than welcomed.*

She talks about the attributions she made and the emancipation she wished for after taking the NCLEX-RN.

VC: *I just broke down and cried after the exams. I didn't know if I passed or failed on that day because the computer stopped at question eighty-four (84)… I said "dear God, I hope I passed." I don't want to be home help aide forever. I really hated it. How can I support my family? I want to have a house… like a real family. I don't want to live under someone else's roof anymore. I was so bitter with my father for making me go through that period of destitution.*

Vicky's case not only exemplifies this role difference between her and husband, it also gives clues on the intergenerational nature of this instrumental-affective cognitive split that eventually led to crises in relationship of two generations.

Her objectives behind her immigration as 1) financial independence, 2) prominence back in the Philippines, 3) a means for fulfilling a holistic mother role for her daughter, and 4) a means for bridging a long standing emotional gap between her and her father. Here, chosen means for achieving this was to clock-in more hours as a supervising nurse in three nursing homes.

Unwittingly, these were the deep-seated ideals Marlon crossed when he bought his truck. As he narrates, he was going through his own esteem issues during the time. He was a custom official back in the Philippines that became a nurse aide in the U.S. He admits that the truck was his way of compensating for a sense of loss for social status and sense of masculinity.

One could imagine her shock, when Vicky's daughter, Marivic, started to block Vicky out of her life for being so uninvolved and unempathetic to her teenage life. It was also then, when her daughter exclaimed that the last thing she wanted to be when she grew-up was a registered nurse. It was then that Vicky uttered the words, "*I became a monster because of what I had to endure in the process of immigration. I just look forward to the day when I can become myself again."*

Although Vicky's objective proves to be unique in terms of her ideal frames, she shares the motherhood and role model frames with most respondents. Sylvia intimates:

SC: *Each case is different… each case is different. My opinion is just based on how I was raised. We struggled as we were growing up. My family lived in small apartment and there were six of us. When I look back, I admire my parents more. Because I still wonder how we managed. So my thinking is, if they were able to do that then, I can do that here too with my children.*

More directly, Rosa explains how these roles can lead to feelings of more targeted deprivation and hostile behavior:

RV: *It's aggravating when I come home from work and the house is dirty. Of course it affects me because I am supposed to be the one doing that, but I can't. And then*

he really doesn't give it much effort. In the Philippines, he should be the one working and I should be in the house feeding and taking care of the kids. It's different here and that's difficult for me. If I don't work, my whole family will die. When I get home after a long day, and the house is not even clean, I'll curse at him. I'm exhausted from work, I get home and I still have to work! Don't you think that when you're tired, your partner should do the things you wished you could do but simply can't. There is really a disadvantage compared to others and I keep suffering for this. It's naturally different when a mother cares for the children. 'Coz the wife, she should cook… she can cook nutritious food and she can really care for the children. She can give them regular baths. With Mike, I constantly have to tell him to give the children a bath. I think it's only on my day-offs that the kids actually take a bath. When I call Mike, I have to be explicit that he should give the children a bath. Very explicit, so he does it.

At the core of Rosa's frustrations, are norms and a paradigm of social exchange. It is a process of social exchange that for most part has to be negotiated between her and her husband Mike. On the other side, Mike also talks about relationship norms standards and status issues that he cannot address in their lives. The negotiations were often based on whose standards and status were superior to the others. The inability to reach an understanding on these norms and address these deep seated issues often led to an escalated battle between the couple.

It might be suggested that competent performance of housekeeping tasks would make little difference to mental health because of their low salience or unimportance to

individuals. One study, however, found that almost one half of the wives, experienced role strain over the quality of their performance of housework and about three-fourths of a sample of both mean and women placed relatively high value on housekeeping and defined good performance as extremely or quite important (Keith, Schafer, 1985; Slocum and Nye, 1982). The observation is that, the conflicts over these tasks were often avenues for other issues. Addressing these issues was more productive when the couple understood the abstract ideals and role behaviors from which these norms were based.

The nuclear family or marital relations were initially neglected for reasons that included either necessity, an attempt to compensate for feelings of financial deprivation, or fulfilling origin country based ideals, expectations, aspirations or mythologies. The partners or husbands often took a supporting role to this endeavor, giving rise to growing number of "housebands" or husbands who opt to take-on homemaker role. In the long-term, career options were suppressed and the partner's participation towards fulfilling financial aspirations was limited. This led to long-term esteem and status issues that were expressed either through the purchase of status and masculinity associated items, or seeking other partner relationships.

During the initial stages, reference groups were often the central focus of responses. At later stages, this became concentrated on the nuclear family particularly, spouses. Unless expectations were clarified at the beginning of the provider-supporter role distribution, interacting with a partner going through their own unfulfilled role behavior models, often led to an exchange of accusations about deficiencies and deprivation attributions.

Partner role models or dialogue skills also come into play at this level. Some were able to resolve their issues through a mix of constructive communication and an accurate understanding of the issues and feelings that surround the conflict. With feelings unjudged, recognized and validated, some couples were able to address their issues and manage their relationships effectively.

Some join organizations that foster the interest of the sector. Some stay the course and advocate for more enduring changes in the meso and macro level. Others fizzle out in interest after attaining either welfare, personal or social status and value expectations.

At it worst, though, the process mixed with skills deficiencies or mismatch, results in either an escalated battle or a one-sided battering (verbal or physical), within the nuclear family setting. With some members of the nuclear family, resignation, submission or withdrawal was the chosen adaptive response. Two more extreme cases, spousal abuse, the more clinical definition referred to as battered spouse or Stockholm syndrome. Two cases resorted to seeking other partners outside their marriage.

Summary

Abstract ideals took on added components as role models. They were and are affectively influenced relationships that were cognitive constructed yet ran so deep and powerful, they seemed absolute. Who the nurses became in the process of immigration, often came at the price of mourning the limits of these abstract, yet holistic sense of themselves, albeit the pride of emancipation from the challenges of the past.

Role behavior or patterning personal standards and behavior on role models is an observable component of the immigrant nurses' personal and professional life, or as Zenaida Spangler theorized, values for caring modalities were inculcated by families when they were growing up (Spangler, 1992, 34)."

Especially in the latter stages of immigration, role behavior is a potent mix of all points of comparison. Gurr outlined the different aspects of relative deprivation. It is described as stealthy in this paper because they manifest only after the initial challenges of immigration have subsided, yet often the continuation of compulsive responses to relative deprivation in the initial stages.

Relative deprivation can be responded through various avenues. They can be felt at the affective level or financial level. Seen at the emotional level, the compulsive response can lead to relational detachment, avoidance, and even aggression. Caught in a compulsive attempt to respond to feelings of financial deprivation, overcompensation may manifest through various compulsions (manic buying, vacationing, dining out, etc.), especially during extended and stressful work period. The activities were generally concentrated around comfort activities associated with origin country mythologies about life in America. In the long run, this form of compulsion to react to feelings of deprivation leads to credit issues and financial stagnation.

Overburdening oneself with a pre-mature purchase of a house, and related expenses in pursuit of mythical expectations, or what one respondent defined to as a feature of a "real family", despite limited career opportunities for both partners, often led to one partner taking more of the financial burden more than the other. Despite its

relative importance to life in America, this often led to origin-country based attributions of personal insignificance for the household oriented partner. Due to the gendered conditions of registered nursing in the U.S., this was often observed in male partners.

The process of resolving the issues that besieged the respondents, takes on many features. But one thing is made clear in the process. In as much as there are contingent surrounding issues, the immigrant registered nurses also had a significant amount of control for key situations. Relative comparisons could be recognized and neutralized, or as Keith and Schafer suggested;

"Understanding and awareness go a long way towards acceptance and motivation for change." If a person can be shown that assessment drawn from comparison may be more distressing than the objective conditions, they may escape some of the potential damage that seemed to result from invidious comparisons (Keith and Schafer, 1985, p.233).

Awareness paves the way towards empowerment. A more comprehensive set of success story examples and suggestions are better explained in the succeeding chapter on conclusion and analysis.

Chapter VII
Conclusion and Analysis

In 1972, Zhou Enlai, the Premier of the People's Republic of China, was asked to comment on the impact of the French Revolution. He responded by saying that "*it is too early to tell*."

Filipino Registered nurses have undoubtedly contributed to U.S. nursing practice. Filipino migrants have also enriched the U.S. society through food, family and community values they brought. Considering their historic participation in augmenting U.S. healthcare workforce shortages, there should be no reason where their future participation should be limited. This study's aim is to make sure that their psychological and emotional well-being is cared for in the process of caring for Americans.

From a purely quantitative perspective, there is enough global supply of registered nurses. The Registered Nursing anticipated shortage is at least twenty to thirty (20-30) percent increases by 2014. In the long-term, this will entail human resources that come both from the United States and abroad. But as authorities have observed retention problems gives rise to problems towards quality care. When one is trained for two years in an associate degree or even coming from a foreign culture or practice, an extended period of mentorship will be required in dealing with the responsibility of human lives and in specific cultural situations. In the case of immigrants, mentoring should not only be done as nurses, but also as immigrants, mothers, providers, fathers, homemakers,

professionals, daughters or sons with dreams and aspirations. Leave it to say that the existing one-month orientation is insufficient, as depicted by current turn-over ratios in the United States. It proves even more insufficient in terms of quality mentoring for those that have more issues to contend with aside from practicing the profession.

Considering the design of current testing is for minimal knowledge, the interim period and gap between minimal knowledge to complex praxis has to be filled so that the stress of being responsible for human lives is not further complicated by the lack of institutional guidance. There appears to be long-term economic benefits from this inflated number of registered nurses training for positions in the U.S. For school owners, more demand leads to higher tuition rates. From a consumer perspective, increased supply eventually means lower cost per unit. The quality and durability, or in this case, retention concerns due to insufficient mentoring programs, falls on the wayside. Thus, both the registered nurses and the American public suffer.

On a theoretical level, the emic delved mostly on the personal level. The unit of analysis remained at the individual level. The commonalities though gave rise to a more general frame work for understanding the plight of respondents. These commonalities led to etic theories which helped understand the connection between the different factors surrounding common conditions. Given only eight respondents, some facets of conflicts encountered would seem isolated and unique. The study population is eight in a real population of 40-50 thousand individuals. The study admits to quantitative limitations in terms of generalizations made of its coverage.

One also cannot understate that the frames, conditions and circumstances noted in this study can be isolated, unique and subjective. The commonalities and consequences of such situations should not be underestimated simply because of the fact that they can happen. What this study wishes to emphasize is that there were serious consequences and common frames for understanding situations that were far too important to ignore. The extreme consequences beckon further study on the matter. What remains clear is that the phenomena can be fully understood from theories based on other grounded observations of human behavior.

Kevin Avruch and **Peter Black**'s frame explained the role of culture in conflict conditions. Culture became important only after it lost its ability to solve life's problems or were its ability to function as effectively was hindered in the new environment. The stress of extended work periods sublimated the registered nurse's culture driven care modalities or empathy for patients. Communication issues amidst uncertainty in the profession also became traumatizing and overwhelming. The trauma demanded a trial-and-error restructuring of cultural responses to different situations which in due time became more consistent patterns of behavior.

Developing new adaptive mechanisms or cultural behavior came with a sense of loss for a past life conditions. It also came with a sense of failure based on internalized standards and norms for success learned either from one's formulated mythologies, upbringing or role models.

Avruch and Black posit that culture can change. But it did not come without some sense of loss, mourning and self-disappointment for the respondents. In as much as

contextual qualifications could be made between one's role models and one's personal context, it became equally important to facilitate the mourning process along with coming to a rational conclusion on one's condition.

Maire Dugan's Nested model oriented the study on the existence of micro to macro forces that influence conflict. In the field of registered nurse migration, it was particularly important to see how these different levels interact. There was very little direct communication happening between macro institutions and the individual nurses themselves. Association between registered nurses remained at the social and meso level yet there was less sector identification that functionally led to macro changes (i.e. immigration or industry reform). In as much as immigration quotas stagnate to suit macro social, political and economic concerns, chain migration or Filipino registered nurse immigration was more often facilitated at the relational level (i.e. between family and friends). This disconnect often allowed the status quo to persist.

Zenaida Spangler and **Madeleine Leininger** provide a guide on what to consider for care-values and modeling behavior. Leininger's cultural care theory, though, can be out-shadowed by the complexity of cultural engagement that happens once the act of immigration is set in motion. As seen from the respondents, the results of this supposedly exclusive professional paradigm can vary from conflict-free to lethal consequences both inside and outside the profession. In as much the internationally trained registered nurses could be simplistically seen as interactive carriers of care values, the conditions seen in this study demand a more interactive and organic understanding of culture.

As found in Spangler's study, there were care-values values that were learned as "they were growing up" but carried into the profession. Actions and decisions to achieve cultural care congruence need not be one-sided as she said. The host or dominant culture could also take an active role in preserving, accommodating and restructuring the beneficial nursing care values and practices of nurses from other cultures (Spangler 1992, p36)."

The main analytical irony is that although the nurses mostly depend upon their upbringing values to guide them through their profession (i.e. caring for the elderly, translated from Philippine-based upbringing), social and professional overcompensation during a shortage could become dysfunctional to the very milieu where the family values are nurtured, in the nuclear and extended family setting, if not to the origin country as well. As observed, the disparity paradigm based on national wealth differences is ultimately internalized individually in the overcompensation phase. Ultimately this individualistic wealth difference perspective leads to overworked international nurses in a shortage. One would ask if this is the optimal condition the American public desires or even deserves after forty 40 years of Medicare and Medicaid contributions.

Carlos Sluzki describes the stages of immigration and the psychological stages immigrants commonly go through. He also describes how losing the social network which one originally used to navigate and respond to one's surroundings could be heavily incapacitated or lost in the process of immigration. As he posits, while the process of social network reconstruction takes place, many interpersonal functions accomplished by

the old network remain unfilled. This period of extreme social distress may last for years (Sluzki, 2008, p8).

Sourcing the reason for the differing intensities and duration of this distress stage led to deeper questions. What did the immigrants expect and why were negative attributions given to the initial immigration experience? Why was the level of personal distress so intense that it affected surrounding relationships? What process does this personal distress undergo to become a degenerative condition? Is it possible to reverse or transform these conditions into more productive multi-level relationships? Such questions led to the search for a conflict analysis frame.

Tedd Robert Gurr explains the process of relative deprivation by first specifying the different psychological bases and levels of comparison. The significant reference points of comparison give context to one's capabilities and aspirations. These reference points justify one's origin country position until a new frame of interpretation is inspired. A negotiated frame of interpretation is constructed collectively sometimes through a single or sometimes a set of events as seen from the origin country. The gap between achievable expectations and aspirations in the origin country first creates a negative gap and eventually widened far enough so that it inspires the interpretation of hopelessness in the origin country otherwise known as the relative "push." Significant reference points, if not knowledge, then act as cognitive markers for the solution. This would include basic knowledge of supply and demand, history of nursing in the United States, friends, acquaintances and family members that are either supportive of the idea or the actual act

of immigration. This creates the compressed positive gap between aspirations and expectations which is more commonly known as the relative "pull."

Reference Groups

Reference groups in the U.S. were often oblivious, either by choice or circumstance, to the limits of existing regulations. There were various motives that ranged from affective to economic. What is clear is that immigration involved a great number of perceived stakeholders and decision makers, not just the individual nurse or their immediate families. What were often communicated were reassurances that turned aspirations into expectations. These reassurances, a mix of affective desires and seemingly objective assessments may or may not capture the context of the potential immigrant. All in all, this leads to mythology making process of the Philippine version of the American dream without temporal or contextual parameters.

In the Philippines, this feeds into a culture of staking everything on the nursing future of a daughter or son. This also leads to feeding frenzy of investors willing to put up nursing schools for continually increasing tuitions. On November of 2008, eighty-nine thousand (89,000) Philippine registered nurses took the Philippine Board Exams.

Chapter V highlighted how this relative perspective is inspired by the shock of loss of once relatively complete old social network or the frustration of one's expectations.

Seen during the first stage, the social network or reference groups became a convenient target. Reference or social network-based concept of information and affect dissemination leads to circular cumulative causation for chain migration. This more

sociological approach does not posit that economic explanations are wrong or non-valid. What seem to be a growing concern is that the economic conditions advocated as causes for both emigration and immigration decision are necessary but not a sufficient explanation of international migration processes (Massey, et.al.,1998). It becomes more relevant for this study to examine how this communication path can be better recognized or utilized.

In as much as these reference groups were well-meaning and even sometimes logistic contributors to the act of immigration, some became recipient of frustration and displaced aggression as a response to perceived loss and deprivation. Ethnicity was occasionally marked hoping that being around fellow Filipinos would sooth feelings, dismissed as "home-sickness." Unfortunately, this new social network became the comparison group for one's personal circumstances. This sometimes aggravated one's sense of deprivation, because it only emphasized the status difference between the start-upper and the socially-embedded community.

It would assist both the reference group and the potential immigrant that this phenomenon could happen simply because past life comparisons will be made. A comparison of different nurse immigration conditions led to possible pre-emptive measures.

1) Reference groups should be fully informed and ready for better immigrant conditions compared to one's own.

Most reference groups in this study confided to having difficult beginnings. One would presume that lessons were already learned from these hard experiences.

Unfortunately, these more systemic problems were reduced to personal, marital or family deficiencies. Reference groups that shared common profiles or professions proved more functional for as long as they had already established their careers through a similar process when the potential immigrant came. Specific timeframes for achieving certain goals were anticipated. Positive frames of hope were provided through reassurances. Both logistical and emotional support was provided in the preliminary stages of immigration.

2) Empathy rather than personal validation.

Though it may seem self-validating that yet another migrant will undergo one's personal struggles, reference groups have to be informed about the financial constraints and be ready to fill-in these limitations in pursuit of a viable career which role models back in the Philippines invested their own lives in. If they intend to take on the role vacated by origin country social networks, this is what it entails despite blame and personal repercussions. The reference group's potential role is to change conditions for the incoming migrants so that nobody else will have to go through the same immigration struggles.

3) Difference is golden, deprivation is expensive.

Reference groups should expect that the start-up immigrant would be ashamed or embarrassed to divulge their negative emotions in the attempt to save face. Reference groups can present a non-threatening stance towards these negative emotions so that they are better articulated and understood.

Fulfilling mythical expectations about the United States need not feel depriving. There could be simply seen as differences. What respondents often observed was their concerns from the Philippines often stayed the same. The struggles for fulfilling these concerns were equally as difficult. In fact, it was only through a relative comparison between origin country conditions and personal conditions that a sense of achievement was felt.

Much like the NCLEX-RN, these differences ultimately pave the way for economic differences. In another world where caring and empathy rule, there are also patients rallying behind the richness of retained Filipino care values. When the dust from the initial stages of immigration settled, these differences between Philippine and American nursing practices became understood. It was then that more abstract role model values started to dominate the nurse's practice.

Nature vs. Nurture

Culture care methods were not only brought in like stagnant objects but interactively nurtured behaviors. As the registered nurses initially reported, they had lost most of their care-giving tendencies. Calling 9-1-1 becomes the automatic course against devoting more time to deliberate on acute care procedures. After extended work hours, empathizing with patient's needs became the least of a registered nurse's concerns. One nurse's remaining care focus and empathy was confided to be cases of Myocardial Infarction, the condition from which her own mother died. Aside from this, clock-in and clock-out mentality guided the predominant work ethic. After work, there was, as one nurse confided, just enough time to sleep and minimally manage the home life. As they

discovered through consequences, making life better for the family was not purely an instrumental or materially oriented endeavor.

When one person spends 72-80 hours per week at work, it only seems logical that these hours will actually be lost somewhere else. There are only so many hours in a week, one hundred and sixty eight (168) to be exact. Less fifty-six (56) to sleep, will leave four (4) hours at home. If one takes the lure of night differentials, it would seem logical that one would not see the family at all during the week. Aside from eating, sleeping and basic managerial work, this does not leave much time for anything else to be done at home.

This response cycle could become escalated and degenerative because there are sufficient feelings of frustration over conditions, of either the children or the partner's life that could feed an escalated pattern.

As Gurr posited on the matter of frustration-aggression, "aggressive responses tend to occur only when they are evoked by an external cue, that is, when the angered person sees an attackable object or person that he/she associates with the source of frustration. The crucial point is that occurrence of such an attack is inherently satisfying response to anger. If the attacker, (i.e. individual suffering relative deprivation) has done some affective or physical harm to the frustrator, his/her anger is reduced whether or not he/she succeeds in reducing the level of frustration per se. If frustration continues, aggression is likely to occur. If the feeling is reduced as a result of the attack, then the tendency to attack is reinforced and the onset of anger in the future is increasingly likely to be accompanied by aggression" (Gurr, 1972, p 34). This self-reinforcing and

gratuitous cycle takes the actual place of addressing the issues that cause the frustration. One may simply decide to submit to, considering its seeming objectivity, enormity, or complexity of conditions. The frustration festers though, just waiting for a cue, which for most part in the lives of the start-up immigrant is occupied by the compressed milieus of profession, nuclear family, extended family or an emotionally detached reference group both in the new and old environment. Awareness though is paramount to empowerment. If one can differentiate between the compulsion to respond to the frustration and the need to identify and address the more historic and wider sources then one has already taken the first step towards resolving conflicts within more micro settings.

Role Model

Dialoguing abstract ideals proved helpful. In some cases, in an act that shocks most Americans, nurturing immigrant in-laws were recruited to assist in child rearing. In some, this proved to be extremely helpful because role models did not become abstracted ideologies or mythologies. They actually spoke for themselves.

One respondent attested that this was a welcomed assistance on her part because her in-laws were so caring both towards her and their grandchildren. She claims that this filled-in a gap between her own orphaned childhood and their lives in America. However, in one of the cases, a violent mother role model aggravated if not added to the physical abuse that was already happening in the marriage.

Although dialogues with role models are important, the role models need not be in the home of the nuclear family. In the case of deceased role models, facilitated mourning sessions was an effective intervention method. In cases of role model based conflicts, this

effectively exposed, grounded and neutralized abstract role model issues. Parental role models became humanized rather than abstracted and less of a psychological burden for both partners.

Generally, although role models themselves inspire or condition role behaviors within the nuclear family, the individual actors never actually lost agency in their personal situations. That was, if they realized that role models were guides by whom they could live by, rather than absolute rights that normatively dictated the way they lived.

Role model validation and nurturing becomes an equally personal and institutional concern. Leave it to say that the real product is being damaged in the process because of social, political and economic parameters of recruitment. Submission to an overworked and unwelcoming system becomes a default response. Feelings of loss and deprivation fester while waiting for a manageable break or opportunity. Short term oriented and overworked life strategies were adapted within the constraints of a shortage and short-term international nurse recruitment environment. Representative activities or symbols that may externally seem insignificant, like household work, time allocation, unspoken words of reassurance and support and the influence of reference groups, become inflated and affectively loaded objects of stress and resentment. For couples, the overriding frustration was mainly due to a seeming reversal of gendered role distribution. This presented a mix between perception (gendered role distribution) and conditions (gendered profession) which deserves further study.

It seemed common to submit to the circumstance that only the female nurses have opportunities in the United States because of immigration limitations and the impractical need to hire sitters or pay for daycare places. The compromise was often based on financial considerations and the insecurity associated with having strangers raise one's children. This compromise was often jointly agreed. Rationally, it seemed that if role models did not provide guidance for this kind of streamlined or role reversal condition, then it was appropriate to invent one's own ways of effectively assimilating. Unfortunately, the short-term savings which was commonly used as an argument by couples ultimately carried long-term self-esteem issues that ultimately became relationally and financially more costly.

Functional gender equality, or for the cases, gendered role distribution, as compared to gender empowerment becomes a more significant issue. Feelings of role model based relative deprivation and disempowerment only led to overcompensating in escalated power debates at home. In most cases for this study, what Gurr refers to as value capabilities or an accurate assessment of existing skills and its enhancement within and outside the household became a more important issue.

Most of the husbands in the case study had college degrees which could have been the basis for advance studies in the U.S. Role models in the origin country provided enough examples for sacrificing and prioritizing on education. Often overlooked was the more enduring long- term effect of this investment compared to the short-term needs and mentality adapted in the start-up phase.

In the long-term, it would have been functional for husbands to take second or advance degrees and pursue a career that would assist their registered nurse partner after 5 to 10 years of stay in the United States. Couples that had two careers reported less difficulties associated with immigration adjustment, married and nuclear family life.

Metaphorically, the success stories conducted their lives more like marathon (or a four hundred meter dash for enthusiasts) and less like a short sprint. In as much as there was an upstart period where they struggled to gain their position in profession and society, it ultimately gave way to pacing the longer stretch implications of physical, emotional and relational well-being of their personal, family and social network life. A painful shifting of gears had to happen after the start-up phase. Because the fear driven start-up seemed so uncertain and critical, putting fears aside and the distrust of one's self and environment became a difficult process to undo, but ultimately proved attainable.

Relative Deprivation

The bases of comparison for relative deprivation are abstracted ideas, past conditions, or standards articulated by a leader as well as a reference group. A perceived discrepancy between these comparison points of becomes the absolute standards and norms that are used to evaluate current condition. The seeming wide gap or discrepancy set-off by the difference in conditions led to a sense of loss, failure and self-disappointment that ultimately led to depressive states.

Abstract ideals seemed not just abstract ideals when it came to role models, they tended to be affectively influenced relationships that were use to normatively constructed sense of who respondent needed to be. Who they thought they currently were often came

at the price of mourning the limits of their abstract yet holistic sense of self, despite the pride of emancipating role models from challenges of the past.

If the nurse is distracted by the short-term rewards of higher salaries and compulsively overcompensating for stress and a sense of material deprivation, it often came at the long-term price of deprioritized nurturing relationships either at home, in the profession or both. In as much the comparative wealth between countries is put in sharp relief by immigration, they are but distractions to the better life that is aimed for rather than the center or means.

Relative deprivation has an insidious side effect, the illusion of absolute conditions. In the initial phases, internalized consequences of failing the NCLEX-RN gave the impression of absolute loss and hopelessness. When in fact the laws of supply and demand would eventually take-over one's employment and career opportunities once exams had been taken and orientation conditions had been surpassed and transcended.

Much like macro conditions, the choices were limited to two. Resolving feelings of deprivation only came with responding to the conditions themselves rather than compulsively responding to the feelings of deprivation. Cognitive submission to macro conditions often led to relational damage inside the compressed social network because it was the most convenient target of displacement even if it was not the sole source of the condition.

When attributions are privatized and character players are limited within the significant yet compressed social network, the attribution of deprivation and its resulting conflict became concentrated and interpersonal. The sources of the feelings are privately

engaged within the helpless and resource scarce milieu of the compressed social network. At this level, the skills and options for addressing conditions are limited and yet the stress, frustrations, and emotions derived from a sense of loss and deprivation are too great.

There were attempts to empower one's relatively deprived position by focusing on in-group/out-group differentiation. Heard during the interviews were associative groupings of American nurses and internationally-trained nurses with documentation. Differentiations were between nurses with and without documentation, Male and female differentiation was often heard between spouses. Positions of superiority, status of social belonging, and in-group and out-group identifications have been exclaimed at the micro-relationships and meso level while the shortage has persisted at the expense of the public healthcare. Interventions, Mediations and facilitated problem solving workshops have help to address this issue.

Overcoming Actual Deprivation

Is the relational damage for care-values within the family and practice purely a private or national concern? These are ideals that are consistent with the practice of being assistive, supportive, facilitative, enabling and equally productive members of a society.

In as much as the American Nurses Association refers to Internationally-Trained Nurses as a general short term fix to the shortage, historic data shows that they are far from it. Although the events of 9/11 seem to be the priority USCIS in terms of immigration quotas, the historical exchange between the Philippines and the United States in terms of registered nurses officially goes as far back as 1911 when the first three

Filipinas, Quintana Beley, Venranda Sulit and Caridad Goco were sponsored by the wife of the former U.S. ambassador to England for their post-graduate work in Philadelphia (Choy, 2003, p.33).

From a macro level, it can be said that the Civil rights movement is not dead. As events between May 17, 1954 (Supreme Court Ruling on Brown vs. Board of Education) and November 4th, 2008 (the Presidential Election of Columbia and Harvard Graduate Barack Obama) depicted, it as alive today as it was thirty five years ago. In as much as it gave rise to the Immigration Act of 1965, let there be no question that racial, if not national origins, differentiation is equally alive and effective in immigration backlogs and the retrogression.

Both the Philippine Registered nurses and the institutions they graduated from have toiled and submitted to the curriculum and standards of its former colonist. After almost a century of this historic submission, it is prudent to say that they have come to represent the majority of the short-term fix being alluded to. There are massive amounts of data that explains the nursing shortage in America. Twenty to thirty percent increase for both international nurses and locally trained registered nurses will be needed. Augmenting from either side can be done through marketing the profession or pro-active immigration legislation. The deficit can be safely filled with an efficient and expedient immigration processing and mentoring system.

The task is enormous but it all begins with the awareness that submission to professional norms, standards and curriculum of its former colonist no longer entails invisibility. There are gaps to be filled between seeking opportunity to gaining equal

opportunity, from family possessions to family well-being, from professional and national differentiation to historic participation, from professional credentialing to cultural upbringing, from social differentiation to social participation, and eventually from the American dream to American struggles.

At this level, all that a Philippine registered nurse en route to America needs to be ready for is as one respondent intimated, bring one's aspirations and relations and "pick a door." Like Rosa Parks, will there be one Filipino registered nurse, that inspires change despite her national origins and retrogressed and backlogged immigration documents? The answer of course, is that "*it is too early to tell*."

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