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Migrating Diseases: Triangulating Approaches—Applying Qualitative Inquiry as a Global Endeavor

Uwe Flick[1] and Gundula Röhnsch[2]

Abstract

Understanding qualitative inquiry as a global endeavor and using it in a globalizing context leads to several challenges. Differences in concepts of what qualitative research is may become visible. Methods like interviews may have a different connotation in other cultures, where our interviewees come from. We may have to conduct and analyze interviews differently. These challenges are discussed here on the background of an ongoing project focused on migrants from former Soviet Union states living in Germany with drugs and alcohol addiction problems. For understanding how the help-seeking processes in this context work and what makes them more complicated, episodic interviews with the clients were conducted in German or Russian and triangulated with expert interviews with service providers.

Keywords

interviews between cultures, episodic interviews, migrants from former Soviet Union states, drug and alcohol problems, challenges for globalized qualitative research

Introduction

In this special issue, the focus is on challenges for qualitative inquiry linked to using it in a globalized context (see Flick, 2014). In this article, we will address the challenges we face when using interviews in a study focused on the service utilization of people with a migration background. Our main target group is (Russian-speaking) migrants from countries of the former Soviet Union (FSU). The problem they might need and use professional help for is addiction to alcohol or drugs. What happens if this target group is in need for professional help for this problem in the German health and social care system and why are many members of this group unserved or not adequately supported? What do we have to keep in mind if want to use interviews in this context for collecting and analyzing expectations and experiences of this target group? How can we understand more generally how the treatment of this social problem works, why it sometimes fails and often is more difficult than for people without such a migration background? Before we discuss the methodological problems more generally, we will outline the study, which is the background for this discussion.

Our Study

This project has been funded since February 2012 by the German Federal Ministry of Education and Research for 3 years in the program health care research (FKZ: 01GY1121). It focuses on the determinants of utilization behavior of FSU migrants with an intensive consumption of alcohol or drugs and therefore a high risk of consecutive diseases like Hepatitis C.

The study pursues research questions such as the following: Which concepts of addiction, health, and illness can be found in FSU migrants? How do they perceive their own substance use and what are their experiences with the health care system? How do they move through the health care system, and what are their priorities? What are their explanations for refraining from service utilization? What are the cultural differences in views and practices concerning drugs, addiction, and treatment, if migrants need help from the German health care system? For reaching a comprehensive understanding of the social processes involved in the access to health care services, the study takes two perspectives for understanding the phenomenon. In addition to interviewing the migrants, we conduct expert interviews with service providers about service utilization, support,

[1]Free University of Berlin, Germany
[2]Alice Salomon University Berlin, Germany

Corresponding Author:
Uwe Flick, Qualitative Social and Education Research, Department of Education and Psychology, Free University of Berlin, Habelschwerdter Allee 45, D-14195 Berlin, Germany.
Email: Uwe.Flick@FU-Berlin.de

and existing barriers. This allows for the triangulation of two perspectives—clients' versus professionals' or migrants' versus locals'—also on a methodological level.

The Problem: FSU Migrants With Addiction Problems in the Therapy Process

Migration is seen as a (critical) life event linked to various psychological and social challenges. Migrants experience a number of losses. They are confronted with parting from their habitual environment, from important relations with friends and relatives and often with losing their former social status. They often experience numerous disappointments in the host country (Sluzki, 1979). These include the experience of not always being welcome but to expect marginalization, rejection, or incomprehensible formalities. Consuming alcohol or drugs can become an "apparent solution" (Czycholl, 2011) in such a situation of stress. Addiction problems are widespread among migrants in Germany, in particular among immigrants from FSU countries. They often consume illegal drugs in a very risky way, often suffer from drug-following diseases like Hepatitis C, and represent a relatively big share of death cases due to drugs (Bundesministerium für Gesundheit [BMG], 2008). Although their need for help seems to be strong, the access to this target group only sporadically seeking support becomes a "particular challenge" (Pfeiffer-Gerschel et al., 2013) for the health care system.

Discourse of Addiction in Germany and FSU Countries

In Germany and other West-European countries, in particular in the medical and therapeutic sector of the health care system, addiction to alcohol or drugs is seen as a (chronic) disease, which calls for a continuous health-related care (Saitz, Larson, Labelle, Richardson, & Samet, 2008; White, Boyle, & Loveland, 2003). Addiction diseases are seen as multifactorially caused by interplays of biological-somatic, psychological, and sociocultural components (like traditional habits of consumption).

From a stronger social science focus, such an understanding of addiction is criticized for assuming a quasi nature-given objectivity of addiction to alcohol or drugs, which establishes addiction as a disease. This ignores the fact that using substances often is part of patterns of coping with life and has a subjective functionality for coping with various stresses and environmental demands or for regulating mental states (Blätter, 2007).

The general discourse about psychoactive substances makes a distinction between alcohol as a legal and societally tolerated drug and illegal drugs like cannabis, amphetamine, or heroin. Such a distinction is very strong and momentous in many FSU countries where the use of illegal drugs is really ostracized in the family and in the society. As studies (Kirtadze et al., 2013; Spicer et al., 2011) show, in particular the use of heroin in Russia but also in countries like Ukraine, Georgia, or Central Asian states has a strong moral connotation. Often societal rights and options to participate in the society are withdrawn from drug consumers. From an own study, Mendelevich (2011) draws the conclusion that in Russia even professionals working with addicted people often assume, that addiction to drugs is a form of deviant behavior that is caused by "outrageousness." For many of the experts interviewed by Mendelevich, religion seems to be the most effective method for treating such an addiction.

Given the strong stigmatization of substance use, many consumers conceal their drug problems from their social environment and do not reveal their need for—professional—help. Many migrants transfer their strong mistrust against the mostly very repressive "offers of help" (Schumatsky, 2013) from their countries of origin to the local care system in Germany.

Opposite to consuming illegal drugs, in many FSU (non-Muslim) countries, the use of alcohol is part of everyday life. Much more than in Germany, alcohol has a function in building communities. To be able to drink much is seen as an expression of subjectively highly estimated virtues like (male) hardship against oneself and others (Schmidt, 2004). Becoming aware that they have a problem with alcohol and maybe are addicted becomes more difficult for the drinkers against this background.

Research Questions and Participants

Practice reports from addiction services in Germany show that many migrants from FSU countries assume—independent from which substance they use—that an addiction to alcohol or drugs can be cured in short time "successfully" by the therapists. The migrants often do not see a need for their active collaboration in the treatment process. In contrast, counseling and therapy in Germany build on the long-term strengthening of self-responsibility and self-reflection for overcoming addictive behavior (Czycholl, 2011; Osterloh, 2002). Such principles often irritate the migrants.

Against this background, we pursue the research questions mentioned above. For answering these questions, we conduct a study mainly based on interviews with the migrants complemented by participant observations and by expert interviews with service providers, which we will refer to later in this article.

All in all, 46 migrants from various FSU countries (Kazakhstan, Russia, Ukraine, Latvia, Lithuania) are

Table 1. Sample of FSU Migrants.

	Male	Female	Total
Age	*n* = 33	*n* = 13	*n* = 46
Up to 20 years	5	2	7
21-30 years	14	6	20
31-40 years	14	5	19

Note. Former Soviet Union.

included. The interviewees are 28.8 years old in average (see Table 1).

Interview and Analysis

Interviews with the FSU migrants focus on how they try to quit alcohol or drugs, how they interpret this withdrawal, and the role (earlier) experiences with the health care system play in this context. We use a specific narrative approach because this target group is hard to reach not only for the health care system but also for research. Weaver (2011) illustrates for her own research the ambivalence against survey research in similar groups:

> The Soviet experience of social science involved frequent, compulsory participation in standardized surveys . . . Academic research was an arm of Soviet supervision and central planning rather than a neutral scientific pursuit. This backdrop leaves my post-Soviet informants deeply ambivalent about social research. On one hand, they believe competent research should involve extensive objective questionnaires. On the other hand, such research is considered disconnected from relevant human experience, unpleasant, and cannot be trusted. (p. 147)

Therefore, we use an approach closer to individual experiences of ways into and out of addictions and address them from a process perspective. We apply episodic interviews (Flick, 1997, 2014) assuming that our interviewees have experienced two biographical disruptions (Bury, 1982): migration experiences coming from a FSU country to Germany and using drugs, becoming addicted, trying to quit the substances, looking for professional help, maybe failing with both, and being drawn back into addiction again. Both experiences comprise processes over a longer period. They run parallel if the substance use began before the migration or subsequently, if the addiction follows migration. They are fragmented in several periods and stages linked to specific situations, for example, situations of deciding to migrate, of turning to drugs or alcohol, of trying to find (professional) help or deciding to discontinue a treatment, and so on. For taking such a disruption-oriented perspective on the relevant experiences, we apply a method approaching small-scale narratives (see Flick, 1997) about specific situations rather than life span narratives of individual life histories. The episodic interview combines small-scale situation narratives with question/answer sequences. Interviewees are invited to recount situations relevant for them in the context of the study's topic—for example, about how they started taking drugs, their decisions to quit them, seeking professional help or experiences with therapists, or how they learned that they are infected by diseases following addiction. Questions refer to the interviewees' representations of addiction or of hepatitis, for example. Main areas covered in the interviews are addiction and hepatitis-related illness experiences and practices; risk awareness; help-seeking behavior experiences with the health care system, and expectations about help. The interviews lasted 60 min in average and were all audio-recorded. Twenty-eight interviews were done in German, 18 were consecutively translated German–Russian/Russian–German or completely done and transcribed in Russian and then verbatim translated to German.

We analyzed the data with thematic coding (Flick, 2014) in a two-step process. First, we categorized all narratives and statements referring to an area (e.g., experiences with the help system) in a case-specific way. Then, we defined comparative dimensions across cases according to which we assorted the cases in groups and analyzed for them specific combinations of features. In contrasting cases, we first compared cases in a group for similarities before working out differences across groups. We then interpreted the resulting types of interpretive patterns and practices for their meanings. For each of these patterns, we reconstructed an exemplary case history, oriented on the processes of consumption and of help-seeking behaviors the interviewee recounted. We were interested in the milestones and turning points when the use of drugs or alcohol or the acceptance of professional help took a different direction. Also, we looked for the occasions the interviewees referred to for reducing or terminating the use of drugs or alcohol, for possible relapses, for utilizing professional help or withdrawing from the help system. We also analyzed the recounted interactions with physicians, therapist, or other drug users, which we understood as the interviewees' individual experiences defining their further help-seeking or consumption practices. Finally, we analyzed how the interviewees interpret certain milestones (like a short-term or continuous abstinence) and which role they ascribe to themselves or formal or informal caregivers.

Our second focus is on how service providers perceive the migrants in their day-to-day work—in particular in drug-related counseling or therapy—and which challenges they see for working with this target group. We interviewed 33 service providers from several areas of the health care system—social workers, psychologists, and physicians (see Table 2) with expert interviews (Meuser & Nagel, 2009).

Our main foci in the expert interviews were on the perception of the clients in therapy and counseling, on how the

Table 2. Sample of the Experts: Service Providers (Gender and Area of Work).

	Gender		
	Male	Female	Total
Area of work	*n* = 18	*n* = 15	*n* = 33
Health	8	7	15
Social work	7	2	9
Migration	1	2	3
Justice	—	3	3
Administration	1	1	2
Education	1	—	1

migrants deal with hepatitis, on what was understood as good care, and on conditions of a good collaboration in working with the target group. We analyzed the expert interviews by working through thematic units of the single interview in a sequential way. Paraphrases are formulated and coded. This is followed by a thematic comparison aiming at building categories. Finally, the theoretical generalization follows, which is based on a sociological conceptualization of the statements (Meuser & Nagel, 2009). The questions we pursued in this part of the study are as follows: What are the requirements of health care for FSU migrants in the view of service providers in the health care system, how are subjective needs of FSU migrants represented? Which awareness of the problem do service providers in the health and social system express for the FSU migrants' use of alcohol and drugs and consecutive diseases related to this? How relevant is the problem; how many people do service providers estimate to be affected? What is lacking from their point of view in the available services to fulfill the needs of FSU migrants? Which cooperation with other services in the health care and which cooperation beyond health care does exist? What are the demands for coordination of services, what are potentials and limits? What are the consumption patterns and protection and risk behaviors that FSU migrants have in the view of the service providers? How do they estimate these coping needs and resources in the target group by regarding the addiction as well as consecutive diseases? The analysis of the perception of the migrants in the counseling or therapy process includes only experts who have direct contact with clients.

We will (a) turn to two case studies of FSU migrants before (b) discussing what we found in the expert interviews. In the final step (c), the two case studies presented here are confronted with the experts' experiences. This triangulation of perspectives will contribute to identifying the part cultural differences play in the process of seeking and finding help in this particular field.

Two Case Studies of FSU Migrants in the Therapy—Patients' Views

Two short case studies illustrate how FSU migrants with alcohol or drug problems move through the German health care system and what expectations they have about how their addiction should be treated. The two cases differ in how far they are informed about addiction-specific help and how focused they are in utilizing such help. Both interviews were conducted in German respecting the interviewees' preferences. Both interviewees were contacted first via service providers (physicians).

Case Study Fjodor

27-year-old Fjodor[1] was born in Kazakhstan and moved with his family to Germany when he was 16. He consumed alcohol and cannabis when in his home country. In Germany, he "experiments" with other illegal drugs and mainly consumes heroin. This is stressful because of the constant lack of money and the resulting tensions in the family. Fjodor looks for ways to stop using heroin and remembers in this context that he has already "heard" (Interview Fjodor, line 122) of methadone. In the beginning, Fjodor has only vague ideas of what that exactly is and how to get hold of this treatment/device:

> methadone, but I did not know where to find that, or where should I go now and ask for it, and then a buddy said, "you can go to that or this doctor," well get yourself substituted. I did not know what it is, but I thought: just try it and get off heroin in any case. (Interview Fjodor, line 123-126)

Fjodor's initial lack of knowledge about the possibilities of a methadone treatment is complemented by his very ambivalent attitude toward this substance. He sees the advantages of being treated with methadone compared with taking heroin. As methadone is prescribed and controlled by a doctor, worries about poisonous admixtures to the substance or about overdosing it are unnecessary. Furthermore, the ruled prescription of methadone means to be free of being forced to acquire money "somehow" for buying drugs, because, "if he (the addicted person) for example has no money, he still has his methadone" (Interview Fjodor, line 373).

At the same time, Fjodor is very interested in terminating his treatment with methadone, as it comes with health-related side effects. He sees an imprisonment for robberies as a chance as in jail the doses of methadone were gradually reduced. Fjodor assumes that, without the imprisonment forced on him, he would have continued to be in the methadone program he did not like. But he talks about the termination of the methadone treatment that began in prison as something resulting from his own initiative:

> Due to that jail thing also stopped again with methadone. Well they have dosed me down . . . I can say, from my view, I have finished that successfully. I wanted to come down already . . . but outside of prison that would not be possible. (Interview Fjodor, line 173-177)

Fjodor displays a rather undifferentiated attitude toward methadone, which he almost equates with a drug and thus bedevils. Fjodor experiences not only the methadone treatment as ambivalent but also the long-term drug therapy he is allocated to in the next step. He feels emotionally supported by the other patients and the therapists in his intention to live "clean" in the long run. What to expect in the therapy and how the processes work, however, is rather unclear for Fjodor. It is too much for him to continuously reflect his addiction and its causes. In addition, he holds in a sobered way that the therapy center does "not make much" of an offer (Interview Fjodor, line 308). But Fjodor neither has any more concrete ideas on what such offers should look like for being an effective help for him nor has he concrete ideas of what to expect from therapists or physicians in the various phases of his treatment. In particular, the physicians seem to be over challenged facing drug addicts' problems, which seem to be a massive confrontation for them.

> Because they currently have so many substituted persons or patients . . . more than fifty, sixty per surgery, and they don't know what to do next. (Interview Fjodor, line 366-368)

At the time of the interview, Fjodor not only had terminated his methadone treatment but also had a relapse, and had been intravenously consuming heroin again since past 4 months. The meeting with the interviewee was facilitated by a professional who organized it. In the interview, no signs were identified that the language was a problem. There were also no visible signs in the interview that a topic was particularly problematic for Fjodor to talk about.

Case Study Anatolij

Anatolij, 26 years, born in Ukraine, migrated to Germany at the age of 15 with his family. He starts consuming drugs in Germany, first with hashish and continues with heroin intravenously. Consuming heroin becomes stressful once Anatolij has to organize his whole day routine around acquiring the drugs, and he starts suffering from strong withdrawal symptoms. For terminating his heroin consumption, Anatolij repeatedly travels to Ukraine where he tries to get rid of his drug addiction under anesthesia. That this happens in a secure ward in a hospital is decisive for Anatolij, as this means there is no way of canceling this cold turkey even in case of withdrawal symptoms:

> then I feel worse, worse, worse. Then you only have in mind that you can freely go away. In the Ukraine, in these hospitals, where I was, when I come in there, then nobody lets me out. No matter what I do. (Interview Anatolij, line 134-138)

His parents are ready to pay several thousand Euros for this fee-based treatment that is not available in Germany. Back in Germany, Anatolij has a relapse every time. In addition, he repeatedly becomes a criminal as a consequence of his heroin addiction. The threat of imprisonment confronts him with questions about his own future and becomes a turning point.

> In my case it was such a kind of dilemma . . . because money I did no longer have, I can't steal any longer, because if they catch me once more, I will go to jail for two years . . . then I prefer to go to the program and better receive methadone than two years of jail and then out again and the heroin from the scratch again. (Interview Anatolij, line 345-352)

Seeing friends' experiences who relapsed after a forcedly drug-free time in prison, he decides for a methadone treatment for "quitting" drugs. Anatolij assumes to be "addicted to this methadone therapy" (Interview Anatolij, line 379), as he has always to take care in everyday life to carry the appropriate dose of the medicament with him. He accepts this as well as the side effects of the treatment. It is important for him that he does no longer feel a desire for heroin and has found his way back into a relatively "well-ordered way of living."

Anatolij is ambivalent about a long-term drug therapy. He feels uneasy about the idea of talking about personal states and feelings in the therapy—in particular in a group of people he does not know. He is also aware that there is no alternative to a long-term therapy, if he wants to live without drugs in the longer run and to overcome his mental addiction.

> There you have to sit around every day and talk. "I have done this and that, what do we do now. So and so." I am not such a guy. I can't do that . . . (I: And why do you want to do a therapy then?). Because I have to free that out of my head somehow, that I have to think of that (heroin). (Interview Anatolij, line 552-565)

Anatolij has rather clear ideas about whom to address for seeking help for getting rid of his addiction. He also knows quite well, how physicians or therapists should behave for really supporting him. They should show a true interest in his situation. For him, a mutual (basic) trust is the basis for enduring critique or short-term crises in the therapist–client relation. If Anatolij feels devaluated as an unloved patient, he restricts himself to what is absolutely necessary in dealing with therapists and physicians.

> To be honest I have searched for this surgery only for making them give me methadone . . . To make conversations is

> something I can do with my drug counselor . . . with this doctor, I don't want chat. And with this nurse neither . . . I see his face how he, how she gives me that. As how they were brutes. (Interview Anatolij, line 402-410)

At the time of the interview, Anatolij had been in the methadone program for 2 years and did not take any heroin during this period. A physician first organized the meeting with him. After receiving information about the study from his doctor, Anatolij took the initiative and called the researchers for making an appointment and came to the university for the interview, which was conducted in German. There were some topics in the interview Anatolij obviously did not want to talk about. Asked what he understands as a good therapist/physician, he said, "You have to have experienced your self, one can not describe this" (Interview Anatolij, line 425). Asked whether his drug counselor sometimes makes suggestion, which are difficult to implement, Anatolij first said, "Sometimes yes" (Interview Anatolij, line 486). Responding to researcher's probing, which kind of suggestions this might be, Anatolij responded, "I can't say that and I don't want to say that either" (Interview Anatolij, line 488). When asked when and under which circumstances he goes to the doctor if he does not feel well, Anatolij first said, "Oh I don't want to talk about this, I don't know when. I don't want to say to avoid that this comes" (Interview Anatolij, line 682-683). When the researcher insisted that she wanted to know, when he would go see a doctor if it had to be, Anatolij recounted a situation, when he saw a dentist. Why this misunderstanding occurred, whether it was on a cultural or an individual level, remained unclear in the interview.

Fjodor and Anatolij—A Comparative Perspective on the Cases

Fjodor and Anatolij have consumed heroin intravenously for years. This has produced several health-related and social problems. At some point, both see no other choice than terminating their heroin consumption and getting substituted with methadone for this purpose. Whereas Anatolij seems to know what is behind a methadone treatment, Fjodor first does not know what he gets himself into with the treatment. After their initial (practical) experiences with the treatment, both see it as ambivalent. Methadone appears as a way, "to receive drugs legally" (Fjodor, line 128). At the same time, they complain about the side effects of this medication and the need for a "dosage management." The two young men differ in the consequences they draw from their perception of the methadone treatment: Anatolij endures the problems (side effects, for example) hoping to get away from the desire for heroin step-by-step because of the treatment. Similar to Anatolij, who assumes in a different context that the withdrawal from heroin best should happen in a closed ward of a hospital, Fjodor welcomes that the methadone treatment is terminated step-by-step in the course of an imprisonment: If there is no escape from the (forced) withdrawal, there is nothing to do except enduring its unpleasant consequences. Both Fjodor and Anatolij see the withdrawal from heroin—or also from methadone—as the decisive step into a drug-free life. A long-term drug therapy seems (almost) superfluous compared with that.

Nevertheless, Fjodor decides in the process—again without knowing which challenges come with it—for a therapy, which he sees as helpful only in a limited way. Anatolij, on the contrary delays this therapy first, although he is aware that there is no alternative to a long-term therapy. In contrast to Fjodor, he knows very well what to expect as support from physicians and therapists and what that support should ideally look like.

Both men seem to be motivated to accept addiction-specific support. Anatolij seeks for help in a relatively goal-directed way on the basis of (basic) information about the available ways of support. Compared with this, Fjodor decides spontaneously to take on specific forms of help about which he is informed in a rather limited way. Thus, it is difficult for him to actively influence the help process and to yield his own needs and interests. The differences in knowledge could be one reason why Anatolij has stabilized for a longer time when the interview happens and shows up regularly at the methadone treatment, whereas Fjodor has relapsed and turned to heroin again.

FSU Migrants in Therapy—Services Providers' Views

If we want to understand how FSU migrants with drug and alcohol problems in Germany find access to professional help, what makes this access complicated, and what their experiences are in this context more comprehensively, we need to study also the second side of that encounter (or failure). We can assume that the migrants experience the treatment process differently compared with service providers' views. In this study, the patients' views are "framed" by service providers' experiences, for which we identified three interpretive patterns.

Lack of Fit

The first pattern applies to six interviewees and is characterized by the experts' rather deficit-oriented view on the migrants. The interviewees assume that the migrants consume alcohol and drugs like heroin in a very intensive way, but are hardly reached by the help system in a sustainable way. For their frequent "failure," these service providers mainly see the migrants themselves as responsible. For these interviewees, the migrants are hardly aware that their own use of substances is very risky and might have far-reaching health-related consequences and impacts on their further life plans. Thus, the migrants would not see any

need for seeking help and to participate actively in the process of support. Help is only consumed in a rather passive way. Without any personal motivation on the side of the migrants to change something about their problems with alcohol or drugs, the experts see any offering of help as not very promising:

> All interventions are in vain, if the readiness and motivation are not given. Or the level of suffering is not high enough that they accept that help at all. (Interview Mr. Siebert, line 294-296)

Experts in this group mention that many of the migrants intend to terminate their drug consumption but after an intense use over years, are no longer able to do so. These clients seem to be tired and serene and no longer trust themselves to "exit" their addiction according to these interviewees. Mostly, they no longer can endure a withdrawal or weaning from the drugs, and relapse. Revolving door effects occur between phases of complete social disintegration linked to an intense intravenous consumption of drugs and treatment periods with medically controlled prescriptions of substitutes:

> and then they hang around again of course on the street, the game starts again from the scratch, that you again from this side with the substitution. (Interview Mr. Garz, line 123-125)

Often the migrants seem not to "fit" in the care system right away. While according to these experts, they impose conditions before they accept any support, they are not really ready to "invest" in the help process from their side and to reflect their ways of dealing with alcohol or drugs. High standards the clients demand from the health care system refer to the external framework conditions in which help is provided—they wish some kind of hotel like location and equipment of the therapy institution:

> that are freeloads . . . something smaller, no, they are not interested . . . all those institutions . . . "X is more beautiful, there are mountains, there are forests" . . . no to give too much and above all, I can break all my promises at every time, but the state has to go on with supporting me and on a very high level. (Interview Mr. Moltke, line 578-594)

At the same time, according to experts, the migrants are very demanding in what concerns the concrete set up of the support. Thus, they often expect a long-term treatment with methadone, even if this seems inadequate in the view of the health care system.

Invisibles

The second pattern characterizes that the service providers perceive the migrants as clients who have to face various challenges and burdens in Germany. This also includes alcohol and drug problems, but these are not seen as the clients' main problems. These interviewees are not sure how far their clients are concerned by alcohol or drug problems and how severe these are. Migrants with alcohol or drug problems become invisible in the health care system, whose (consumption-related) needs for help can be easily ignored by the health care system. Such a pattern could be identified for eight interviewees.

> This is an issue for a specific group. But nothing that somehow for them, for this group in particular would be something special . . . It is relevant. Uhm I can't say so. Well I believe that it is a rather minor part of the adolescents. (Interview Mrs. Antes, line 725-737)

Some interviewees in this group highlight that the migrants' alcohol or drug consumption often has sociocultural backgrounds or is rooted in the youth culture. Substance use is described as an age-appropriate experimenting with psychoactive substances and thus as episodical. Clients appear as "completely normal adolescents with completely normal problems, youth typical problems" (Interview Mr. Stark, line 259-260). Attempts to intervene against the alcohol or drug consumption are unnecessary for these experts. They assume that the substance use will sort itself out over time or will lose its relevance, as soon as the problems behind it have been solved.

If these interviewees mainly stress the sociocultural embedding of substance use, they refer to the migrants being torn apart between the cultures of their country of origin and the one they now live in. Drinking alcohol in particular becomes a performance, which serves for coping with such identity problems. The migrants therefore "play" with the prejudices and stereotypes in the public and the media about their sociocultural background and try to distance from these stereotypes or to confirm them. In the view of the health care system, in such situations, an addiction-specific help is less relevant than to strengthen the life world skills of the clients:

> such a tendency of young people who say "I am now here a Russian German, I have to completely distance myself from this image, for example I don't drink any alcohol . . . do a super A level degree" . . . and there are adolescents . . . who overly fulfill this ascription . . . "No I will show again right away that I am a real Russian . . . can also drink more than a German so to say." (Interview Mr. Samel, line 59-72)

Interviewees in this group can qualify the idea that alcohol or drug problems rather are relevant for a (smaller) subgroup of the FSU migrants. They refer to the drastic consequences of an intense use of substances. Serious consequences of using alcohol or drugs are for these experts that a risky consumption pattern may lead to serious diseases like HIV/AIDS or Hepatitis C. This is particularly serious, if the migrants have no access to a regular medical treatment because they have no health insurance. These

interviewees assume at least implicitly that the migrants are stressed more by not being treated in the regular medical care system or by (traumatic) experiences as fugitives than by the alcohol or drug consumption per se:

> one case, where AIDS has already started, you can only assume, due to their consumption . . . because we talk about chronic diseases here, it is more complicated again, because, if the medical care is effective at all, then it is effective for acute patients. (Interview Mrs. Seewald, line 680-701)

Challenge

This third pattern characterizes that the experts refer to the target group's very specific alcohol- or drug-related attitudes and practices. An appropriate addiction-specific treatment of clients from FSU countries appears as a particular challenge against this background. The service providers can cope with this challenge, if they take the cultural-specific background of the target group into account. Such a pattern could be identified for 16 interviewees.

To be addicted to drugs like heroin is linked to very strong feelings of shame and guilt for migrants from FSU countries according to these interviewees. The migrants feel inferior and think that they are helplessly at the mercy of their addiction diseases. Such fatalism narrows the choices how they can act in this context:

> such a self image that says—well I exaggerate that now—"Well we are genetically minor human material and you can not help us anyway." I can't do anything. And that is really drastic, because it takes of very long, until they take their own decisions. (Interview Mr. Gleim, line 46-50)

According to these interviewees, the migrants condemn themselves for having become addicted. Often it seems a "normal" part of their everyday world to consume alcohol in high doses quite regularly. To depend on drugs, however, appears to be a weakness, which does not fit their own self-image. In this context, the migrants refer to the stereotype of a "pauperized person addicted to drugs," from which they distance themselves. Once these migrants can no longer ignore that they have a problem with alcohol and drugs, they tend to overestimate their own control over frequency and intensity of their own drug consumption according to these interviewees.

> They quickly see themselves as losers. As devil's children . . . try very very long not to be categorized like that or not categorize themselves like that. And try to convince themselves "I have a minor problem and I will sort that out again." (Interview Mrs. Gyptner, line 304-431)

Experts in this group highlight that the migrants do not see themselves as responsible for the development of their addiction diseases. Their own families do not concede such a responsibility to them. According to these interviewees, these migrants can be almost incapacitated by parents or older siblings, if they try to influence the therapy process according to their own ideas. At the same time, the migrants are not ready to take on responsibility for the further development of their diseases. Instead, the experts mention that the migrants assume that the doctor has to "make them healthy" again. In the health care system, it is mainly the physicians, whom the migrants "trust in an almost unlikely manner" (Interview Mrs. Gebauer, line 212).

These interviewees assume that the addition to drugs for the migrants files without further ado among the other diseases treated by the doctor. The need to become active to positively influence the addiction, thus, is not seen.

> That "Being put together." To be repaired . . . without contributing much themselves. As other diseases are treated by the doctor and you cannot contribute much . . . Limited readiness to let oneself be actively challenged. (Interview Mr. Gilge, line 382-385)

These experts refer to a rather mechanistic concept the migrants have of their own addiction. It appears as a physical disease, against which it would be best to prescribe a pill. Furthermore, the migrants believe "the doctor then knows what to do" (Interview Mrs. Gebauer, line 232) and expect directions of how to act "correctly" facing their drug addiction. According to these interviewees, the doctor is not only confronted with the addicted person's very high expectations. Also, the migrants' parents hope that the physicians can "heal" their drug-addicted children with medications in a very short time and thus are above to make everything "come back to order" and family and social life will go on again as usual.

> Parents very often come and say "look here he is, look at him he does not function appropriately. Give something to him," and then it has to go at a fast pace. (Interview Mr. Stoll, line 361-362)

The generally high expectancies the migrants have on physicians are contrasted by a strong skepticism against therapists according to these interviewees. Therapists cause a feeling of rejection in the migrants with their imposition to reveal personal thoughts and feelings in the treatment process—maybe even in front of a larger group of other patients the migrants did not know before. As the migrants see the physical symptoms of the addiction in the foreground, they often think that a withdrawal of the drugs and a substitution is sufficient for being "healed" from their addiction to drugs. Psychotherapeutic treatments in the context of a mental weaning from the drugs appears an unnecessary harassment to them:

> that all is some kind of kids' stuff and first is put to question very much, huh? "Which should I do such a rubbish right now, I am here because I feel bad physically and I need my medication and beyond that I want, I need some rest and don't want to be bother that much if possible." (Interview Mrs. Grahl, line 206-210)

Experts in this group also refer to the particular strength of migrants from FSU countries that can be used in the process of treatment, counseling, or therapy. Thus, the migrants stick to rules and arrangements, if they are comprehensible to them, much better than clients without migration backgrounds. These are often oriented to subcultures, protest in principle, and refuse demands and arrangements as soon as they come from some kind of "authority." A strong social control by their own group in the case of the migrants, who punishes any deviation from (internalized) norms in principle contributes to a stronger acceptance of rules on the side of the migrants. Such an effect-building on self-socialization can be utilized for the therapy.

> He said "the therapist do not have to take care that the rules are obeyed, we will do that" and woe to anyone not sticking to the rules, he will have problems with the others in the group, not with the institution. (Interview Mrs. Janka, line 635-638)

These interviewees point out that flat hierarchies between therapists and patients possibly over-challenge for clients as they question ideas of obedience and respect. This may also make the migrants start to doubt about the therapist's authority and professional expertise, if the treatment is dominated by the basic principle of an equivalent togetherness of help seeker and therapies. If traditional role concepts in the process of therapy and counseling are maintained and if ways of treatment are sought, which prevent the migrants from "opening" up in front of other patients, it is easier for them to accept help.

> If someone enters a room, who is higher in the hierarchy, older or a superior, then you will shut up first . . . if our doctor puts on a white gown and says: "so and this is how it works now," then it works more easily . . . interactive group therapy at eye level, that is more complicated. (Interview Mr. Gessner, line 247-255)

FSU Migrants in Therapy—Views of Clients and Experts

In what follows, the views of Anatolij and Fjodor on the treatment of their addictions and the expectations they link with it are related to service providers' perceptions.

Both young men have started a substitution treatment due to the stress resulting from their drug consumption. However, they are critical about a (long-term) drug therapy or avoid it despite their better judgment. Fjodor and Anatolij are irritated because these therapies are talk oriented and require a high degree of self-reflection. That migrants from FSU countries shriek back from treatments of drug addiction that are not based on directive behavior instructions or, even better, on the prescription of medication for "becoming healthy," is also highlighted by our experts. They also explain that the migrants often tend to assume that the physical withdrawal of heroin is sufficient for living without drugs in the long run. As our interviews show, Fjodor and Anatolij tend to such an assumption.

Our still preliminary analysis of the interviews also makes evident that some of the experts refer to high demands migrants from FSU countries have about treating their addictions. This includes for example that they are prescribed methadone continuously. Some of our experts see this as evidence that the target group "takes a rest" on this kind of treatment and is not ready to endure the exertions of a drug withdrawal.

The experts' views about the migrants' unrealistically high claims are not reflected in the interviews with Fjodor and Anatolij. In contrast, both even mention that the methadone treatment is uncomfortable for them because of its side effects. A successive termination of this treatment in the context of an imprisonment thus is—sweepingly—welcomed. Beyond the particular issue of methadone therapy, our interviews with the two young men show how a certain group of the FSU migrants still is unsecure about what to expect in the context of an addiction treatment in general. Having limited information about what they can expect as support in their special case and about whom to turn to for this maybe is a (unreflected) reason for the passivity of the target group, which a number of our experts complain about.

In the last part of this article, we want to pick up again the main topic of this special issue and add some methodological reflections about using interviews in such a study with an issue and target group in the context of globalization.

The Methodological Challenge: Using Interviews in a Non-Western Context

If we want to use our methodologies like interviewing beyond our traditional cultural contexts, we are confronted with methodological challenges on five levels: (a) concepts of what research is, (b) issues of access to fields and participants, (c) how to do interviews, (d) how to locate our data between cultures, and (e) how to analyze the data without under- or overestimating the role of culture and cultural differences. These challenges become relevant also for studies focused on migrants with a different cultural background, in this case, migrants from FSU countries, and their experiences in "our" culture.

Challenge 1: Qualitative Research in FSU Countries

When conducting research with migrants from FSU countries, we may face differences in the background assumptions about what research is like and what certain methods are about. Qualitative interviews and participant observation are historically often seen as "sounding out." The methodological approach of qualitative research is often unknown: Open formulation of questions without fixed answer options are misunderstood as researchers' lack of preparation. The researchers' neutral attitude and the principle of non-direction rather produce participants' distrust than opening a space for unfolding their specific experiences. The idea of presenting longer narratives is often unusual for the participants and produces fears of too much intimacy and "interrogation." Questionnaires are ambivalent as they are seen as the (more) competent academic research but known as instrument of Soviet control at the same time (Fröhlich, 2012).

For the context of interview research in Non-Western societies, we should consider and reflect a number of tacit assumptions on which the use of interviews is based in Western societies (see also Gobo, 2011). Western European societies are interview societies. The impact of this on the way identities are constructed and communicated may be discussed critically (e.g., Atkinson & Silverman, 1997). But it makes it quite a common idea and experience that people are interviewed for research or other purposes (like in talk shows, journalism, or the like). It is also common to talk about your own personal history and individual experiences to a professional stranger, for example a researcher. It is not uncommon to have such a conversation recorded if some rules are defined. Rules refer to rather technical aspects like anonymization, the guarantees of data protection, limited access to the data and a reflected and secure use of excerpts in publications for example. However, these technical issues have an important impact on the security and trust in the participation in a research situation. Questions can be very structured or rather open and invitations to tell one's story or life history are not uncommon in research in societies like Germany. For some participants it may be an irritating idea but still quite usual that your statements later are analyzed and interpreted for underlying or background meanings of what has been said.

In East-European societies like the FSU states, but also the former East Germany, interviews have (had) a different connotation. This becomes relevant if we want to conduct interviews in that local context or in Germany with people, who immigrated from such countries. There, to be interviewed may mean to be investigated. It was not so usual to talk about your own personal history and individual experiences to a professional stranger. In particular, recording, for example in the context of interviews meant that there were files and reports about you. Consequently, recording and analysis meant a loss of control and were experienced as dangerous. These background assumptions can influence the decisions whether or not to participate in an interview study referring to whichever topic as well as the readiness to speak openly about one's experiences in an interview. Weaver (2011) mentions another relevant point in this context. She holds that "Interviews must be adapted to culturally appropriate discourses and address local expectations of competent social research" (pp. 145-146). In her study, she interviewed American, Russian American, and Russian communities in the United States and Russia and shared the experience that "Although ethnically 'Russian' and ethnically 'American' informants offered me similar answers on a range of topics, the circumstances under which they would discuss those answers varied in patterned—and eventually predictable—ways" (p. 146).

Thus, conducting interviews with post-Soviet participants is confronted with two general reservations: (a) about how far social research(ers) can be trusted or how far there is a second (political) agenda which determines the (further) use of the information given in an interview for example; (b) that social research should consist of questionnaires or structured interviews with clear and focused questions. Open questions or unobtrusive attitudes in asking or letting participants tell their stories would be seen not only as not onerous or threatening but also as not competent. Fröhlich (2012) reports similar experiences from interviewing people in NGOs in Russia.

Challenge 2: Access to the Field and Interviewees

A major challenge is how to find access to the target group of interviewees relevant for this study. The first way is to access them directly, for example in periods of participant observation in meeting points, clubs, and so on. As our field protocols show, this can be difficult:

> When the researcher and S. (a native speaking Russian research student) come to the youth club, four young emigrants (Aussiedler) who speak an almost accent-free German are among the visitors. When S. addresses the emigrants in Russian, the (informal) "leader" of the group looks full of distrust and immediately switches to German. After that, the four withdraw from the researchers into an upper level of the building. (Protocol I: July 2012)

This withdrawal can be a general age-specific refusal of (adolescent) unwillingness to participate in a study. But that the refusal began immediately after being approached in Russian can also be a sign that the language (shift to Russian) played a role as an obstacle here.

Other potential interviewees withdrew their consent for being interviewed, once the issue of recording the interview comes up. The second way is to access migrants/clients via service providers, which had to be applied in most cases. But here as well, confirmed contacts often ended in the nowhere. Twenty-six institutions and their staff were contacted. Six of them were reliable mediators of access to their migrant clients. Providers sometimes act as gatekeepers by referring to mistrust and resistance in the target group and to their problematic situation. In these cases, the service providers rather obstructed than facilitate the contact to potential interviewees. In general, it is difficult to reach the clients, who are sometimes unreliable because of their drug consumption. But sometimes migrants addressed the researcher autonomously. Native speaking interviewers can be seen as an obvious threat, which leads to fear of breach of secrecy and withdrawal. Thus, the access to the migrants is often organized via the service providers who work with the target group and are informed about the study aims in written form. On this basis, the providers try to win immigrants for a participation in the study and to put them in contact with the researchers.

Challenge 3: Conducting Interviews With Russian-Speaking Migrants

The third challenge refers to how to conduct the interviews. The first point here is the language in the interview. This decision should take into account the symbolic meaning of language, which is linked to an expression of power, status, identity, and personnel influence. To conduct the interview in Russian means that we need to work with interpreters or translators (see Edwards, 1998; Edwards & Temple, 2002; Lopez, Figueroa, Connor, & Maliski, 2008; Temple & Young, 2004). High demands for interpreters/translators include that they have very good skills in original and target language (Russian and German). They also need culture-specific skills like knowledge about symbolic codes and rules of behavior, which allow them to be sensitive for the latent structures of meaning in the process of interpretation and translation. This means that they may be potentially over challenged by the double role of being interviewer (responsible for the content) and interpreter. Coming from the same culture as the interviewees and sharing their language is not necessarily sufficient for sharing a life world reference between interviewers and interviewees due to differences in age, gender, social status, belief systems, and the like. In the beginning of the interview, it is necessary to give detailed information about the procedure and to emphasize that there is no wrong or right in the interviewees' views.

Once the interviewees had accepted the interview situation the migrants in our study were generally ready to reflect and talk about their situation. One major exception was questions about the family, which is sacrosanct in the FSU area, where family problems tend to be concealed. This was also a trend in our interviews. During the interview, the interviewer often fed back what had been said for avoiding feelings of being sounded out on the side of the participants. The interpreters and translators were native Russian-speaking students with social science background, who received training before the interviews. Edwards (1998) underlines how important it is to work with "suitable interpreters" (p. 199), who had been trained for their role in the current project. Edwards also suggests not to see interpreters as an influence to minimize as far as possible (making it invisible) but to make interpreters visible, to see them as a form of key informants, and to include their own experiences and relations to the target group and issue. In our project, it was necessary to translate information letters and interview guides into Russian, and to control their adequacy through back translation. That we let the interviewees always choose the language for their interviews had the result that most interviews were conducted in German as they referred to their good language skills. However, 18 interviews were conducted in Russian. This means, these interviews involved three persons: the researcher (directs the contents of the conversation), the interpreter, and the interviewee. These interviews were based on consecutive interpretation during the interviews.[2] This was followed by a complete transcription of the interview and verbatim translation of this text into German, which was controlled by a second interpreter/translator. In general, the interviews conducted in Russian were less yielding than those in German.

Challenge 4: Data Between Cultures

The data then included statements about the interviewees' understanding of addiction like the following example:

> Heroin is like a swamp, if you are in it, you can't get out . . . if you are a junkie, you don't live well, you are a plant. One waters you, you move and sleep but the meaning of live you won't experience . . . go for a good meal or swimming, talking to a girlfriend, a junkie does not have this . . . that is not human, that is already animal-human. (Interview Sergey, line 312-331)

Here, we see a concept of addiction, in which the interviewee focuses on being abandoned to the drugs. He sees drug addiction as an unavoidable decay linked to ideas of having no future and to expect a miserable death. Such views express analogies to very fatalist ideas in FSU countries. They show that many FSU interviewees see a controlled use of alcohol and drugs as impossible. After some years with drugs, addiction, and experiences with the German drug treatment system, such views can be seen as analogies to views in FSU countries or as a result of therapies in the German health system.

> But everything becomes uninteresting because you lack it. You take something and it seems that you are doing fine, but once you stop, you miss it immediately. It lacks—you consume it since many years and that is part of your life. (Interview Vadim, line 268-271)

Such statements see addiction as a minor problem in the subjective meaning of using alcohol and drugs. Substance use "serves" for coping with problems and regulating emotions. This is a "typical" experience for people with extensive use of alcohol and drugs. If interviewees express such a view, can this indicate the interviewees' integration into social networks consisting of local (German) people? Do such views show that there is a universality of experiencing alcohol and drugs—which reduces cultural influences on such experiences to being minor? This leads to the question of how to locate statements between the individual situation of the (addicted) interviewee and the general features of the problem (addiction). This also raises the question of the cultural specificity in the interviewee's background of migrating between two cultures, or more generally: Which is the role of culture for understanding what is said in the interviews?

Challenge 5: Analyzing the Data

In projects like our example, an assumption of difference often is the basis for the analysis: The research question builds on assumptions that this specific group of migrants faces particular problems (in accessing professional support) or has a specific (culturally informed) understanding of help and of their problems. The data analysis focuses on potentially culture-specific views. The interpretation of the data oscillates between diverse cultures (here German and cultures of former FSU countries). The starting points then are questions like: Does the ethnic background influence the understanding of diseases, addiction and the help-seeking behavior? If such questions are pursued without enough reflection, overestimating the cultural influences may result. However, migrants' views and practices related to health, addiction, and disease also depend on individual factors, social milieus, or life conditions (beyond their migration background). But we should also keep the opposite problem in mind: the danger of underestimating or ignoring culturally influenced interpretations. We should take into account not only contents but also implicit (culturally specific) narrative patterns. For culturally grounding interpretations of statements and practices, ethnographic and historical knowledge about the group under study are necessary prerequisites for the researchers. One way again is to use interpreters as mediators of culture (Kluge, 2011). That means to integrate native speakers also in analyzing the data, for example, for checking back the meaning of words and idioms, of words or phrases. As a basis for such an extended understanding of the contents of interviews in different language adequately Inhetveen (2012) suggests to not only carry out oral translations during the interview but also a written translation of the transcript after the interview and to compare both for differences. Schröer (2009) for this purpose suggests integrating culture-native co-interpreters to bridge the gaps between the researchers and their "foreign objects." Both suggestions are applied in our study.

Two Sides of the Global in the Local: The Need for Triangulation

In this article, we outline methodological challenges linked to a project focused on the experiences of a specific group of migrants (coming from FSU countries) with alcohol and drug problems in the health care system of their host country (Germany). The article is focused on studying an encounter—whether it happens or not—between two parties with differing backgrounds. It shows how interviewing the migrants needs taking into account their cultural backgrounds, and the differences in understanding (qualitative) research and the issue (drugs, addiction, and therapy). It also focuses on the need of seeing these clients' experiences in the framework of providers' experiences and views for highlighting the differences between both, and thus elucidating the cultural part of such differences. The methodological challenge then is: How to analyze the encounter between potential clients with a different ethnic background (e.g., FSU) and the local health system (representatives) in a methodologically sound way? How to catch both sides in the process and how to seize the cultural aspect of this process in a sensitive way? A helpful methodological approach in this context was to design the study with triangulation (Denzin, 1989) on several levels as a systematic triangulation of perspectives (Flick, 2011): We emphasized "investigator triangulation" by including several research students with a language background in Russian and coming from the same cultural contexts as our potential interviewees. We used several theoretical background theories ("theory triangulation") like social representations theory and the "social problems work" approach (see for this Flick, 2011). The methodological triangulation in this project was based on using several approaches (between methods triangulation) in the form of different types of interviews and participant observation. The data we received and triangulated made differences between concepts of addiction visible. Such a research asks for a careful reflection about the process leading into the field, to the data and from the data to conclusions.

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References

Atkinson, P., & Silverman, D. (1997). Kundera's immortality: The interview society and the invention of the self. *Qualitative Inquiry*, *3*, 304-325.

Blätter, A. (2007). Soziokulturelle Determinanten der Drogenwirkung [Socio cultural determinants of drug effects]. In B. Dollinger & H. Schmidt-Semisch (Eds.), *Sozialwissenschaftliche Suchtforschung* (pp. 83-96). Wiesbaden, Germany: VS Verlag für Sozialwissenschaften.

Bundesministerium für Gesundheit. (2008). *Drogen- und Suchtbericht* [Drugs- and addiction report]. Berlin, Germany: Drogenbeauftragte der Bundesregierung.

Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness*, *4*, 167-182.

Czycholl, D. (2011). *Kompetenznetzwerk Sucht-Selbsthilfe für Migranten aus dem Osten (KOSMOS). Aufbau eines neuen internetgestützten Selbsthilfeportals für junge Drogenuser (Exjuse)* [Competence-network addiction-self-help for migrants from the East (KOSMOS). Establishment of a new Internet-based self-help portal for young drug users (Exjuse)]. Hannover, Germany: Fachverband Drogen und Rauschmittel e.V.

Denzin, N. K. (1989). *The research act: A theoretical introduction to sociological methods* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

Edwards, R. (1998). A critical examination of the use of interpreters in the qualitative research process. *Journal of Ethnic and Migration Studies*, *24*, 197-208.

Edwards, R., & Temple, B. (2002). Interpreters/translators and cross-language research: Reflexivity and border crossings. *International Journal of Qualitative Methods*, *1*(2), Article 1. Retrieved from http://www.ualberta.ca/~iiqm/backissues/1_2Final/pdf/temple.pdf

Flick, U. (1997). *The episodic interview: Small scale narratives as approach to relevant experiences* (LSE Methodology Institute Discussion Papers - Qualitative Series 5). Retrieved from http://www.lse.ac.uk/methodology/pdf/QualPapers/Flick-episodic.pdf

Flick, U. (2011). Mixing methods, triangulation and integrated research—Challenges for qualitative research in a world of crisis. In N. Denzin & M. Giardina (Eds.), *Qualitative inquiry and global crisis* (pp. 132-152). Walnut Creek, CA: Left Coast Press.

Flick, U. (2014). *An introduction to qualitative research* (5th ed.). London, England: SAGE.

Flick, U. (2014). Challenges for qualitative inquiry as a global endeavor—Introduction to the special issue. *Qualitative Inquiry*, *20*, 9, 1059-1063.

Fröhlich, C. (2012). Interviewforschung im russisch-sprachigen Raum – ein Balanceakt zwischen methodologischen und feldspezifischen Ansprüchen [Interview research in the Russian-speaking area—An act balancing between methodological and field specific demands]. In J. Kruse, S. Bethmann, D. Niemann, & C. Schmieder (Eds.), *Qualitative Interviewforschung in und mit fremden Sprachen* (pp. 186-202). Weinheim, Germany: Beltz Juventa.

Gobo, G. (2011). Glocalizing methodology? The encounter between local methodologies. *International Journal of Social Research Methodology*, *14*, 417-437.

Inhetveen, K. (2012). Translation challenges: Qualitative interviewing in a multi-lingual field. *Qualitative Sociology Review*, *8*, 28-45. Available from www.qualitativesociologyreview.org

Kirtadze, I., Otiashvili, D., O'Grady, K. E., Zule, W., Krupitsky, E., Wechsberg, W. M., & Jones, H. E. (2013). Twice stigmatized: Provider's perspectives on drug-using women in the Republic of Georgia. *Journal of Psychoactive Drugs*, *45*, 1-9.

Kluge, U. (2011). Sprach- und Kulturmittler im interkulturellen psychotherapeutischen Setting [Mediators of language and culture in intercultural psychotherapy settings]. In W. Machleidt & A. Heinz (Eds.), *Praxis der interkulturellen Psychiatrie und Psychotherapie. Migration und psychische Gesundheit* (pp. 145-154). München, Germany: Urban & Fischer.

Lopez, G. I., Figueroa, M., Connor, S. E., & Maliski, S. L. (2008). Translation barriers in conducting qualitative research with Spanish speakers. *Qualitative Health Research*, *18*, 1729-1737.

Mendelevich, V. D. (2011). Bioethical differences between drug addiction treatment professionals inside and outside the Russian Federation. *Harm Reduction Journal*, *8*, Article 15.

Meuser, M., & Nagel, U. (2009). The expert interview and challenges in knowledge production. In A. Bogner, B. Littig, & W. Menz (Eds.), *Interviewing experts* (pp. 17-42). Basingstoke, UK: Palgrave MacMillan.

Osterloh, K. (2002). Arbeit mit MigrantInnen aus der GUS, die illegale Suchtmittel konsumieren – am Beispiel der mudra Drogenhilfe Nürnberg [Working with migrants from the GUS who consume illegal drugs—The example of the Mudra drug counseling service in Nuremberg]. In Landeszentrale für Gesundheit in Bayern e.V. (Ed.), *Sucht und Migration. Suchtprävention und -arbeit mit Menschen aus der GUS* (pp. 49-61). Traunreut, Germany: Landeszentrale für Gesundheit in Bayern e.V.

Pfeiffer-Gerschel, T., Kipke, I., Flöter, S., Jakob, L., Budde, A., & Rummel, C. (2013). *Bericht 2013 des nationalen REITOX-Knotenpunkts an die EBDD. Neue Entwicklungen und Trends* [Report 2013 of the national REITOX-nodal point to the EBDD. New developments and trends]. München, Germany: Deutsche Beobachtungsstelle für Drogen und Drogensucht DBDD.

Saitz, R., Larson, M. J., Labelle, C., Richardson, J., & Samet, J. H. (2008). The case for chronic disease management for addiction. *Journal of Addiction Medicine*, *2*, 55-65.

Schmidt, L. (2004). Aussiedlerjugendliche in der Suchtprävention: Hintergründe eines spannenden Verhältnisses [Adolescent emigrants in the addiction prevention: Backgrounds of a fascinating relation]. In Aktion Jugendschutz, Landesarbeitsstelle Bayern e.V. (Ed.), *Es muss nicht immer Wodka sein . . . Ideenbuch zur Suchtprävention mit jugendlichen Spätaussiedlern* (pp. 9-19). München, Germany: Aktion Jugendschutz, Landesarbeitsstelle Bayern e.V.

Schröer, N. (2009). Hermeneutic sociology of knowledge for intercultural understanding. *Forum Qualitative Sozialforschung/ Forum: Qualitative Social Research*, *10*(1), Article 40. Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs0901408

Schumatsky, B. (2013). *Keine Menschen, keine Probleme. Drogenmissbrauch und Politik in Russland* [No people, no problems. Drug abuse and politics in Russia]. Retrieved from http://www.deutschlandfunk.de/keine-menschen-keine-probleme.724.de.html?dram:article_id=259318

Sluzki, C. E. (1979). Migration and family conflict. *Family process*, *18*, 379-390.

Spicer, N., Bogdan, D., Brugha, R., Harmer, A., Murzalieva, G., & Semigina, T. (2011). "It's risky to walk in the city with syringes": Understanding access to HIV/AIDS services for injecting drug users in the former Soviet Union countries of Ukraine and Kyrgyzstan. *Globalization and Health*, *7*, 1-15.

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, *4*, 161-178.

Weaver, D. (2011). Neither too scientific nor a spy: Negotiating the ethnographic interview in Russia. *Comparative Sociology*, *10*, 145-157.

White, W. L., Boyle, M., & Loveland, D. (2003). Alcoholism/ addiction as a chronic disease: From rhetoric to clinical reality1. *Alcoholism Treatment Quarterly*, *3/4*, 107-130.

Author Biographies

Uwe Flick is professor for qualitative social and educational research at the Free University of Berlin. He worked at the Alice Salomon University in Berlin in the fields of health services research earlier, which is still his major area of research with a focus on vulnerability and service utilization. He is author or editor of numerous textbooks and handbooks, most of which have been translated in several languages in Europe, Latin America, and Asia. Books include *An Introduction to Qualitative Research* (5th ed., 2014, SAGE), *The SAGE Handbook of Qualitative Data Analysis* (2014, SAGE), *Introducing Research Methodology—A Beginners' Guide to Doing a Research Project* (2011, SAGE), and *the Qualitative Research Kit* (2007, 8 volumes, SAGE).

Gundula Röhnsch works at the Alice Salomon University in Berlin, Germany, in a project focused on service utilization of Russian-speaking migrants with alcohol and drug problems in Germany. Before that, she worked in a number of research projects focused on chronic illness of homeless adolescents and sleeping problems in nursing homes.