

What Does Migration Mean to Us? USA and Russia: Relationship Between Migration, Resilience, Social Support, Happiness, Life Satisfaction, Depression, Anxiety and Stress

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Abstract In the present study, migrants and non-migrants in the USA and Russia were compared regarding positive and negative variables of mental health. Data of resilience (RS-11), social support (F-SozU), happiness (SHS), life satisfaction (SWLS), depression, anxiety and stress symptoms (DASS-21) were collected in representative samples in Russia (non-migrants: $N = 2129$; migrants: $N = 188$) and in the USA (non-migrants: $N = 2191$; migrants: $N = 116$). In Russia, no significant differences between migrants and non-migrants were found. In the USA, social support and (marginally) resilience were significantly lower in the migrant sample. Cross-culturally, multiple regression analyses showed that for non-migrants all positive variables were associated with depression, anxiety, and stress symptoms. In both migrant samples, the associations were more specifically. While in the US migrant sample, happiness and life satisfaction were of particular importance, in the migrant sample in Russia, happiness and social support played a significant role. Practical applications for enhance of subjective well-being and limitations of gained results are discussed.

Keywords Migration · Mental health · Russia · USA

Introduction

During the last decades, migration has become an important topic worldwide. Different circumstances lead to migration. Personal and family related problems, economic and political reasons, unemployment, traumatic life events, discrimination and violence in the home country can cause people to migrate (Miyasaka et al. 2002).

The start and end point of the migration process are difficult to define clearly. It begins already in the home country, includes the physical transition away from home and continues in the host country involving different individual, social and cultural, internal and external facets and factors (Bhugra 2004). All migration stages can include multiple stressful factors, which negatively influence mental health and trigger, e.g., depression and anxiety (Arévalo et al. 2015). However, studies comparing mental health between migrants and the native population are rare and often use small clinical sample sizes (Levecque and Van Rossem 2015; Swinnen and Selten 2007). Most of them describe lower mental health in migrants (e.g., Kirkcaldy et al. 2005).

In a cross-national study of twenty European countries, migrants showed higher depression values, especially those born outside of Europe, than the native population (Levecque and Van Rossem 2015). A study in Canada reported that migrated South Asians have higher depression values than the native population (Lai and Surood 2008). Also in Canada, Islam et al. (2014) showed that South Asian migrants experience higher prevalence rates of diagnosed anxiety disorders and self-reported extremely stressful life events compared to the South Asian Canadian-born population. In Israel,

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migrants had higher stress values in comparison to the native population (Ritsner and Ponizovsky 1999).

Which Factors Influence Migrants' Mental Health?

Different studies sought to investigate the reasons for the enhanced depression, anxiety and stress values of migrants and to understand which factors protect their mental health, in part describing contradicting findings (Butler et al. 2015). Some of these studies showed that gender is related to migrants' level of mental health. Women with a migration background have higher values of negative mental health, e.g., depression (e.g., Setia et al. 2012). One reason for this difference could be varying socio-economic conditions (Ali et al. 2004). Women are more frequently unemployed than men, which often causes depression among them (Hollander 2013). Men seem to have more protective factors, like commitment to the host country (Ritsner et al. 2001). However, other studies found no significant gender differences (Ahmadi et al. 2014; Aroian and Norris 2003; Hosseini 2016).

Furthermore, language barriers are associated with negative mental health (Lerner et al. 2005). Sufficient host language proficiency increases migrants' possibilities to manage their life in the host country, to get more resources, to decrease stress and the feeling of helplessness which often accompanies the migration process (Berry 1997).

Additionally, experienced problems in socioeconomic integration and discrimination were reported to trigger migrants' risk for depression (Chou 2012; Lorant et al. 2003). Policy governing migrants' rights and status in a society can influence mental health by building either barriers and increasing social exclusion or by facilitating the integration process (Maxwell 2010).

Some additional variables have been shown to protect mental health. High values of resilience ("psychosocial stress-resistance"; Ungar 2008) are associated with positive mental health in the migration process (Bhugra 2004). Resilient people have high ability to master stressful situations by involving individual and social resources (Leppert et al. 2008). These people have high self-esteem, self-discipline, control and problem solving abilities. They are optimistic and flexible (Fredrickson 2004) and recover quickly from stressful situations (Rutter 1995). In some studies, resilience moderated negative effects of stress and prevented development of depression and anxiety (Connor and Zhang 2006; Friberg et al. 2006; Wagnild and Young 1993). Hosseini (2016), who investigated Iranian migrants living in Australia, described a positive relationship between resilience and age in this specific sample.

The social context of the new living situation can protect mental health and increase well-being of migrants (Becares and Nazroo 2013). Especially, social support of a solid social network, which increases one's sense of belonging, identity, meaning and purpose, is associated with positive mental

health (Cohen 2004). Socially integrated people develop adequate coping strategies to manage stressful situations and experiences (Umberson et al. 2010). Social support offered by one's social network, instrumental or emotional (Lin et al. 1986), buffers the effect of migration stress (Cohen 2004). It serves as a protective factor against depression and anxiety (Fydrich et al. 2009; Seeman 1996), improves individual coping abilities and increases well-being (Shteyn et al. 2003). Parenting, including social support and a supportive social network of close friends, enhance individual's resilience (Peltonen et al. 2014). Lack of social support is linked to increased stress and depression (Iecovich et al. 2004; Lerner et al. 2005).

Two further variables which were shown to reduce depression, anxiety, and stress symptoms are subjective happiness and life satisfaction. People with a high happiness level are characterized as optimistic and resistant to negative environmental influences. They develop effective coping strategies to manage stressful situations (Lyubomirsky et al. 2006). Life satisfaction is often defined as a cognitive evaluation process of a person's quality of life (Diener et al. 1985). Earlier research showed that people expressing higher life satisfaction values have higher positive mental health values and are more resistant to mental disorders (Wood and Tarrrier 2010). Both – subjective happiness and life satisfaction – are positively related to emotional well-being, self-esteem, individual functioning, job success and interpersonal relations (e.g., Diener and Seligman 2002; Renshaw and Cohen 2014; Schimmack and Diener 2003). However, little is known about migrants' subjective happiness and life satisfaction in comparison to native population.

In conclusion, in different countries migrants were shown to have higher negative mental health values than the native population. Various studies found variables like social support (Fydrich et al. 2009), resilience (Masten 2001), subjective happiness (Diener and Seligman 2002), and life satisfaction (Renshaw and Cohen 2014) to decrease negative mental health (e.g., depression symptoms). Even though most of those studies were conducted only with native population samples, their results frequently are generalized to the whole population of the country including people with a migration background. Studies which investigate specifically the association between positive and negative mental health variables in the migrant population are rare. Therefore, the aim of the present study was to compare depression, anxiety, and stress symptoms, as well as resilience, social support, subjective happiness and life satisfaction values between migrants and the native population. Additionally, cross-culturally the association between those variables should be investigated.

The investigation took place in Russia and in the USA. These two countries were selected for the present study due to following reason: Both countries have different cultural, historical, social and geographical conditions. They have large

populations comprising various ethnic minorities. Migrants come to these countries for multiple reasons (e.g., Pietilä and Rytönen 2008). However, little is known about migrants' mental health in Russia. Migration studies in the USA partly describe contradicting results. To our best knowledge, this is the first study which investigated the described variables simultaneously in both countries. Considering most of the earlier results, in both countries, migrants are expected to have higher levels of depression, anxiety, and stress symptoms (Hypothesis 1) and lower level of resilience, social support, subjective happiness, and life satisfaction than the native population (Hypothesis 2). Furthermore, the association between depression, anxiety, and stress symptoms, social support, resilience, subjective happiness and life satisfaction will be investigated in the migrant and non-migrant samples in Russia and in the USA separately. Possible found differences could help to clarify the higher negative mental health values in migrant samples and to provide evidence how to improve migrants' mental health.

Materials and Methods

Procedure and Participants

This study is part of the ongoing cross-cultural BOOM (Bochum Optimism and Mental Health) project which investigates risk and protective factors of mental health (e.g., Brailovskaia and Margraf 2016; Schönfeld et al. 2016). The samples of the present study were collected by telephonic interviews conducted by trained professional interviewers in the host country's native language in Russia and in the USA. Systematized sampling procedures regarding age, gender and education were used to ensure the representativeness of the samples for the population in both countries. In whole, the study had 4624 participants, 2317 in Russia and 2307 in the

USA. After the data collection, the sample in each country was divided into two groups. One group comprised of participants who indicated that they had no migration background (born in Russia or in the USA). The second group consisted of participants who had a migration background (not born in Russia or in the USA). In Russia, the native-born sample comprised 2129 participants. The second sample consisted of 188 people who had migrated to Russia. In the USA, the native-born sample consisted of 2191 participants. The second US sample comprised 116 participants with migration background. Table 1 summarizes participants' demographic data.

Considering various statistical migration reports, present sample sizes fit the distribution of people with and without a migration background in the Russian population and were just slightly lower than the distribution in the US population (e.g., Bhaskar et al. 2013; Jensen et al. 2015; United Nations 2016). Furthermore, a priori power analyses (power > .80, $\alpha = .05$, effect size $f^2 = 0.30$) were calculated with the G*Power program (cf., Mayr et al. 2007). They revealed that the samples were large enough to be quite certain to detect correctly that the hypothesis is true when it is indeed true. All procedures received Research and Ethics Committee approval of the Ruhr-Universität Bochum. All participants gave informed consent to participate at the beginning of the telephonic interview.

Measures

The Depression Anxiety Stress Scales 21 (DASS-21; Lovibond and Lovibond 1995), a self-report questionnaire consisting of three 7-item subscales, measured depression, anxiety, and stress symptoms (negative mental health) over the previous week. The items are rated on a 4-point Likert scale (0 = *did not apply to me at all*, 3 = *applied to me very much or most of the time*).

Resilience conceptualized as a protective factor ("psychosocial stress-resistance") was measured with the

Table 1 Demographic data of all participants (four samples)

	Russia		USA	
	Migration	Non-Migration	Migration	Non-Migration
Age (years)	43.19	40.65	48.61	55.76
<i>M</i> (<i>SD</i> , range)	(14.43, 18–77)	(16.53, 18–100)	(18.62, 18–99)	(17.27, 18–99)
Gender (men, %)	50.5	46.1	40.5	39.4
High education (bachelor, master or higher degree, %)	48.9	45.5	32.8	26.2
Married (%)	57.4	52.9	56.9	60.2
Living alone (%)	14.9	17.1	16.4	18
Parents' migration background				
mother (yes, %); father (yes, %)	65.4; 62.8	4; 3.4	87.9; 82.8	5.6; 6.8

Russia: non-migrants: $N = 2129$, migrants: $N = 188$; USA: non-migrants: $N = 2191$, migrants: $N = 116$; M = mean, SD = standard deviation

Resilience Scale 11 (RS-11; Schumacher et al. 2005). The RS-11 contains 11 items (e.g., “I feel that I can handle many things at a time.”) which are rated on a 7-point Likert scale (1 = *disagree*, 7 = *agree*).

To assess social support, the short version of the Questionnaire Social Support (F-SozU K-14; Fydrich et al. 2009) was used. This instrument measures subjective experienced or anticipated support from the social network with 14 items rated on a 5-point Likert scale (1 = *not true at all*, 5 = *very true*).

The Subjective Happiness Scale (SHS; Lyubomirsky and Lepper 1999) was used to measure the level of subjective happiness. The four items are rated on a 7-point Likert scale (range: 1–7).

Global life satisfaction was assessed with the Satisfaction with Life Scale (SWLS; Diener et al. 1985), a one-dimensional questionnaire consisting of five items which are rated on a 7-point Likert scale (1 = *strongly disagree*, 7 = *strongly agree*).

The Russian and English language versions of the DASS-21, as well as the English versions of RS-11, F-SozU K-14, SHS and SWLS were validated in earlier studies (see Antony et al. 1998; Bieda et al. 2016; Henry and Crawford 2005; Maercker et al. 2015). The Russian versions were translated from the original following the standard translation-backtranslation-modification procedure by the BOOM research group (Berry 1989).

Statistical Analyses

All statistical analyses were conducted with the Statistical Package for the Social Sciences (SPSS) version 21 (Corp 2012). In Russia and in the USA, means of age, depression,

anxiety, stress, resilience, social support, subjective happiness and life satisfaction were compared between the samples with and without migration background by calculating multivariate analysis of variance (MANOVA). In the Russian and in the US samples, the Box’s test became non-significant. Therefore, Pillai’s trace was used as the multivariate test to analyze group differences. To determine reliability of the used scales, Cronbach’s alpha was computed. Furthermore, to assess the association between the investigated variables within the four samples zero-order bivariate correlations, and multiple linear regression analyses with gender, age and the four positive variables (social support, resilience, happiness, life satisfaction) as independent variables and depression, anxiety and stress, successively, as dependent variables (significance level set at $\alpha = 0.05$) were calculated.

Results

Descriptive Statistics and Mean Comparison

Table 2 reports descriptive values of the investigated constructs in the Russian and in the US samples. All analyzed variables were close to normally distributed (assessed with Kolmogorov-Smirnov test, analyses of skew, kurtosis and histogram analysis).

First, the variables age, depression, anxiety, and stress symptoms, resilience, social support, happiness and life satisfaction were compared between participants with and without a migration background in Russia. The MANOVA showed no significant results. The Pillai’s trace was non-significant, $V = .004$, $F(8,2308) = 1.103$, $p = .358$, $\eta^2 = .004$. In contrast, the comparison between the migrant and the non-migrant

Table 2 Descriptive values of depression, anxiety, stress, resilience, social support, subjective happiness and satisfaction with life (Russian and US non-migrant and migrant samples)

	Russia						USA					
	Migration			Non-Migration			Migration			Non-Migration		
	<i>M</i> (<i>SD</i>)	<i>Min</i>	<i>Max</i>	<i>M</i> (<i>SD</i>)	<i>Min</i>	<i>Max</i>	<i>M</i> (<i>SD</i>)	<i>Min</i>	<i>Max</i>	<i>M</i> (<i>SD</i>)	<i>Min</i>	<i>Max</i>
Depression	3.62 (3.64)	0	17	3.76 (3.86)	0	21	4.40 (4.79)	0	21	4.34 (5.01)	0	21
Anxiety	2.92 (3.37)	0	15	3.12 (3.75)	0	21	4.22 (4.26)	0	21	4.51 (4.66)	0	21
Stress	5.43 (4.32)	0	19	5.42 (4.61)	0	21	6.59 (4.26)	0	21	6.24 (4.89)	0	21
Resilience	65.79 (9.72)	17	77	65.32 (10.22)	11	77	64.72 (10.52)	11	77	66.76 (11.34)	11	77
Social Support	60.71 (9.33)	24	70	61.32 (9.50)	14	70	56.99 (12.62)	14	70	59.43 (11.72)	14	70
Subjective Happiness	20.19 (4.76)	8	28	20.05 (4.92)	4	28	21.53 (4.62)	4	28	22.20 (4.69)	4	28
Satisfaction with Life	23.65 (6.60)	5	35	23.60 (6.63)	5	35	26.77 (6.06)	10	35	27.27 (6.64)	5	35

Russia: non-migrants: $N = 2129$, migrants: $N = 188$; USA: non-migrants: $N = 2191$, migrants: $N = 116$; M = mean, SD = standard deviation, Min = minimum, Max = maximum

sample in the USA showed significant differences. The Pillai’s trace was significant, $V = .013$, $F(8,2298) = 3.692$, $p = .000$, $\eta^2 = .013$. The sample without a migration background was significantly older ($F(1,2305) = 18.712$, $p = .000$) and had significantly higher social support ($F(1,2305) = 4.736$, $p = .030$) and marginally significantly higher resilience values ($F(1,2305) = 3.565$, $p = .059$) than the migrant sample. No significant group differences for depression, anxiety, stress, happiness and life satisfaction level were found.

Correlations

Tables 3 and 4 present the relationships between the measured variables. In all four samples, there was a significant positive relation between depression, anxiety and stress symptoms. Also, resilience, social support, happiness and life satisfaction correlated significantly positively. In contrast, depression, anxiety, and stress symptoms were significantly negatively related to the four positive variables. Tables 3 and 4 also show the reliability of the used scales, which ranged from .39 (SHS) up to .94 (F-SozU K-14). The low reliability of the SHS can in part be explained by its low number of items.

Regression Analyses

Multiple linear regression analyses with gender, age, resilience, social support, happiness and life satisfaction as independent

variables and depression, anxiety and stress symptoms, respectively, as dependent variables showed significant results (see Table 5).

In the migrant sample in Russia, depression symptoms were significantly negatively associated with happiness and social support, $R^2 = .214$, $F(6181) = 8.189$, $p < .001$. Anxiety ($R^2 = .093$, $F(6181) = 3.100$, $p < .001$) and stress symptoms ($R^2 = .144$, $F(6181) = 5.086$, $p < .01$) were significantly negatively associated with happiness. In the Russian non-migrant sample, depression ($R^2 = .196$, $F(6,2122) = 86.124$, $p < .001$), anxiety ($R^2 = .120$, $F(6,2122) = 48.319$, $p < .001$), and stress symptoms ($R^2 = .151$, $F(6,2122) = 62.893$, $p < .001$) were significantly negatively associated with all four positive variables. Happiness had the main effect for depression (no overlapping of the 95% confidence intervals).

In the US migrant sample, depression symptoms were (marginally) significantly negatively associated with happiness, life satisfaction and social support, $R^2 = .331$, $F(6109) = 8.975$, $p < .001$. Anxiety symptoms were marginally significantly negatively associated with resilience, $R^2 = .148$, $F(6109) = 3.144$, $p < .01$. Stress symptoms were significantly negatively associated with life satisfaction, $R^2 = .145$, $F(6109) = 3.090$, $p < .01$. In the US non-migrant sample, depression ($R^2 = .338$, $F(6, 2184) = 185.900$, $p < .001$), anxiety ($R^2 = .210$, $F(6, 2184) = 96.591$, $p < .001$), and stress symptoms ($R^2 = .233$, $F(6, 2184) = 110.674$, $p < .001$) were significantly negatively associated with all four positive variables. Based on beta coefficients in each regression model, subjective

Table 3 Correlations between depression, anxiety, stress, resilience, social support, subjective happiness and life satisfaction and construct reliability (Russian non-migrant and migrant sample)

Russia							
Migration							
	(2)	(3)	(4)	(5)	(6)	(7)	α
(1) Depression	.70**	.74**	-.21**	-.32**	-.38**	-.31**	.79
(2) Anxiety		.69**	-.11	-.16*	-.25**	-.19*	.76
(3) Stress			-.14	-.20*	-.33**	-.22**	.84
(4) Resilience				.25**	.35**	.39**	.80
(5) Social Support					.35**	.35**	.87
(6) Subjective Happiness						.50**	.47
(7) Satisfaction with Life							.74
Non-Migration							
	(2)	(3)	(4)	(5)	(6)	(7)	α
(1) Depression	.77**	.79**	-.31**	-.30**	-.34**	-.32**	.82
(2) Anxiety		.76**	-.22**	-.21**	-.26**	-.22**	.83
(3) Stress			-.24**	-.24**	-.28**	-.29**	.87
(4) Resilience				.46**	.33**	.36**	.82
(5) Social Support					.32**	.33**	.89
(6) Subjective Happiness						.48**	.39
(7) Satisfaction with Life							.76

Russia: non-migrants: $N = 2129$, migrants: $N = 188$; $\alpha =$ Cronbach’s alpha

* $p < .05$. ** $p < .001$

Table 4 Correlations between depression, anxiety, stress, resilience, social support, subjective happiness and life satisfaction and construct reliability (US non-migrant and migrant sample)

USA							
Migration							
	(2)	(3)	(4)	(5)	(6)	(7)	α
(1) Depression	.71**	.69**	-.39**	-.35**	-.41**	-.43**	.89
(2) Anxiety		.72**	-.29**	-.24*	-.21*	-.30**	.84
(3) Stress			-.23*	-.17 ^(*)	-.25**	-.34**	.80
(4) Resilience				.32**	.39**	.38**	.86
(5) Social Support					.39**	.40**	.94
(6) Subjective Happiness						.40**	.41
(7) Satisfaction with Life							.81
Non-Migration							
	(2)	(3)	(4)	(5)	(6)	(7)	α
(1) Depression	.81**	.77**	-.39**	-.38**	-.53**	-.41**	.89
(2) Anxiety		.76**	-.33**	-.29**	-.42**	-.30**	.83
(3) Stress			-.34**	-.29**	-.45**	-.35**	.86
(4) Resilience				.40**	.49**	.53**	.90
(5) Social Support					.45**	.39**	.94
(6) Subjective Happiness						.51**	.44
(7) Satisfaction with Life							.84

USA: non-migrants: $N = 2191$, migrants: $N = 116$; α = Cronbach's alpha

(*) $p < .10$. * $p < .05$. ** $p < .001$

happiness had the strongest negative association with all three dependent variables (i.e., depression, anxiety, and stress symptoms).

Discussion

Migration is a complex long-lasting process that often affect mental health (Butler et al. 2015). Some earlier studies reported higher depression values in migrants than in the native population. They found positive associations between migration, manic depression and unipolar depression (e.g., Grove et al. 1986; Hener et al. 1997; Pope et al. 1983). Furthermore, pre-migration stress caused by, e.g., unemployment, was described to increase negative mental health at the post-migration stage, e.g., depression (Lerner et al. 2005). In the post-migration period, low education level, low income, low social-economic position, and poor life quality predicted anxiety and stress (e.g., Levecque et al. 2007). However, there are also studies, e.g., conducted in the USA, which described migrants as having a lower risk to develop mental disorders in comparison to the native population and US-born of the same ethnic background (e.g., Cheng and Chang 1999). They explained this result by the “health migrant effect” implying that people who decide to migrate are the healthiest and most resistant ones (Solé-Auró and Crimmins 2008).

In the present study, depression, anxiety, and stress symptoms, on the one hand, and social support, resilience,

subjective happiness and life satisfaction, on the other hand, were investigated in native and migrant samples in Russia and in the USA. Present results in part contradict earlier assumptions. In both countries, no significant differences between people with and without a migration background regarding depression, anxiety, and stress symptoms were found (contradicting Hypothesis 1). Thus, in the tested population migrants did not have noticeably elevated negative mental health values.

Furthermore, unexpectedly, in Russia, no significant differences between migrants and the native population were found (contradiction Hypotheses 2). Earlier studies described similarity between the host and home culture, as well as language proficiency to facilitate the integration process of migrants and to decrease migration-stress (Berry 1997). Many migrants in Russia come from old USSR countries (Union of Soviet Socialist Republics), such as Kazakhstan or Uzbekistan (Flynn 2003; Rybakovsky and Rayzantsev 2005). Often, they are familiar with the Russian culture and language because they learned them at home and at school. Most of them do not feel foreign when they come to Russia. There are no language barriers to hinder the expression of feelings and thoughts, understanding and interacting successfully with the rest of the population (Miyasaka 2000). This facilitates finding work, building relationships and enhances positive factors such as happiness and life satisfaction.

Among the US samples, some (marginal) significant differences were found. The native population had higher values

Table 5 Multiple regression analyses with gender, age, resilience, social support, subjective happiness and life satisfaction as independent variables and depression, anxiety and stress as dependent variable (Russian and US non-migrant and migrant samples)

	Russia						USA					
	Migration			Non-Migration			Migration			Non-Migration		
	ΔR^2	β	<i>p</i>	ΔR^2	β	<i>p</i>	ΔR^2	β	<i>p</i>	ΔR^2	β	<i>p</i>
Depression	.21			.20			.33			.34		
Gender		.11	.09		.07	.00		.20	.02		-.02	.17
Age		-.07	.32		-.02	.31		.09	.28		.10	.00
Resilience		-.03	.67		-.13	.00		-.13	.22		-.10	.00
Social Support		-.20	.01		-.14	.00		-.16	.10		-.12	.00
Subjective Happiness		-.26	.00		-.20	.00		-.20	.05		-.36	.00
Satisfaction with Life		-.10	.21		-.13	.00		-.23	.03		-.13	.00
Anxiety	.09			.12			.15			.21		
Gender		.14	.05		.13	.00		.15	.12		-.02	.32
Age		.07	.33		.07	.00		-.06	.54		.07	.00
Resilience		.01	.88		-.10	.00		-.20	.10		-.12	.00
Social Support		-.10	.20		-.09	.00		-.16	.14		-.09	.00
Subjective Happiness		-.17	.06		-.14	.00		.01	.96		-.29	.00
Satisfaction with Life		-.10	.28		-.10	.00		-.13	.25		-.06	.01
Stress	.14			.15			.15			.23		
Gender		.15	.04		.15	.00		.12	.19		-.01	.71
Age		-.05	.47		-.02	.27		.01	.90		-.01	.62
Resilience		.01	.95		-.09	.00		-.04	.75		-.10	.00
Social Support		-.10	.19		-.11	.00		-.03	.77		-.07	.00
Subjective Happiness		-.29	.00		-.15	.00		-.12	.28		-.31	.00
Satisfaction with Life		-.05	.58		-.15	.00		-.26	.03		-.12	.00

Russia: non-migrants: *N* = 2129, migrants: *N* = 188; USA: non-migrants: *N* = 2191, migrants: *N* = 116; β = standardized coefficient beta

of social support and resilience (confirming Hypothesis 2). In the USA, the variability of migrants’ countries of origin is much higher than in Russia. Migration to the USA takes place from many different countries worldwide (Larsen 2004). Most migrants start a completely new life in the USA, learn a new language and adopt to a new individualistic culture. This seems particularly problematic for people from collectivistic cultures, e.g., Asia (Lai and Surood 2008). Some migrant groups, e.g., from Asian cultures, consider mental health as highly stigmatized. Despite a high need for mental healthcare, they fail to contact professionals and perceive a high barrier to the availability of mental healthcare (Gadalla 2010). Language barriers enhance problems in expressing feelings and symptoms to physicians leading to difficulties in doctor-patient relationships, diagnosis and treatment (Miyasaka 2000). Those could be one of the reasons behind the identified differences in the present study. Thus, for further studies, it is strongly recommended to collect more information about the countries participants with a migration background come from, to be able to assess the degree of similarity/dissimilarity of the host and native culture. Moreover, earlier research

described the education level of migrants to be positively related to their resilience level (Hosseini 2016). In the present study, the education level of both migrant samples was quite high. However, in both migrant samples, it was not significantly associated with resilience.

In all four samples, depression, anxiety, and stress symptoms were positively correlated. This corresponds with earlier results (e.g., Wittchen and Jacobi 2005) which described negative environmental conditions often to lead to stress reactions accompanied by depression and anxiety symptoms (e.g., Hansson et al. 2010; Shkolnikova et al. 2009).

Regardless of migration background, the four investigated positive variables were positively related. This matches results of other studies which showed, e.g., a close link between social support and resilience (Masten 2001; Masten et al. 2009).

According to earlier research, a significant negative relationship of the positive variables with depression, anxiety, and stress symptoms was found in all samples (e.g., Brailovskaia and Margraf 2016). In both non-migrant samples, people who were socially supported, resilient, happy and satisfied with life

were more resistant to negative mental health. Regression results revealed happiness, which is often described as the basis of a pleasant and meaningful life (Seligman 2002), to be an especially important variable in this context. In both migrant samples, the associations seem to be more specifically. While in the US migrant sample, happiness and life satisfaction were of particular importance, in the migrant sample in Russia, happiness and social support played a significant role.

Present results fit earlier research which found especially social support to decrease negative mental health (Connor and Zhang 2006; Coyne and Downey 1991). Loneliness and isolation belong to the main causes of negative mental health, especially depression (Levecque and Van Rossem 2015). Long-distance relationships are linked to stress (Bhugra 2004). Often, migration means losing one's supportive social network. Particularly, people who migrate alone without knowing someone in the host country are at risk to develop negative mental health (Butler et al. 2015). It seems essential for them to make new acquaintances and to build a network of friends and support systems in the early post-migration period (Arévalo et al. 2015; Biegel 1985; Miyasaka et al. 2007).

Regarding present results, it seems reasonable to offer more low-threshold prevention programs for migrants to improve and to protect their mental health, enhancing the positive variables: resilience, social support, subjective happiness and life satisfaction. Also, programs aimed to improve anxiety and stress management are important. Considering the significance of social support for mental health, governmental programs to facilitate migrants' integration seem advisable (Levecque and Van Rossem 2015). Migrants need more accessible information where to find professional help and mental health services. In addition, mental health programs should be adjusted to the specific characteristics and requirements of different migrant groups to be responsive to their unique needs (Islam et al. 2014).

Limitations and Future Directions of Research

The present study has some limitations which are worth mentioning. As described earlier, migration is a long-lasting process which can impact mental health (Islam et al. 2014). This impact differs inter alia depending on the duration of stay in the host country (Levecque and Van Rossem 2015). Some studies reported a significant increase of depression and anxiety especially in the post-migration period (Butler et al. 2015). However, Ponizovsky et al. (1998) found a decrease of the depression level of Ethiopian migrants in Israel over time. In contrast, in the same study, no depression decrease was found in Russian migrants. Setia et al. (2012) showed that after twelve years of stay migrants in Canada do not differ significantly from the native population regarding mental health. Because in the present study no information about the number of years of migration to the host country was

recorded, it cannot be excluded that some found results are in part affected by different acculturation level of the participants depending on their duration of stay. Therefore, present cross-sectional results should be extended by longitudinal studies investigating the relationship between the migration process and mental health.

The telephonic interviews were conducted in the host country's native language. This methodical approach disadvantages those migrants who have not yet developed full language proficiency of the host country. To tackle this problem in part and to avoid linguistic misunderstandings, at the beginning of each interview, participants were asked to inform the interviewer, when they did not understand the questions. Then, the interviewer explained the appropriate questions more explicitly by using examples.

Certainly, there are many different factors, like gender, education, job characteristics, culture, language, religion, experience of discrimination and health-related knowledge which are related to migrants' mental health status (Hollander 2013). To improve and to protect mental health all such factors should be considered.

Conclusions

Migration today is a burning social issue affecting millions of people worldwide. It is a long-lasting stressful process that can increase depression, anxiety, and stress symptoms. The present study highlights various variables associated with mental health and compares them between migrants and the native populations in Russia and in the USA. Present results show that some variables like subjective happiness, social support and life satisfaction are particularly meaningful for migrants. Mental health of migrants and the development of specific prevention programs to enhance those protective variables should receive more attention in future research.

Compliance with Ethical Standards

Informed Consent Informed consent was obtained from all individual participants included in the study.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

This article does not contain any studies with animals performed by any of the authors.

The datasets during and/or analysed during the current study available from the corresponding author on reasonable request.

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Conflict of Interest The authors declare that they have no conflict of interest.

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