

Perspectives on Quality of Life Among Older Asian Indian Immigrants in USA

Shaju N. George, Y. S. Siddegowda

Abstract: *United States being a multi-cultural and multi-ethnic society, ongoing efforts are made to understand various groups and communities for various purposes. Older Asian Indian Americans are also one such group who needs attention whose potential to function at various capacities can contribute to better knowledge about this group, Improving quality of life as a point of interest for older Asian Indians in the United States, can help when considering programs and services for such population. in order to improve their quality of life.*

Keywords: *multi-cultural and multi-ethnic society, United States, Older Asian.*

I. INTRODUCTION

Drawing primarily from the behavioral sciences, quality of life among older people primarily refers to health and their ability to function. It is a multidimensional concept that encompasses physical, social, psychological, economic, and cultural or environmental dimensions that influence the perception of an individual's well being (Abeles, 1993). According to World Health Organization (WHO), health is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1946).

The domains of health-related quality of life take into consideration physical health functioning, psychological health, cognitive and sexual functioning, social role performance and work productivity, and life satisfaction (Stewart & Ware, 1992). Considering the given definition of health in relation to functional ability as a major contributing factor in determining quality of life in old age, this paper will focus on functional elements that older Indian Americans consider important in living their day to day lives. Unlike the small number of Asian Indian immigrants in USA which include people from various states of India who came to the United States as professionals in 1960s and earlier who settled in different parts of the country and farm laborers from Punjab who settled primarily in the west, those immigrants of 1990s who came under the family reunification act reveal considerable variation along the dimension of education, occupation, class and gender experience (Abraham, 2000). Consequently, the family reunification act facilitated chain migration of families consisting of children, parents, and relatives of immigrants to the United States who were less educated than the previous wave of immigrants. It is possible that many of the new immigrants relied on their family members and relatives who sponsored them to immigrate into this country for assistance.

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For these immigrants their traditional values and culture emphasize reliance on self and family for assistance and not on public welfare system. Most Asian Indian households follow a hierarchical family structure and oriented towards Hindu-Muslim family traditions (Brown, 1986; Ashcraft, 1986). Often the head of the household is the oldest male member who makes major decisions pertaining to the family. Communication usually follows from the head of the household to the rest of the family members. Children are expected to obey their parents until they are married and moved out to be on their own. Family members and relatives generally arrange marriages. According to Ashcraft (1986), "the inextricable embeddedness of Asian- Indians in an extended family dominated life-style distinguishes them from the more individual-oriented European-American pattern and as such requires a different professional response" (p.55).

Based on the historical times of the arrival of older Asian Indian Americans to this country, one must take note of the substantial differences in the life experiences and current situation of older Asian Indian Americans between and within various Asian American ethnic groups. A likely confusion when referring to Asian Indians in literature is that earlier classification of Asian Indians in the US census was grouped under the category of 'Asians', 'Other' or 'Southeast Asians' or 'Asian and Pacific Islander' or 'South Asians'. What may be very close to describing Asian Indians is South Asians although there are major differences among South Asian population who are from Nepal, Bhutan, Pakistan, Bangladesh, Sri Lanka and India. Many Asian Indians have also migrated to United States from other countries such as South Africa, Guyana, Fiji, Kenya, Tanzania, United Kingdom, Mauritius, Trinidad, and Tobago (Wikipedia, 2007). Given the diversity of this population, it is likely that their functional ability in terms of what they are able to do and what is predictable can be varied according to different categorizations.

II. DEFINING QUALITY OF LIFE

Quality of life at every age is influenced by social, psychological, and economic factors. However, it is also important to keep in mind that what is less important to a younger person may be a critical factor in old age in maintaining integrity, independence, and autonomy. Quality of life is a widely used term by clinicians and researchers, yet because of the popular meaning attached to it, there is some source of confusion about it. Quality in its purest form implies subjective rating by individuals. These subjective evaluations can be life in general or of various psychosocial components including work and economic aspects.



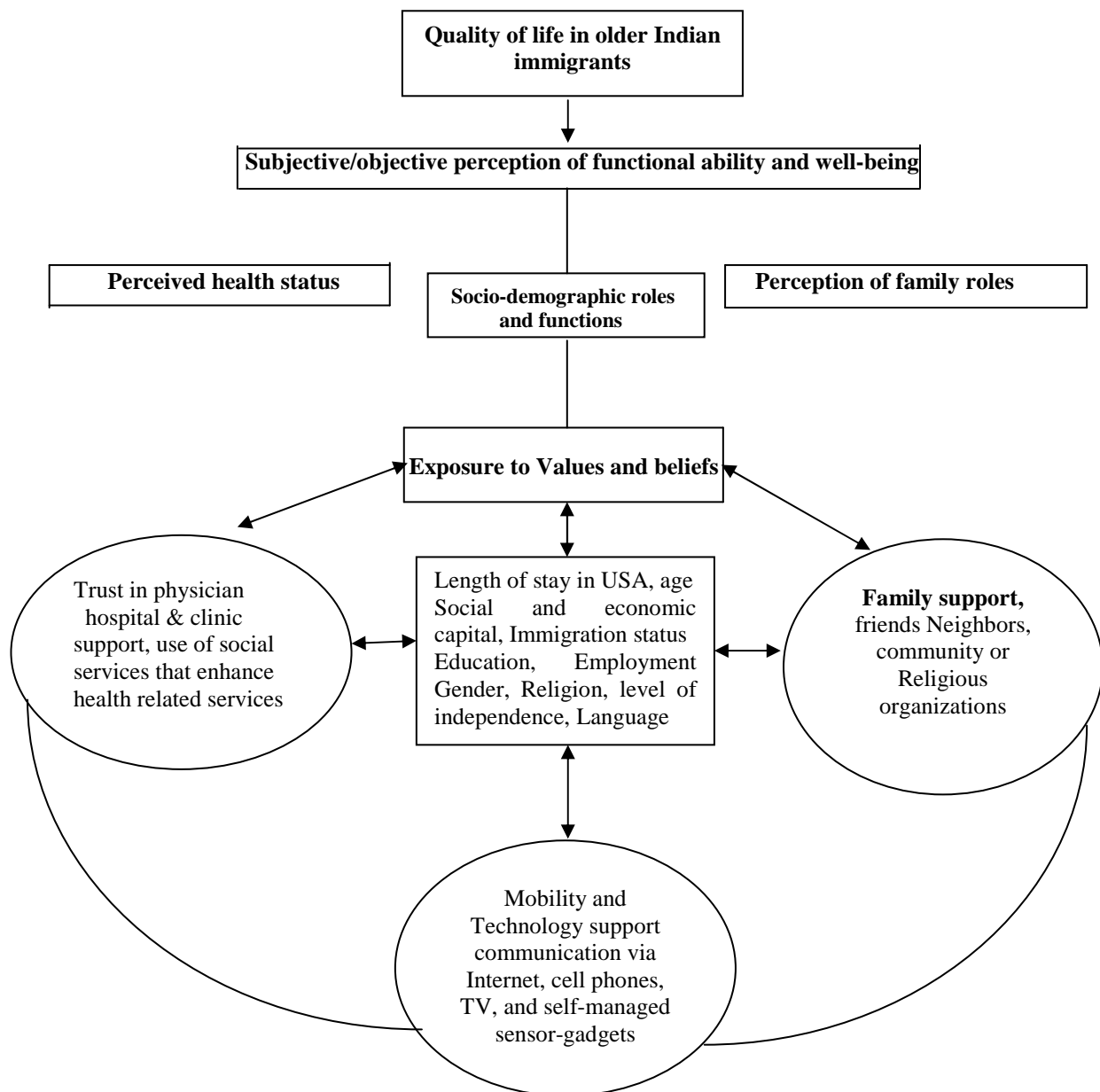
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Because subjective evaluations are difficult to observe, investigators try to infer ratings from observable 'objective' aspects of life. For example, we may infer that a person on wheel chair with some disease, having low income with limited mobility have poor overall quality of life. Such inferences can be risky because subjective quality or well-being from external circumstances does not take fully into account the values, needs, and adaptability of individuals to various life circumstances (Flanagan, 1982). Majority of

older Indian Americans are first generation immigrants who arrived late in their age and who face multiple cultural and social dilemmas related to health, spirituality, family life, and retirement. Taking quality of life as a construct stemming from overall life satisfaction and total well being in the socio-environmental context, older Indian Americans have to confront many decisions in retirement. The following chart will provide an outline in exploring the functional dimensionality of this group.

A. Research Dimension



B. Who are Asian Indian Americans?

Asian Indian Americans are very diverse in their age, education, religion, language, culture, and income levels (Barnes and Bennet, 2002). It has been further noted that Indian Americans are the most rapidly growing older ethnic group in the United States (Kalvar, 1998). Out of the total 281 million U. S. populations, the Indian American population make up one of the largest Asianethnic groups after the Chinese, and comprises 1.9 million people (Doorenbos, 2003). In general, Asian Indian Americans are

a diverse group whose culture, customs, and religious practices are based in Hindu-Muslim tradition and embrace values and beliefs rooted in a collective system of family life.

III. LITERATURE REVIEW

A. What is known about Asian Indian Immigrants?

Most studies on Indian Americans in USA have been done on young adults, and children. Although several descriptive studies have been done on Asian Indian population in USA with regard to customs, culture, and family traditions, very limited studies have been carried out on older Asian Indian immigrants in USA. The likely reason is that it is still an emerging new group beginning to appear in significant numbers on the Census sheet. Researchers have identified several facilitators and barriers such as family care giving, financial, transportation, cultural sensitivity, poverty, education and language as variables influencing health needs. (Aten, Siegel, & Roghmann, 1996; Davis, Gergen, & Moore, 1997).

The National Hospice and Palliative Care Organization points out three reasons in reference to inadequate use of health services by ethnic groups. Recognizing this gap, Doorenbos (2003) was prompted to undertake a study on Hospice access for Asian Indian immigrants. Out of the three reasons namely, absence of information about hospice, lack of financial resources, and cultural differences, the descriptive correlation study shows that most of the Asian Indian immigrants have limited or no knowledge of hospice services. Financial resource is not a barrier to hospice use. An important finding in the study is that cultural differences related to death and dying rituals are misunderstood by hospice staff. It is also noted that although cultural differences on end-of-life issues are well recognized, minimal information exists regarding death and dying cultural practices among Asian Indian immigrants, and 83 percent of them are of the Hindu religion. From the health service provider perspectives, majority of US health providers who are familiar with Judeo-Christian traditions may find Hindu traditions and cultural practices very alien to them and unable to adequately provide activities geared towards meeting culturally sensitive needs.

Two reports, one from Canada and the other from United States show contrasting findings with regard to variations in the use of health services by ethnic minority groups.

The study carried out in Canada on "Variations in health services utilization among ethnic population" concluded that there was no difference in the use of general physician and specialist services between white people and members of visible minorities but less use of cancer screening and hospitalization by the latter group (Quan, Fong, De Coster, Wang, Musto, Noseworthy, and Ghali, 2006). This study contrast the findings reported by Zhan (2003) who says that Asian and Pacific Islander Americans underutilize U.S. health services. Most studies on ethnic minorities in the United States are consistent with the findings of Zhan.

Ponterotto, Joseph, Baluch, and Suraiya (1998) refer to the Suinn-Lew Asian self-identity acculturation scale which is a leading Asian American multidimensional acculturation scale, pointing out the positive relationship between acculturation and preference for friends and peers in place of religious leaders and community leaders. The implications of the study outcome need further exploration as there are anecdotal evidences showing large proportion of people

seeking religious activities to meet their psychosocial needs including spiritual desires. It is possible that these people seek out such activities where they can socialize with peers and friends as well as fulfill some of their ethnic and cultural identity needs. The importance of such mode of community participation may mean continuity with the past and being in touch with the ancestral culture and tradition that may have lasting implications in the maintenance of good mental health.

B. What is Not known About Older Asian Indian Immigrants?

Empirical and qualitative studies are limited on older Indian Americans. Most studies focus on acculturation factors, culture and traditions, identity aspects, child rearing practices, and family relationship roles. Although these are related areas in defining quality of life, they have very little relevance to specific activities older Indian Americans engage in on a day to day basis and the psychological, and social meaning attached to them. There is no literature on gender role differences and how care-giving impacts quality of life for this ethnic group. Similarly there is no documented evidence of participation in senior center services for this group as a way enhancing quality of life. Anecdotal reports indicate that older Indian Americans find such programs not fitting well with their needs due to language and cultural barriers and the lack of established familiar interpersonal relationship. Asian Indians tend to use interpersonal relationship encounters as a means of sharing confidential and intimate relationship matters. Literature do not address how older Indian Americans meet their spiritual needs in old age because retirement traditionally is considered a period when people spend longer hours with God and their grand children. Literature does not address the needs of disabled older individuals whose spouses have to accompany their partners for medical visits or other errands. If the care giving spouse is a female person, she is often culturally limited and inadequately equipped to handle her own needs as well as the needs of her disabled spouse. There is not enough evidence in literature showing how the less acculturated and the more acculturated older individuals who immigrated at different periods meet their social relationship needs. Answers to these issues cannot be obtained with one or two questions. They need leading questions that address their values, beliefs, spiritual and cultural needs that may provide clues to answering them.

Theories on cultural capital, acculturation, motivation, and self efficacy may provide relevant insight into how individuals relate to themselves in their changing environment by engaging in different meaningful activities and whether their adaptation to the new environment is meaningful, purposeful, and healthy or unhealthy.

IV. SUGGESTIONS AND RECOMMENDATIONS FOR FUTURE

- Quality enhancement can be achieved through individual motivation in an environment of hope and satisfying life experience.



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The cultural capital of every individual may be activated when external support is conducive to promoting the goals and aspirations of that individual. A therapeutic environment where group support can facilitate hope for the future especially among older people is necessary to sustain a balanced outlook. Social workers can promote such environment through group therapy and various other spiritually and culturally enhancing milieus.

- Most studies on Indians are grouped under the classification of South Asians. The Asian Indian Immigrant community being a multi-ethnic cultural group in large numbers, efforts need to be made to allow for the community to stand alone as a separate ethnic group apart from all South Asian group in order to capture its uniqueness. In the era of technology, such an attempt is feasible and policies have to be put in place for all countries to render their unique contributions.
- Majority of the immigrants, other than dependent children and dependent older adults who are unemployable moved to USA looking for economic opportunity. Learning new language, acclimatizing to new culture, new technology, settling in a new dwelling, and understanding government regulations bring additional stressors along with the benefits of all the opportunities the new country has to offer. Financial planning and thoughtful consideration of health and well-being need to address long range goals to alleviate undue financial and health burdens in older years both for themselves as well as for their family members. A coordinated effort by health providers, financial planners, legal counsel, and service providers in early adulthood may make immigrants eligible for qualifying financial and health care provisions at various stages in life. United States being a country where immigrants from various nations work and live together, it is worth the effort for the US government to make provisions for orientation to US history and the democratic process at an early stage of immigration rather than waiting for citizenship. While immigration being a privilege, all immigrants can be encouraged to be active participants in the democratic functioning of the society and in the field of volunteerism.
- Social net-working among immigrants can encourage employment opportunities and in some situation ethnically homogenous work environment has created positive outcomes both for the employer as well as employees (Waters and Waldinger, 1990).

5. Brown, R. H. (1986). Self and polity in India and the United States: some philosophical reflections and field observations. In V. H. Sutlive, N. Altshuler, M. D. Zaora, and V. Kerns (Eds.),
6. Tradition and transformation: Asian Indians in America. Library of Congress, USA.
7. Davis, H., Gergen, P.J., and Moore, R. M. (1997). Geographic differences in mortality in young children with sickle-cell disease in the United States. Public Health Reports, 112, 52-58.
8. Doorenbos, A. (2003). Hospice access for Asian Indian Immigrants. Journal of Hospice and Palliative Nursing, Vol. 5, No. 1
9. Flanagan, J.C. (1982). Measurement of quality of life: current state of the art, Vol.63, 2. Archives of Physical Medicine and Rehabilitation.
10. Kalvar, J. M. (1998). The Asian Indian elderly in America. New York: Garland Publishing.
11. Ponterotto, Joseph G., Baluch, Suraiya, et al (1998). The Suinn-Lew Asian self-identity cculturation scale (SL-ASIA): critique and research recommendation. Measurement & Evaluation in Counseling & Development, July 1998, Vol.32 Issue 2, p 109.
12. Quan, H., Fong, A., De Coster, C., Wang, J., Musto, R., Noseworthy, T. W., and Ghali, W. A. (2006). Variation in health services utilization among ethnic populations. William, W. (2004). Addressing cultural issues in TB prevention program.
13. Stewart, L. A and Ware, E.J. (1992). Measuring functioning and well-being: the medical outcomes study approach, Duke University Press.
14. US Census 2000. The Asian Population: 2000. US Census Bureau. Wikipedia (2007) [Wikimedia Foundation, Inc.](https://www.wikimedia.org/), a US-registered [501\(c\)\(3\) tax-deductible non-profit charity](https://www.wikimedia.org/wiki/501(c)(3)_tax-deductible_nonprofit_charity).
15. World health organization (WHO). 1946. Official Records of the World health organization, No. 2, P.100, New York
16. Zhan, L. (2003). Asian Americans: vulnerable population, Model Interventions, and Clarifying Agendas (pp. 283- 316). University of Massachusetts. Jones and Bartlette Publishers.

REFERENCES

1. Abraham, M. (2000). Speaking the unspeakable: Marital violence among South Asian immigrants in the United States. Rutgers University press. New Brunswick, New jersey.
2. Ashcraft, N. (1986). The clash of traditions: Asian-Indian immigrants in crisis. In V.H. Sutlive, N. Altshuler, M.D. Zamora, and V. Kerns (Eds.) Tradition and Transformation: Asian Indians in America. Studies in Third World Societies. USA.
3. Aten, M.J., Siegal, D. M. and Roghman, K. J. (1996). Use of health services by urban behavior. Journal of Adolescent Health, 19, 258-266
4. Barnes, J.S. and Bennet, C.E. (2002). The Asian Population: 2000. Washington, DC: US Census Bureau.